

Substance Abuse Treatment for Women Offenders

Guide to Promising Practices

Technical Assistance Publication Series

23

Patricia A. Kassebaum

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

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Foreword

Over the past two decades, we have gained considerable new knowledge about women and addiction—about why women become addicted and how these women can be helped to overcome their addiction and the related problems in which addiction is frequently embedded. For many addicted women offenders, their substance abuse is coincident with poverty and multiple psychosocial problems, including mental illness, a history of trauma and abuse, and involvement in abusive relationships. Today, substance-abusing women are entering the jails and prisons of our Nation at unprecedented rates. Yet little research has been done to demonstrate what works best to habilitate and heal addicted women offenders in the criminal justice system.

Services for women offenders are fragmented or absent all across the country, and funds are scarce for developing the comprehensive networks of community service that women need. Yet there is great interest in improving services for women. Many new programs to treat women have been started or are planned in correctional systems across the country. Communications, cooperative planning,

the use of peers, volunteers, and mentors, and other creative strategies need not be expensive and can be effective ways to fill the service gaps. This *Guide* describes many such promising and creative strategies.

In an effort to develop and assess programming for women offenders, the Center for Substance Abuse Treatment (CSAT) is funding a series of treatment programs for women in prisons and jails. Evaluation results from these projects are just beginning to emerge, but already much has been learned. This report shares the knowledge being gained from nine selected women's programs—four in State prisons and five in jails or detention centers. All are serving women who have severe substance abuse problems, often of long duration. These programs include long- and mid-term residential therapeutic communities (TCs), a prison 4-hours-per-day treatment program, and two intensive short-term (2-week) programs that focus on motivating both sentenced and pre-sentenced women into treatment.

This report is intended for professionals from a wide range of disciplines who work with women involved in some aspect of the criminal justice system. The substance abuse counselors and

treatment professionals who work in either the community treatment or corrections fields come from a variety of backgrounds that may include social work, psychology, and psychiatry. Corrections professionals may include sheriffs, wardens, probation and parole officers, and others. This *Guide* will also be helpful for State and community-level policymakers who plan and fund substance abuse and corrections programs.

We hope this information—coming from the published literature, an expert advisory panel, the CSAT grant project staffs, CSAT professional staff, and from program documents—will offer helpful guidelines and ideas for designing promising programs to help addicted women in the criminal justice system. Some of the most promising practices include:

- Building a treatment approach that is rooted in an understanding about how women grow and develop, and about how these social and developmental factors affect addiction.
- Using sanctions in creative and reasonable ways that will reinforce treatment goals and engage women in treatment for the necessary length of time.

- Assessing each woman's needs in a comprehensive, yet flexible, manner so that needs are matched to the intensity and length of care required.
- Providing continuity of care, from the pre-sentencing period through in-custody treatment to continuing treatment and support during the months following release, so that women have an opportunity to develop

the skills and resources to survive and contribute to their communities.

- Ensuring that women receive the housing and other services that they need so desperately in the early post-release period, to help them avoid both relapse and recidivism.

As a final note, this report is not intended to be a complete guide or handbook for setting up

new programs. It is instead intended to offer women-specific concepts and strategies—a planning framework—for those in the corrections and treatment fields who want to design comprehensive services for women offenders. The resources listed may assist planners to identify more in-depth information.

Eric B. Broderick, D.D.S., M.P.H.

Acting Administrator

Substance Abuse and Mental Health Services Administration

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM

Director

Center for Substance Abuse Treatment

Advisory Panel Members

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Gwen Empson
Program Director
WCI Village
New Castle, Delaware

Matonia L. Harris
Treatment Manager
Sister Project-Walden House, Inc.
Sister Project/Sheriff's Department
San Francisco, California

Maxine Harris, Ph.D.
Co-Director
Community Correction
Washington, D.C.

Mary E. McCaul, Ph.D.
Comprehensive Women's Center
Baltimore, Maryland

Anne McDiarmid
Dakota County Community Corrections
Hastings, Minnesota

Elizabeth Peyton
Director
Treatment Access Center
Wilmington, Delaware

Bonita Veysey, Ph.D.
Women's Program Director
The National GAINS Center
Delmar, New York

Part I

Setting the Stage for Treatment

Chapter 1—Women Offenders and Addiction: Research Findings

How best to treat women in our prisons and jails is a new and significant concern for U.S. policymakers. The number of women incarcerated in the United States—once a minuscule number—tripled in the 1980s alone. In the 15 years from 1980 to mid-1995, the number of women incarcerated in U.S. prisons rose by 460 percent, compared to an increase of 241 percent for men (BJS 1995*b*). The same pattern appears with the jail population. More than three times as many women were in jail in mid-1997 as in mid-1985 (BJS 1998*a*). On average, the number of women in jail has grown by 10 percent each year from mid-1985 to 1997 (BJS 1998*a*). These figures represent high present and future costs for these women—both in terms of separation from their families and children and in their inability to contribute economically to U.S. society.

Most of the women entering our criminal justice system are young—under 40 years old—and 8 of every 10 are parents. New findings show that up to 80 percent of the women offenders in some State prison systems now have severe, long-standing substance abuse problems. In 1986,

Congress significantly increased the penalties associated with crack cocaine. With the setting of mandatory minimum sentences and “three strikes and you’re out” laws, many women are now being incarcerated who would previously have remained in their communities under criminal justice supervision.

Many of these women are arrested for drug offenses and crimes committed to support their drug habits, in particular theft and prostitution. The drug-dependent women being drawn into U.S. jails and prisons suffer from the multiple risk factors that complicate substance abuse in women—factors of poverty, psychosocial problems, mental illness, histories of trauma and abuse, and involvement in abusive relationships. Many were sexually abused as children.

Approach of the Center for Substance Abuse Treatment

The Center for Substance Abuse Treatment (CSAT) is convinced that these addicted women can be helped through comprehensive programs designed specifi-

cally for women, treating the factors associated with women’s substance abuse. Evidence shows that effective treatment programming does empower these addicted women offenders to overcome their substance abuse, to lead a crime-free life, and to become productive citizens. Effective women-centered treatment—whether in a prison or community setting—benefits a woman and her children and represents a small investment but enormous savings for U.S. society. It costs considerably less to treat a woman than to build a jail cell to incarcerate her or to pay for a foster care placement for her child. Treatment is likely to offer long-term positive outcomes for the woman, reducing both her addiction and her criminal activity.

CSAT supports the concept that drug-dependent women should have access to—and be strongly encouraged to receive—comprehensive drug abuse treatment. That treatment should be available in the most appropriate location for the woman, whether that location is in prison, jail, or in a community setting with ongoing supervision. Whenever possible, treatment should be provided in the community, so that the woman’s family can remain intact

and the woman has the chance to become sober and drug-free under real-life conditions.

CSAT is supporting a number of women's programs in prisons and jails, as well as community corrections treatment networks, based on this comprehensive approach to treating women. CSAT encourages all correctional systems, in States and local com-

munities, to adopt this comprehensive approach for women in their jurisdictions. CSAT believes the following reasons are compelling.

The increasing incarceration of women offenders has had a particularly grave impact on poor women of color.

native community sanctions for women (Owen and Bloom 1995). Even with the large increase in incarcerated women, the total number of women prisoners is not large compared to men. The numbers of incarcerated women total more than 78,000 in prison and 59,000 in jail (BJS 1998a).

According to Drug Use Forecasting (DUF) data, more

than half of women in 20 of 21 cities test positive for illicit drugs at the time of their arrests. The most common drug used by women is cocaine. In 12 cities, more than three-quarters of women arrestees test positive for illicit drugs (NIJ 1997) and, in most cities, a higher percentage of women than men test positive for multiple drugs. Recent State studies show very high percentages of woman offenders who have drug problems or are in the criminal justice system for crimes related to their substance abuse.

Minority women are being disproportionately affected. The increasing incarceration of women offenders has had a particularly grave impact on poor women of color. By 1994, the proportion of African American females incarcerated in the United States was seven times higher than for white females. The rising use of crack cocaine among minority women in poverty appears to be a major factor. During the last decade, the number of African American inmates in State, Federal, and local jails and prisons has grown at a faster pace than for non-minority inmates. The number of black (non-Hispanic) women incarcerated for drug offenses in State prisons increased by 828 percent from 1986 to 1991 (Mauer and Huling 1995).

Without treatment, incarceration becomes a "revolving door" for substance-abusing women. Addicted women offenders need substance abuse treatment in order to begin their recovery process and then to maintain abstinence. Addicted women who have not received appropriate treatment end up back on drugs and incarcerated because they are unable to stay "clean" (drug-free) and sober. These women then cannot meet the terms of their probation or they commit new crimes to support their habits.

Probation violators are a rapidly growing segment of the prison population. In Delaware in 1993, probation violators made up 23 percent of all prison admissions.

Reason 1: Substance abuse is driving the explosion of incarcerated women into prisons and jails.

Women offenders have traditionally represented a small proportion of the total offender population. But over the past decade, the number of incarcerated women has dramatically increased, expanding at rates far higher than for males. The number of women in jails rose from 15,900 in 1983 to 51,600 in 1996—a 9.5 percent increase per year; women now account for more than 10 percent of the inmates in U.S. jails (BJS 1998b).

This surge of women into jails and prisons has been correlated with the legal system's increasingly punitive response to drug-related behavior, and with the lack of viable treatment and alter-

• In Massachusetts, the Massachusetts Committee on Criminal Justice estimated that 90 percent of women prisoners in 1993 had alcohol or drug problems.

• In New Jersey, 85 percent of women offenders are in the correctional system for drug-related offenses—78 percent for drug-related crimes and an additional 7 percent for selling drugs for profit (Gonzalez 1996).

• In Iowa, 61 percent of the female prison population is

Based on standardized screening criteria, more than 70 percent of these violators were found to need residential substance abuse treatment—the most intensive level of treatment (Peyton 1994). Among New Jersey women offenders, 63 percent of those incarcerated for violating probation had been imprisoned originally for a drug offense.

Reason 2: Substance-abusing women involved with the criminal justice system have alcohol and other drug (AOD) problems that are severe and chronic.

Several measures show that women offenders are more likely than male offenders to use drugs, they use more serious drugs than male offenders, and they use them more frequently. Women are more likely than men to be under the influence of drugs at the time of their crimes (Bureau of Justice Statistics [BJS] 1992; National Institute of Justice [NIJ] 1991, NIJ 1997).

A number of States are now using standardized instruments to screen all offenders in their correctional systems for AOD problems. These assessments show that the substance abuse problems of incarcerated women are chronic and severe, indicating the need for comprehensive, intensive treatment. Examples of State findings include:

- *Delaware*: Among incarcerated women in prison, 26 percent meet the screening criteria for long-term residential treatment (compared to 12 percent of men). An additional 44 percent of women meet the criteria for

short-term residential treatment, and 7 percent need intensive outpatient treatment. Only 9 percent of Delaware's incarcerated women need no treatment (Peyton 1994, p.12).

- *Illinois*: Among women inmates who report a dependence on any drug within the prior year, 86 percent meet screening criteria for residential rehabilitation (a severe level of dependency), 11 percent need intensive outpatient treatment (a moderate level of dependency), and 3 percent require outpatient treatment for a mild level of dependency (Illinois Criminal Justice State Plan 1995).

The Illinois Department of Corrections finds that women enter prison at a more advanced and severe stage of drug abuse than men. Addicted women offenders therefore need longer treatment. Women who stay in

drop out can be assumed to be less motivated to change their behavior than the women who stay.

Reason 3: Women offenders suffer from a constellation of high-risk factors associated with both substance abuse and relapse.

Women prisoners in the United States have many similar characteristics across the country, according to national surveys conducted by the Bureau of Justice Statistics (BJS 1992, 1994, 1995a) and the American Correctional Association (ACA 1990). For the high proportion of women with severe substance abuse problems, substance abuse complicates and exacerbates other problem areas, such as family problems, lack of economic self-sufficiency, physical and sexual abuse, and the inability to

... women enter prison at a more advanced and severe stage of drug abuse than men.

Illinois' in-custody treatment program for at least 90 days are less likely to recidivate than those in treatment for shorter times. Further, women who complete the treatment program are even less likely to recidivate (Illinois Criminal Justice State Plan 1995, p. E-4). These Illinois findings underscore the importance for programs to motivate women into treatment. Women often "self-select" their length of stay in treatment, since treatment is generally voluntary. Women who

cope with caring for children. To help women recover and prevent relapse, treatment needs to help women address all these issues.

The women experience a host of psychosocial and medical problems, including physical and sexual abuse and victimization. Imprisoned women come mainly from poverty. Female prisoners have very low incomes, are disproportionately from minority groups, such as African American and Hispanic, tend to be undereducated and unskilled, and

have sporadic employment histories. Imprisoned women are mostly young, single heads of households. More than three-quarters of all women in prison have children, and two-thirds of the women have children under the age of 18 (BJS 1994). Women prisoners also have a host of medical, psychological, and financial problems and needs (Owen and Bloom 1995).

Mental health problems are common. Among women in jail nationally, more than one in three inmates reports having received treatment for a mental or emotional problem other than drug or alcohol abuse. Approximately 1 in 4 female inmates has received counseling, 1 in 4 has taken medication prescribed for mental or emotional problems, and 3 in 20 women have been admitted to a mental health facility and stayed at least overnight (BJS 1998b).

More than 80 percent of female jail detainees suffer from one or more lifetime psychiatric disorders, according to a random study of nearly 1,300 detainees awaiting trial at the Cook County jail (Teplin et al. 1996). This study, one of the first to survey mental health problems of women inmates, found that major depression and substance abuse were the most common problems. More than 70 percent of those surveyed were dependent on drugs or alcohol or both. In addition, one-third (34 percent) were suffering from post-traumatic stress disorder (PTSD)—a common aftermath of physical and sexual abuse or rape. The rates of PTSD did not vary by age, race, or education. Almost

one-fifth (17 percent) had experienced a major depressive episode, with 14 percent having a depressive episode in the 6 months before arrest.

Blatant as these figures are, the researchers felt they may be low because of underreporting of drug abuse, their inability to interview some severely disturbed women, and the fact that some women found their traumatic event(s) too upsetting to discuss (Teplin et al. 1996). The researchers point out that, in practice, few jails currently have the budget to treat the mental disorders of the growing female population. In this Chicago study, 80 percent of the women with major depressive episode and 41 percent of those with drug and alcohol abuse/dependence were arrested on nonviolent misdemeanor charges. These women, as well as nonviolent felons, could be treated outside the jail after pretrial hearings, if a community-based program were available to treat released jail detainees, with their often complicated diagnostic profiles and special treatment needs (Abram and Teplin 1991; Teplin 1984).

Similar findings emerged in the Women Inmates' Health Survey (WIHS), the first large-scale epidemiologic study of women prison inmates in the United States, which was conducted by the Research Triangle Institute. Using DSM-III-R criteria, the WIHS interviewed virtually all of the 805 women felons entering North Carolina prisons over a 17-month period. Compared with women in community epidemiology studies, the women inmates had high rates of

substance abuse and dependence, of antisocial and borderline personality disorders, and somewhat higher rates for mood disorders. The highest lifetime prevalence rates were for drug abuse and dependence (44 percent), alcohol abuse and dependence (39 percent) and major depressive episode (13 percent) (Jordan et al. 1996). Only 11 percent of the women were incarcerated for a violent offense.

Inmate profiles show multiple problems. A profile of the typical woman prisoner, compiled by the New Jersey Department of Corrections, highlights the intensity of the problems these women face (Gonzalez 1996). The profile is based on screening of all women offenders with the Addiction Severity Index (ASI)—a widely used, validated instrument for assessing addiction and associated problems. In New Jersey (where 85 percent of women offenders are incarcerated for an offense related to their drug use), the typical woman offender:

- Is approximately 30 years old and is incarcerated for a drug-related crime or selling drugs for profit.
- Spends approximately \$1,000 per week to support her addiction. She has been addicted an average of 9 years. She is likely to have used cocaine or heroin on a daily basis (70 percent of those using drugs report daily use, with 23 percent using drugs more than three times a day). The typical woman offender also uses alcohol in conjunction with other drugs.
- Has worked at primarily unskilled or semiskilled labor

for minimal wages. When working, she has not exceeded 24 months of consistent employment at any one job.

- Failed to complete high school or complete any type of technical trades education.
- Is a single head of household with minor, dependent children.
- Has experienced emotional, physical, or sexual abuse.
- Is likely to have grown up in a home with an alcohol- or drug-abusing adult (43 percent lived with an alcoholic relative and 45 percent lived with a drug-abusing relative).

Reason 4: Women offenders require specialized, women-specific substance abuse treatment.

Women offenders need specialized treatment for their substance dependency. Traditional substance abuse treatment models were originally designed for men; they address alcohol and drug addiction from a male perspective. Women's substance abuse is different. Addiction tends to occur more rapidly for women than for men, to involve more than one mood-altering substance, and to produce serious medical consequences over a briefer period of time. Women are more likely than men to have co-morbid psychiatric disorders.

Typically, women offenders with substance abuse problems have been victims of violence—physical abuse, domestic violence, and rape. On the basis of compiled studies, Mondanaro et al. (1982) conclude that 46 percent of all drug-dependent

women have been victims of rape and from 28 to 44 percent have been victims of incest. Evidence suggests that these figures are even higher among incarcerated women. For example, a study in California prisons showed that nearly 80 percent of women inmates have experienced some form of abuse, including:

- *Physical abuse*: 29 percent report being physically abused as children and 60 percent as adults

Women offenders need specialized treatment for their substance dependency.

- *Sexual abuse*: 31 percent report being sexually abused as a child, including incest, and 23 percent as adults

- *Emotional abuse*: 40 percent report emotional abuse as a child and 48 percent as an adult (Bloom et al. 1994).

The psychological impact of this violence includes depression, post-traumatic stress disorder, and low self-esteem. The study of pretrial detainees in Chicago's Cook County jail showed that one-third, a "striking" percent, had post-traumatic stress disorder (PTSD)—with most of these women being the victims of rape or other violent assault (Teplin et al. 1996). In the study of convicted female felons entering prison in North Carolina, 30 percent of the women reported having experienced both a traumatic event and six or more PTSD symptoms in the past 6 months (Jordan et al. 1996). The CSAT prison and jail grantees report that up to 90 percent of women

in their programs have been physically or sexually abused, and that these addicted women offenders feel powerless and victimized.

By the mid-1970s, women's treatment experts had begun calling for treatment programs designed to address women-specific issues—those issues directly related to women's substance abuse. Odyssey House—one of the first treatment centers to offer

programs for addicted women and their children—described the situation:

Addicted women—especially those with children—face a unique set of problems which in the past have precluded successful treatment outcomes: a male-model approach to therapy; programs with inadequate knowledge, capacity, and resources to meet the special needs of women; the chronic medical and complex psychosocial problems unique to women; and the pressure of dependent children (Kandall 1996, p. 207).

Today's treatment programs for women offenders can be designed to address the special needs of these addicted, impoverished, and undereducated women. New women-specific programs are designed to empower the woman and help her learn to trust and bond with other women for support. When

possible, there is an effort to strengthen the woman's relationships with her children and to reunify her family.

The new approaches also help women offenders develop the coping and life skills they need to build a productive and self-sufficient future. These skills extend to many needed areas—to parenting, controlling anger and stress, learning to identify personal cues of relapse, and managing a budget. And the programs try to prepare a woman, through education, vocational tests, and nonstereotyped job training, for a place in the labor market.

Reason 5: Few appropriate treatment programs for women now exist within the criminal justice system.

Nationwide, there is a lack of comprehensive treatment services available for women offenders. Programs often accept women without offering specialized services for them. Relatively few treatment programs are geared to the special needs of women, fewer still accept women and their children, and even fewer treat pregnant women. Generally, the only services offered by 90 percent of prisons are drug education or mutual-help groups, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Unfortunately, these programs by themselves do not provide the kind of intensive, comprehensive substance abuse treatment and medical attention that many women need to overcome addiction.

An American Jail Association survey in 1992 of 1,737 jails, with 57 percent responding, revealed that only 28 percent of the

Nation's jails offer drug abuse programs for men and women offenders, including 12-Step volunteer groups; only 19 percent fund drug treatment programs. More than 80 percent of programs operate with a volunteer staff (Peters et al. 1992). A 1989 BJS study of women in jails (BJS 1992) found that

- 42 percent of women reported daily drug use, but only 11 percent were participating in drug programming.
- 13 percent of the women are self-reported alcoholics; 10 percent participated in alcohol programming.

Most prison and jail programs are not intense enough to meet the needs of women offenders who have severe and long-term substance abuse problems. Intensive residential rehabilitation—the form of treatment needed by most women offenders—is not widely available in correctional settings. In prisons nationwide, fewer than 9 percent of women offenders receive residential treatment (BJS 1994).

There is also a severe deficiency in comprehensive programming that includes family unification and parenting components. In a survey done by the Office for Treatment Improvement (OTI) in 1992, one-half of all State facilities reported a lack of mother/child programming, including playrooms and residential care. Another one-third of State facilities reported that their programming in parenting skills, relapse prevention, and sexuality was inadequate to meet the demand for services (OTI 1992).

A study of four California prisons for women showed existing prison programs are unable to

satisfy the demand for treatment from their women prisoners. Programs have long waiting lists that prevent many women from participating. Programs that address parenting or substance abuse have the longest waiting lists; up to 450 inmates are waiting to participate in these programs (Bloom et al. 1994).

The number of treatment programs for female drug-abusing offenders has been increasing. But because the numbers of drug-abusing women offenders keeps rising, the National Institute of Justice reports that the increased number of programs has not significantly reduced the gap between those needing and receiving services. In fact, the percentage of drug-abusing female offenders being served, relative to those in need, is probably no greater than in the late 1970s (NIJ 1994).

Reason 6: Most women offenders do not receive continuing care upon release into the community—a service essential for maintaining recovery and reducing recidivism.

Continuing care after offenders return to the community is recognized as one of the most critical needs for those with substance abuse problems (ONDCP 1992, p.71; NIJ 1991). However, a 1992 survey of State prisons found fewer than one-half of States provide this aftercare for women, with only one-third arranging for day treatment, transitional living services, or residential treatment in the community. In another survey of 336 women's programs in jails and prisons made in 1993, Prendergast et al. (1995) report

that continued care facilities are very limited in communities, serving only a fraction of the women who require aftercare. For example, the California Department of Corrections contracts with only one community-based program for incarcerated mothers and their young children. This program has a total statewide capacity of just 100 women and their children (Bloom et al. 1994, p.13).

Fewer than half of both jail and prison programs report that they make arrangements for transition services other than substance abuse treatment (Prendergast et al. 1995). These other needed transition services would include safe and sober housing, financial assistance, medical care, and case management.

Reason 7: Substance abuse treatment, especially a continuum of care, is effective in reducing AOD abuse and recidivism.

A large body of research demonstrates that treatment of their substance abuse reduces offenders' use of drugs and alcohol, and also reduces their recidivism. Women who relapse are about seven times as likely to have a new arrest as those who do not use drugs during the post-release period (Martin and Scarpitti 1993).

The Drug Abuse Treatment Outcome Study (DATOS), the most recent comprehensive national study on the effectiveness of community-based drug treatment in the United States, corroborates the findings of earlier large-scale research studies.

These studies are the Drug Abuse Reporting Program (DARP), which examined outcomes for clients entering treatment in 1969-74, and the Treatment Outcome Prospective Study (TOPS), which examined outcomes for clients treated in 1979-81. All three studies—DARP, TOPS, and DATOS—demonstrate that drug treatment works to produce positive changes in both drug use and criminal activity (Simpson 1984; Hubbard et al. 1989; Hubbard et al. 1997).

DATOS assesses the outcomes of clients treated during 1991-1993 in 96 community-based

cent decline in heavy drinkers, a 61 percent decline in illegal activity, a drop from 77 to 35 percent in those jailed in the year before versus after treatment, a decrease in those with any arrests from 56 to 31 percent, and a decline of 46 percent in suicidal thinking.

- *Outpatient drug-free treatment, with 42 percent of clients referred by the criminal justice system.* Clients showed a 57 percent drop in the number of weekly cocaine users, a 64 percent reduction in weekly marijuana users, a 52 percent decline in heavy drinkers, a 36

... treatment of their substance abuse reduces offenders' use of drugs and alcohol, and also reduces their recidivism.

treatment programs in 11 major cities. The DATOS study followed up 3,000 randomly selected clients at 1 year after treatment. These clients, treated in four different treatment modalities, all showed large and significant improvements; their drug use, illegal activities, and psychological distress were each reduced on average about 50 percent (Hubbard et al. 1997). Clients improved regardless of the form of treatment. Findings for clients (34 percent of whom were women) in two common treatment modalities were:

- *Long-term residential treatment, with 35 percent of clients referred by the criminal justice system.* Clients showed a 67 percent drop in the number of weekly cocaine users, a 53 per-

cent decline in illegal activity, a drop from 69 to 25 percent in those jailed in the year before versus after treatment, a decrease in those with any arrests from 37 to 21 percent, and a decline of 42 percent in suicidal thinking (Hubbard et al. 1997).

As in the other national research studies, the DATOS study found that the length of time clients stayed in treatment was directly related to improvements in their follow-up outcomes (Hubbard et al. 1997). In both the residential and outpatient treatment, clients who stayed in treatment for 3 months or longer had significantly better outcomes regarding their drug use and illegal activity; posttreatment outcomes continued to

improve as time in treatment increased. The study found that programs varied widely in their ability to retain patients over time. Programs achieving longer treatment retention rates had better client-counselor relationships, provided a wider range of services, and showed a higher rate of client satisfaction with the program (Simpson et al. 1997).

For incarcerated offenders, the strongest, most consistent pattern of success comes when offenders receive a full continuum of treatment. This continuum starts with appropriate screening and treatment during custody and is followed by post-release treatment in the community (Lipton 1995). For those substance-abusing women offenders who do not need to be incarcerated, the continuum would begin after their screening, when the woman is assigned to enter either a community residential treatment facility or an intensive outpatient treatment program combined with supervision in the community.

Incarcerated women with severe substance abuse problems need intensive residential treatment programs, such as therapeutic communities (TCs). The effectiveness of prison TCs has been well documented. There have been four large-scale research evaluations of TC programs for offenders, three of which include women. These program evaluations all demonstrate the same consistent findings—that prison-based TCs can produce significant reductions in recidivism rates among chronic drug-abusing offenders; successful outcomes continue over time. Success is related to how long the

offender stays in treatment. For example, New York's Stay n' Out prison TC was effective in reducing recidivism rates, while prison counseling groups did not. Findings were:

- Among women who stayed in treatment less than 3 months, 79 percent had positive parole outcomes (compared to 40 percent positive outcomes for men)
- For women spending 9 to 12 months in treatment, 92 percent had favorable outcomes on parole (compared to 77 percent for men).

The Forever Free prison treatment program—one of the CSAT-supported women's projects described in this *Guide*—found this same type of pattern regarding continuum/time in treatment.

- Among graduates of the Forever Free program, more than two-thirds of those who voluntarily enter residential treatment in the community are successful on parole, compared to half of the graduates who enter community outpatient or no treatment (Prennergast et al. 1996).
- Of those recommitted to prison after receiving community treatment, more than two-thirds are returned for a technical violation rather than a new offense, compared to half of those who did not receive community residential treatment.
- Women who complete 5 months or more of residential treatment have better parole outcomes. The reported use of drugs in the past year is also much lower for women in the residential treatment group

than for others. It is important to note that these women could self-select to enter residential treatment after their release from prison. A woman's motivation to change her behavior is a significant factor in positive treatment outcomes.

Reason 8: Treating women while in custody benefits the woman, the institution, and society.

In-custody substance abuse treatment, including short-term interventions directed at motivating a woman into treatment, offers multiple benefits—for the woman, the correctional facility, and society. This period represents an opportunity to use "constructive coercion" to motivate a woman offender into entering treatment and continuing treatment after her release to the community. Research over 25 years has shown that the longer addicted offenders stay in treatment, the better the outcome—both in terms of reduced recidivism and substance use (De Leon 1984; Wexler et al. 1988b; Anglin and Hser 1990). Those who are coerced into treatment do at least as well as voluntary clients—and sometimes do better—because the coerced clients tend to remain longer in treatment than those who volunteer (De Leon 1988; Platt et al. 1988; Hubbard et al. 1989; Leukefeld and Tims 1988, 1990).

The woman offender benefits from in-custody programs. While a woman is in prison, there is the time and opportunity—perhaps for the first time—for compre-

hensive treatment. In a prison situation, time is one of the few resources that most inmates have in abundance. There are no competing demands of children, work, and neighborhood peer groups. Intensive programs, such as residential TCs, present other new opportunities—to interact with “recovering addict” role models, to acquire prosocial values and a positive work ethic, and to initiate a process of education, training, and understanding of the addiction cycle (Inciardi et al. 1994). Many young women, facing incarceration for the first time, are humiliated and frightened. This is an ideal opportunity for them to be introduced to treatment and to the possibility of help and hope in their lives.

Ethnographic studies of street addicts, who are heavily involved in crime to support their habits, show that this group does not seek treatment of their own volition (Lipton 1995). The correctional system removes women from an environment in which they are using, and from its accompanying stresses and strains. For many, this may be the first time in years that they have been drug free and thinking clearly. It also gives many women a respite from a destructive lifestyle in which they pay for drugs through prostitution and abuse. Incarceration represents a forced, artificial removal from a woman’s substance-using lifestyle. As one program director put it, “This is a brief window of opportunity to make significant contact with a woman—to reach out and motivate her to seek help.”

The correctional system benefits from treatment programs. Establishing a drug treatment unit can

bring positive benefits to a correctional facility. Substance abuse treatment programs, especially in women’s prisons, provide an opportunity for growth and rehabilitation for the women. The programs promote responsible, mature inmate behavior, increase safety for security staff, and provide a positive structure for the offender’s time in custody and in the community after release.

Research shows that treatment programs have fewer disciplinary infractions and correctional management problems than

other units. Prison therapeutic communities (TCs) have been found to be the most drug-free and trouble-free sectors of the institutions in which they are housed (Hooper et al. 1993). Infractions of prison rules, as well as threats of violence, also decline (Lipton 1995). The CSAT-funded women’s programs demonstrate this. In the first 2½ years of operation at the Philadelphia OPTIONS program, disciplinary reports went from 10 to 12 per month down to 0 to 2 per month. In addition, when drug treatment programs and random urinalysis are introduced to a facility, both drug use and drug dealing (rampant in some prisons) decline (Vigdal and Stadler 1989).

The community benefits from increased public safety and decreased crime. The research shows unequivocally that substance abuse is related to crime.

The cost to society of this crime is enormous, not only in money but in the emotional and physical suffering of victims. Although women offenders are much less involved in predatory crime than their male counterparts, research suggests that the frequency with which women commit crimes is approaching that of men (Anglin and Hser 1987).

CSAT’s first large-scale national study of clients in publicly funded treatment programs—the National Treatment Improvement Evaluation Study (NTIES)—bolsters the often-repeated finding

While a woman is in prison, there is the time and opportunity—perhaps for the first time—for comprehensive treatment.

that AOD treatment reduces subsequent crime among substance-abusing offenders. Most important, this large-scale study showed that substance abuse treatment reduces subsequent crime on an impressive scale. Among 1,374 women clients in this study, preliminary results demonstrate large decreases in the clients’ involvement in violent crime, illicit drug distribution, and prostitution after both residential and outpatient treatment (CSAT 1995b). The percentage of clients involved in prostitution was reduced from 28 percent before treatment to 7 percent some 12 months after treatment ended (CSAT 1995b). The final NTIES report shows that, before treatment, more than 50 percent of women clients reported having been involved in some form of illegal activity. After treatment, arrests dropped by 67 percent;

there was a decrease of 82 percent in women selling drugs, a decrease of 88 percent in those reporting shoplifting, and a decrease of 89 percent in reports of “beating someone up” (CSAT 1997a).

Numerous State studies also show that treatment effectively reduces the level of crime among addicted users. A report by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) details

positive results of treatment in reducing crime among treated offenders in 13 States (Young 1994). Table 1 shows selected examples of State outcome data.

Reason 9. Treatment saves money.

It costs less money to treat a woman offender for substance abuse than to incarcerate her. Effective treatment results in savings to society that outweigh the costs of treatment by a factor of at least 4 to 1. These are the costs for incarcerating and treating a substance-abusing woman:

- **Incarceration.** It costs from \$20,000 to \$30,000 per year to incarcerate a woman in prison or in a women’s jail (Lord 1995; Gray et al. 1995). It costs \$54,209 per bed to build a new State facility and \$78,000 per bed for Federal facilities (CSAT 1995a, p. 13). California alone, which now has about 11,500 women prisoners (Department of Corrections 1998), has had to build two new State facilities with more than 3,000 beds for women (Austin et al. 1992).
- **Foster care for children.** Foster care for the child of an incarcerated woman adds \$3,600 to \$14,000 a year, excluding administrative costs, to that total (Lord 1995; American Public Welfare Association 1995).
- **In-custody AOD treatment.** Residential treatment programs can be operated in jails or prisons for about \$3,000 to \$9,000 per inmate per year in addition to the costs of incarceration (Lipton 1995). The program’s total cost would depend on the

Table 1. State data on treatment and reduction in crime

- **Oregon**—Follow-up data on the arrest rate of females in the 3 years subsequent to treatment are particularly dramatic for residential and outpatient clients. For women who successfully completed residential treatment, the rate of subsequent arrest was 23 per 100 clients, a rate three times lower than the subsequent arrest rate (66 per hundred) of a matched group with untreated AOD problems. For women who successfully completed outpatient treatment, the rate of subsequent arrest was 27 per 100 clients, contrasted with a 66 per 100 rate among a matched group of untreated clients.
- **Ohio**—Follow-up data on 668 clients show that 410 clients remained abstinent 1 year after treatment. For these clients, there were major declines in criminal behavior and consequences. Criminal arrests declined by 92 percent and time in jail decreased by 93 percent (Ohio Department of Alcohol and Drug Addiction Services).
- **Texas**—Follow-up data on clients who had been arrested in the 12 months before entering treatment showed that, 1 year after treatment, 70 percent had not been rearrested. Among those who completed the treatment program, 80 percent were arrest free at the end of 12 months (Texas Commission on Alcohol and Drug Abuse).
- **California**—Clients who had committed any criminal activity declined from 74 percent before treatment to 20 percent after treatment. There was a 68 percent drop in selling drugs, a 53 percent drop in exchanging sex for money or drugs, a 62 percent drop in breaking into a house or vehicle, and a 75 percent drop in use of a weapon or physical force (California Department of Alcohol and Drug Programs).
- **Minnesota**—Among all public and private clients in the State, 36 percent had been arrested during the 6 months before entering treatment; this decreased to 6 percent in the 6 months after treatment (Minnesota Chemical Dependency Division).

Source: NASADAD report (Young 1994).

type of program, on the mix of professional clinical staff and certified AOD counselors, and on the size of the caseload.

- **TC treatment.** Therapeutic communities, the most intensive form of in-custody treatment, can be provided at reasonable cost. In Illinois, a 250-bed TC housed within a medium security prison costs approximately \$790,000 annually, or about \$3,200 per inmate per year (CSAT 1995a). These costs include a process and outcome evaluation and post-release case management. No capital costs associated with program startup, incarceration, or security are included.

Most of the CSAT-supported prison and jail programs described in this *Guide* are mid- to long-term TCs. CSAT's experience reinforces the finding that TCs in the criminal justice system can be operated at quite reasonable cost. Housing, program facilities, and security are provided by the institution. Among the CSAT-supported women's programs, the daily cost per inmate for incarceration averaged \$51. The average cost of treatment per day for each woman was \$9.22. For individual TCs, the range in cost was as follows:

- Daily cost per client for incarceration: \$50 to \$75
- Daily cost per client for treatment: \$9 to \$18.27 (CSAT 1998)

Treatment in community settings is less expensive than the combined cost of incarceration and treatment. Approximate treatment costs in the community would include:

- **Residential AOD treatment in the community.** Residential drug treatment for a woman in

the community will cost from \$17,000 to \$20,000 per year.

- **Outpatient treatment in the community.** Outpatient treatment costs about \$2,700 per year. For the women addressed in this *Guide*—offenders with chronic, severe substance abuse problems—outpatient treatment after release from custody should also be combined with safe, sober housing and a graduated system of urine monitoring, supervision, and social services.

Successful AOD treatment of offenders creates cost savings to society. What does treatment mean in terms of dollars saved to society? One overview of AOD treatment for offenders concluded that the savings these programs produce—in costs related to crime and drug use—pay for the cost of treatment in about 2 to 3 years (Lipton 1995).

The President's Commission on Model State Drug Laws (1993), in an extensive review of the socioeconomic benefits of addictions treatment, concluded that

... given the very high risk behavior of many narcotics addicts with criminal justice involvement, and given also the ability of quality treatment to diminish [intravenous] (IV) drug use and its attendant risks for HIV transmission, it is almost certain that the total benefits to society, estimated to be in ratios as high as 4:1, are seriously underestimated. When the potential effects of narcotic drug use, cocaine addiction, or HIV positivity on fetuses carried by pregnant addicts is factored in, true cost-benefit

analysis (CBA) ratios must be much higher than even the positive ones adduced here (pp. 6-30).

Among more than 4,400 clients served in CSAT-funded programs, treatment reduced by 59 percent the percentage of those who had sex for drugs or money and reduced by 54 percent the percentage of those who had sex with an IV drug user (CSAT 1997). A few States have begun to calculate the savings for their citizens of treating substance abusers. Following are three examples.

- **California**—Taxpayers save \$7.14 in future costs for every dollar invested in treatment. Most of these savings come from reductions in crime. The cost of treating approximately 150,000 clients was \$209 million. The benefit to California taxpayers, in the first year after treatment, was approximately \$1.5 billion (National Opinion Research Center and Lewin-VHI, Inc. 1994).
- **Minnesota**—Annual savings from treating 18,400 clients total \$39.2 million; \$8 million of this is the savings from reduced arrests, excluding DWI arrests (Turnure 1995).
- **Oregon**—The State justice system is estimated to save approximately \$14 million per year from the fewer arrests, convictions, and incarcerations resulting from completed AOD treatment. In the 3 years subsequent to treatment, only 6 percent of clients who complete treatment are incarcerated in the State prison system, compared to 12 percent who terminate without completion. At an average of \$50 per day for

incarceration, treatment saves an estimated \$59,300 per 100 clients who successfully complete treatment. When theft and victim costs are included, the total savings for Oregon reach \$32.2 million per year (Finigan 1995).

Treatment saves money in health and social costs. When women offenders go untreated for their addiction, society also pays a heavy cost in health and social damage. These are young women, likely to become preg-

nant, many of whom pay for their drugs through high-risk sexual behavior. More women than men in correctional settings now test positive for the human immunodeficiency virus (HIV) (Vlahov 1990). If this lifestyle is not interrupted, these women are at risk of HIV not only for themselves but as a conduit to their babies and to their sexual contacts. The lifetime cost of treating a single HIV-positive individual suggests what a large payoff there can be for effectively

treating a substance-abusing woman offender. Table 2 illustrates the extent of potential health and social savings when a woman is effectively treated.

For both male and female offenders, their untreated addiction exacts a high social cost. With men, their higher rate of violent crime creates major costs to society. Substance-abusing women are responsible for much less social cost resulting from violent crime than men are. However, untreated addiction among women exacts a deep and tragic social cost. For these women, the costs are compounded not only by the health and personal damage to themselves, but by the serious and potentially permanent damage that is done to the physical and emotional health and well-being of their children, as well as the disintegration of their families. Effective treatment for women offenders is an important means of building parenting skills, reuniting families, and strengthening the potential and future of the children.

For the children of substance-abusing women, treatment can often save the costs of providing foster care, as well as the future social costs that society may pay for the emotional damage endured by these children. As women drug offenders have been swelling prison populations, an increasing number of children are being cast adrift. When mothers are incarcerated, only 25 percent of the children live with their fathers and the rest go to relatives or foster care. The National Council on Crime and Delinquency (NCCD) estimates that on any single day in 1991, there were

Table 2. Potential health and social savings from successful treatment of AOD abuse among women

- **Preventing new cases of HIV/AIDS:** An average lifetime cost for treating a person with HIV/AIDS is now at least \$102,000, up from \$85,000 in 1991 (Hooker and Bryant 1993).
- **Preventing fetal alcohol syndrome (FAS):** Up to \$1,400,000 is spent on lifetime care costs for each case of FAS (CSAT 1995b, p. 19).
- **Preventing drug-exposed infants:** It costs from \$48,000 to \$150,000 to treat complications of infants born to addicted mothers (Health Insurance Association of America 1994). The costs of caring for a boarder baby,* even if the infant has no medical complications, range from \$200 to \$500 per day, or up to \$15,000 per month (CASA 1996).
- **Reducing welfare costs:** An average of \$6,000 per year is saved for each woman who leaves welfare and gains employment (Children’s Defense Fund 1995).
- **Reducing foster care costs:** An average of \$3,600 per year is saved for each child removed from foster care and reunited with his or her family (American Public Welfare Association 1995)

*Boarder babies are infants under 12 months of age who remain in the hospital past the date of medical charge because parental care is not available. More than three-fourths of these babies are drug-exposed and over half are of low birth weight.

approximately 125,000 minor children of women in adult U.S. prisons and jails, a figure that would now be higher (Bloom and Steinhart 1993). At a minimum, loss of the mother causes emotional trauma and anger for children; it can mean lasting emotional damage. The NCCD study documents the high percentage of problems among these children, from learning to behavioral and health problems.

Both States and individual comprehensive programs for women report that, as a result of treatment, women make substantial gains in all the above areas. Among CSAT-supported comprehensive demonstration programs for pregnant and parenting women, 81 percent of women referred by the criminal justice

system have no new charges following their treatment (CSAT 1995*b*). These comprehensive programs show impressive results in helping women to be self-supporting. The following outcomes and gains have been reported by several representative programs.

- In California, more than half the addicted women (55 percent) treated in a residential demonstration program for women and their children were supporting their children—without any help from AFDC (Aid to Families with Dependent Children)—within 1 year of completing AOD treatment (CSAT 1995*b*).
- In Pennsylvania, the savings generated by just two CSAT-supported treatment programs

for pregnant/parenting women and their children include:

- \$114,000 saved over a 1-year program from the 46 percent of participants (19 women) who became employed.
 - \$90,000 saved from 26 women being united with their children over a 1-year period.
 - Potential savings in the millions of dollars from the delivery of 15 babies who had no complications due to substance abuse and no cases of FAS (Bair 1998).
- In Florida, the 180 women treated in a single residential program have regained custody of 580 children who were previously under State guardianship (CSAT 1995*b*).

Chapter 2—Specific Treatment Approaches for Women Offenders

The women’s prison and jail treatment programs described in this *Guide* reflect a body of new knowledge and experience about treating women with drug addictions. By the mid-1990s, a great deal of exciting and promising work was being done in treating poor and disadvantaged women for substance abuse, much of it funded through the Center for Substance Abuse Treatment (CSAT). Yet little of this new knowledge was being transferred to programs for incarcerated women.

Against this background, CSAT initiated a program to award grants for innovative demonstration programs in prisons and jails. The CSAT-funded treatment programs for women offenders would be designed to address the complex needs of this drug-dependent, impoverished, and undereducated population.

Why Women Need Specific Treatment Approaches

In the 1970s and 1980s, experts began to look more closely—and to be concerned—at how women were faring in the traditional substance abuse treatment pro-

grams, which had been designed for men. Women were badly outnumbered by men in treatment groups and were not recognized as having different treatment needs. Providers began to be aware that women in coeducational groups tended to focus on meeting the men’s needs rather than their own.

Until the mid-1970s, there had been almost no evaluation and research done on the outcomes for women in treatment. When the research began to tease out separate findings for women, it was felt that women were not faring as well as men in these traditional drug and alcohol treatment programs (Nelson-Zlupko et al. 1995). In that era of nonspecific programs for women, women entered treatment at significantly lower rates than men, and had lower rates both for being retained in treatment and for completing treatment (Beckman and Amaro 1984; Blume 1990; Reed 1985; Stevens et al. 1989).

In a movement that has accelerated since the 1970s, treatment providers began to develop programs for women that incorporate two elements:

- Treating women in all-female rather than coeducational settings, where the environment can be more nurturing, sup-

porting, and comfortable for speaking about such issues as domestic violence, sexual abuse and incest, shame, and self-esteem.

- Addressing the special needs of women, such as child care, transportation, and parenting skills.

Recently, women’s treatment experts have been calling for new treatment models designed specifically for women. Adding special services to a male treatment model is not sufficient. Considerable work has gone into how to modify the traditional male treatment models so they fit the psychological and social needs of women. Chapter 5 discusses some resources and methods that the CSAT grantees used for modifying their 12-Step and TC models for women.

The experience with using all-female models to serve disadvantaged women is particularly rich and varied. Since the 1980s, the Federal government has funded well over 100 demonstration treatment programs for disadvantaged women who have substance abuse problems. Since 1992, the block grant funds administered by CSAT have required that States set aside 10 percent of these funds for specialized women’s programs.

Based on their experience, a number of States, such as New York and Minnesota, now recommend women-only programs as the treatment of choice for women who have a history of physical and sexual abuse. These new perspectives are an important tool for helping women offenders in prison, who have an overwhelming history of abuse.

The outcomes research on these all-women treatment programs is still sparse. Practitioners, however, see evidence that these programs work well. One study, which compared women in a female-only program to women in a coed program, found those in the all-woman program did better after 2

... a number of States, such as New York and Minnesota, now recommend women-only programs as the treatment of choice for women who have a history of physical and sexual abuse.

years on several measures: fewer deaths, less alcohol consumption, less need for inpatient care due to relapse, higher job stability, better relationships with children, and maintenance of child custody (Dahlgren and Willander 1989). At the Betty Ford Center, women in their female-only program were found more likely to remain sober for 12 months than women in coeducational treatment programs (New Standards, Inc. 1993). After this evaluation, the Betty Ford Center discontinued coeducational treatment and moved all women into the female-only program (CASA 1996).

Overview of CSAT's Prison and Jail Programs for Women

In 1993, CSAT awarded grants to seven demonstration programs to treat drug-dependent women in prisons and jails. These programs, along with two women's jail treatment projects from the CSAT Target Cities' program, are described in this *Guide*. The four prison and five jail programs encompass several types of treatment programs, as shown in table 3. Most are residential therapeutic communities (TCs), an

intensive type of treatment designed for those with severe substance abuse problems. One is a less intense 6-month program where women receive treatment for 4 hours daily and are encouraged to enter community residential treatment after release. Two are short-term, intensive jail programs designed to motivate women offenders into community treatment after their release. Part III of this document highlights the practical experience—and the strategies—of these programs. Part IV provides summaries of the programs, along with a listing of materials

developed by the projects that may be of interest to others.

These CSAT prison and jail treatment grantees represent all-women programs and are based on CSAT's comprehensive model for treating women. The programs represent a pioneering effort to introduce the new alternative approaches for treating women into institutional settings with a criminal justice population.

Assumptions of the CSAT Women Offender Programs

The programs operate from varying basic philosophies about addiction. In each project, the designers and staff have grappled with how best to help their women clients—deciding which developmental model, which approach, which strategies to use. The programs vary radically in length, from a 2-week intensive pre-sentencing jail program to an 18-month prison program. The length of a program sets obvious practical limits on its treatment goals. A short-term pre-sentencing program designed to motivate women into community treatment cannot deal with the range of issues or therapeutic approaches that are possible for a 6-month or 12-month residential treatment program.

Though they differ in theory and length, all the CSAT programs have certain core elements and principles in common. All are predicated on the principle that good treatment is designed to address women-specific issues and that good treatment

Table 3. Characteristics of CSAT Demonstration Programs for Women Offenders

Program	Prison programs		Jail programs	
	Residential	Residential TC (Mid/long-term)	Residential TC (Mid/short-term)	Intensive Intervention
Forever Free* California Institution for Women Frontera, California	X 6 months minimum			
Choices Pine Bluff, Arkansas (Community Punishment Facility)		X 3–24 months		
WCI Village Wilmington, Delaware		X 6–18 months		
Recovery in Focus Pendleton, Oregon		X 6 months		
OPTIONS County Jail System Philadelphia, Pennsylvania			X Average 6 months	
SISTER Program San Francisco, California			X Average 53 days	
Stepping Out Project San Diego, California			X Average 62 days	
Incarcerated Women's Recovery Project North Rehabilitation Facility Seattle, Washington				X Up to 12 weeks Average 14–17 days
Women's Acupuncture and Awareness Center City Detention Center Baltimore, Maryland				X 2 weeks

*Clients in the Forever Free program live together but co-mingle with the general prison population during their work assignments.

programming for women addresses issues directly related to their substance abuse behavior. Their basic approach is to build a treatment program for women offenders that directly addresses the clinical issues affecting women's abuse and relapse. These clinical issues are discussed in chapter 4.

Women-centered, women-specific programs are built on certain assumptions about treatment that can differ fundamentally from programs designed for men. Developing an effective program for women in prisons or jails requires a theoretical ap-

Women-centered, women-specific programs are built on certain assumptions about treatment that can differ fundamentally from programs designed for men.

proach to addiction treatment that is sensitive to women and to the realities of their lives. Such a theoretical approach needs to include three components: (1) a theory of addiction; (2) a theory of women's psychological development, especially of how women learn, grow, and heal; and (3) a theory of trauma, since the majority of drug-dependent women offenders have experienced physical, sexual, and emotional abuse as children and/or as adults (Covington, in press).

Assumptions About Addiction

In the past, the most common treatment model of addiction has been the medical model, which views addiction as a disease.

Traditionally, addiction has been compared to diabetes. Both are chronic diseases; to maintain physical and emotional stability, both require adherence to a certain lifestyle. This model is effective in making the analogy that addiction, like diabetes, should not carry a moral stigma and cannot be managed by will power.

However, the medical model sees the disease of addiction as being rooted solely in the individual. Many treatment providers today see the origins of addiction in a broader, more complex context. Some people have a strong genetic predisposition to addic-

tion. Other addicted people, including many in the offender population, have simply grown up in an environment in which drug dealing and addiction are a way of life.

Covington (in press) suggests that addiction as a disease/disorder can be best understood holistically, and that cancer is the most meaningful analogy. Today, many health professionals are revising their overall concept of disease. The new holistic approach recognizes not only the physical aspects of disease, but also its emotional, psychological, and spiritual aspects (Northrup 1994). Covington likens addiction to cancer because both diseases involve all these dimensions, as

well as being linked to lifestyle choices and to the environment.

In all the CSAT demonstration projects described in this *Guide*, addiction is dealt with holistically. Not only its physical aspects, but the emotional, psychological, spiritual, and lifestyle components are essential topics in treatment. Several of the programs stress how important the spiritual aspects are for women offenders. Addiction is viewed and treated as a complex disorder imbedded in both the individual and the society.

Assumptions About Women's Emotional Development

These CSAT-supported programs for women offenders also reflect the new evolving concepts about women's psychological development. Traditional developmental theory is based on a separation/individuation model. The new theories of women's psychological development, generated in part by the women's movement, represent a major shift in thinking about women. In earlier theories, women's development was discussed as the opposite of that for men—with men having the "active" qualities of being dominant, assertive, and independent, while women were seen to have the "weaker" qualities of being naturally passive, compliant, submissive, and dependent. Current thinking stresses the enormous strength and value in the way women deal with the world, particularly in their focus on relationships as a central organizing principle for women's lives.

The new theories about women and addiction look at

how women have been delegated certain more dependent social roles having to do with emotions, nurturing, and caregiving. These are in fact highly valuable roles, central to a woman's emotional development. The woman's development hinges on her relationships with others, including serving and caring for others, and on her connections with others and feelings. These organizing principles in women's lives are a source of great strength, not a weakness.

One useful model for understanding the importance of relationships in women's lives and in the process of their recovery is called the "Relational Model" (Covington and Surrey 1997). The Relational Model, developed by the Stone Center in Wellesley, Massachusetts, posits that the primary motivation for women throughout life is not separation, but establishing a strong sense of connection with others (Covington, in press). In a growth-fostering relationship, a woman develops a sense of mutuality that is "creative, energy-releasing, and empowering for all participants," and is fundamental to her psychological well-being (Covington and Surrey 1997). A woman who has healthy, growth-fostering relationships will derive expanded vitality, empowerment, self-knowledge, self-worth, and a desire for more connection. On the other hand, a woman who is disconnected from others or is involved in abusive relationships will experience the opposite—disempowerment, confusion, and decreased vitality and self-worth. Disconnection

from others thus provides the backdrop for addiction.

In terms of the Relational Model, the way to help addicted women change, grow, and heal is to create programs and environments in which women can form relationships and mutual connections with others. With this model, women's treatment programs aim to establish a setting where the women can experience healthy relationships with

ty of drug-dependent women offenders have been physically, sexually, and emotionally abused for most of their lives. Such abuse is a primary trigger for relapse among women (Covington and Surrey 1997).

Traditional addiction treatment does not address issues of physical and sexual abuse during the period of early recovery. The CSAT demonstration programs view this history of abuse as a

The way to help addicted women change, grow,
and heal is to create programs and environments
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and mutual connections with others.

their counselors and each other (Covington, in press). The programs are designed to encourage women to come together, learn to trust each other, to speak about personal issues, and to form bonds of relationship. This model focuses on strengths in women's relationships as a means of recovery (CSAT 1994b).

Assumptions About Trauma and Recovery

As detailed in chapter 1, studies of women in both prison and jail find high rates of psychological trauma in these populations (Teplin et al. 1996; Jordan et al. 1996). This trauma is related to the elevated rates of substance abuse and other psychiatric disorders among women inmates. According to the CSAT demonstration programs, a vast majori-

central issue in the women offenders' addiction and recovery; all programs address this issue. (The strategies used by the grantees are described in chapters 4 and 6.)

The women's programs need a theory of trauma appropriate for the early stages of recovery. An important guide is the book *Trauma and Recovery* (1992) by psychiatrist Judith Herman. Herman writes that

The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, then, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation (p. 133).

She defines the following three stages in the process of healing from trauma:

- **Stage 1: Safety.** Treatment at this early stage involves addressing the woman's concerns about safety in all domains.
- **Stage 2: Remembrance and mourning.** The survivor tells the story of the trauma and mourns the old self that the trauma destroyed.
- **Stage 3: Reconnection.** The survivor faces the task of creating a future; she now develops a new self.

Women who are in early recovery from addiction also need to focus on safety as their appropriate first stage in treatment (Covington, in press). If women are to recover from trauma, then programs will need to set up a safe environment in which the healing process can take place. Providing such a safe environment within a prison or jail may not be easy, but it is the essential environment required for recovery. Dr. Herman lists 12-Step groups as one example of the type of groups appropriate for Stage 1 recovery from trauma. Such groups focus on issues of self-care in the here and now and provide a supportive environment of peers with similar concerns.

Assumptions About the Treatment Environment in a Correctional Setting

Unfortunately, prisons and jails are not set up to provide a safe and warm environment in which women offenders are encouraged to come together in trust and to form bonds of relation-

ship. As Elaine Lord, superintendent of Bedford Hills Correctional Facility for women, points out (1995):

Work with women involves "bearing witness" so that they can examine their life histories in a safe setting in which they can sort out the pathways that took them to prison, come to be aware of themselves in terms of those life histories, and finally accept and examine their own responsibility for their own actions. ... There is a need to reconnect to other people and discover once again capacities for trust, autonomy, initiative, competence, identity, and intimacy.

The warden points out that prisons are not fertile ground for such work, that the rigidity and authoritarianism of prisons by their very nature can be yet another experience of power and control as belonging to others, not to the woman. Prison does not allow women to experiment with their own decision-making but rather reduces them to an immature state in which most decisions of consequence are made for them (Lord 1995).

Therapeutic communities (TCs) within a jail or prison setting represent one treatment model that is capable of counteracting this authoritarianism and powerlessness. The CSAT-supported TCs aim to set up an environment in which the women assume responsibility for their own actions and can develop a budding sense of personal power.

Setting up this type of separate and autonomous environment within a prison or jail setting—whether for a TC or other treatment model—requires considerable planning and coordination within an institution. All the CSAT prison demonstration projects seem to have worked out a successful balance between the rules of the institution based on security needs and the separate rules of their treatment program.

Chapter 7 discusses some of the strategies that these treatment programs used to gain institutional support.

Approaches of the CSAT-funded Women's Programs

The CSAT women-specific programs view substance abuse as being intricately intertwined with all the major facets of a woman's life. The substance abuse cannot be addressed as an isolated problem. If a woman is to heal and maintain recovery, the treatment program must help her address both her social and psychological needs. These areas include the impact of physical and sexual abuse during childhood, depression, domestic violence, the drug and alcohol abuse of her partner, relations with her children, and the guilt, shame, and low self-esteem and confidence that her life experience has produced.

The CSAT demonstration programs use the new "alternative approaches" that empower the woman and help her develop self-esteem and a sense of self. These approaches appreciate the impor-

tance of relationships as a central principle and source of strength in women’s lives. Women offenders learn to trust and bond with other women for support. When possible, there is an effort to strengthen the woman’s relationships with her children and to reunify her family.

The CSAT-supported programs also help women offenders develop the coping and life skills they need to build a productive and self-sufficient future. These skills extend to many needed areas—to parenting, controlling anger and stress, learning to identify personal cues of relapse, and managing a budget.

Women have great difficulty remaining drug free and sober if they don’t have the ability to support their families. The longer programs try to prepare a woman, through education, vocational tests, and non-stereotyped job training, for a place in the labor market. The shorter term programs try to arrange for education, jobs or financial support, drug-free housing, and ongoing peer support for the women after release. All the programs have worked hard to develop a continuum of care that extends into the community after the woman is released from the institution.

All these women-specific programs aim to provide a similar environment: one that affirms and empowers women. The atmosphere is warm, caring, and supportive. The programs encourage trust, bonding, and sharing of feelings among the women participants. Staff are primarily women. Because the women offenders have been vic-

timized and abused, staff members are sensitive to the way issues of power, authority, and dominance play out between staff and participants.

The programs encourage assertiveness, independence, and autonomy for the women. At the same time, there is strong emphasis on taking personal responsibility for one’s behavior. Women “call each other out” with forthright honesty, but this confrontation is designed to be positive and helpful. The programs intend to offer real hope and motivation to women who often see themselves as hopeless and unworthy.

Recommendations for Treatment Programs

The CSAT-funded women’s demonstration programs followed CSAT’s recommendations on what to include in treatment programs for incarcerated women. CSAT recommends that all treatment programs for women in the criminal justice system be built along the following principles.

First, CSAT recommends that States and local communities develop comprehensive treatment programs for substance-abusing women offenders. These programs should address the many complicated physical, emotional, and social factors that affect women’s abuse of substances and their recovery.

Second, the treatment programs in local correctional facilities (jail or prison) need to be part of a comprehensive continuum of care that continues after the

woman’s release from custody. CSAT recommends that services listed on the next page be provided as essential services for women with substance abuse dependency problems.

Critical Role of Corrections Administrators

Many of the CSAT-funded programs for women described in this *Guide* did not begin until after they received CSAT funding, most in 1993. This accumulated startup experience with a group of treatment programs, begun at a range of institutions, dramatically demonstrates the important role of corrections administrators.

A prison or jail is inherently a more complicated environment for starting a treatment program than other settings. The major mission of the corrections institution is to provide security. Most prisons and jails are not set up to provide the type of environment needed for women’s treatment programs—an environment that offers emotional safety and support and the opportunity for growth, autonomy, and empowerment.

The CSAT programs were all able to establish viable programs, balancing the needs and rules of the institution with the needs of their AOD treatment programs. Those programs that have completed outcome evaluations all showed a positive impact on the women’s substance abuse and/or recidivism (see the program summaries in chapter 8).

Recommendations

1 *Each woman should receive a thorough assessment of her needs that is female-specific and culturally relevant.* Very few instruments exist that are specific for women or even women-focused. The important issue is to be aware that the assessment needs to be comprehensive and to include domains that are particularly relevant to women. Appropriate instruments, as woman-focused as possible, should be used to obtain a complete criminal history; medical history; history of substance abuse; physical, emotional, and sexual abuse history; psychological history; and educational level.

2 *While the woman is incarcerated, a treatment team should do an in-depth assessment to identify the range of her medical, substance abuse, criminal justice, and psychosocial problems and develop an individualized treatment plan.* That plan should address all the needs identified in the assessment, including homelessness. Treatment services should begin in the institution.

3 *Each woman should be tested for HIV/AIDS and be provided with pre- and post-test counseling* as appropriate to State law, regulations, and administrative guidelines. In prison and jail programs for women, HIV testing should be available. The women need to be educated about HIV and encouraged to undergo HIV/AIDS testing. Counseling should be provided for all women tested for HIV/AIDS.

4 *Medical care should be provided for the woman through formal arrangements with community-based health care facilities.* This care should include screening and treatment for infectious diseases, including sexually transmitted diseases and hepatitis, and immunizations. It should also include obstetrical and gynecological care, including prenatal obstetrical services for pregnant clients.

5 *Substance abuse education and counseling, psychological counseling (where appropriate), and other women-specific and culturally appropriate therapeutic activities should be provided throughout the continuum of care.* Services should be offered in the context of family and

other interpersonal relationships, including individual, group, and family counseling. Counseling based on individualized treatment plans should be provided for women who have experienced physical, sexual, psychological, and emotional abuse and trauma. Counseling based on the individualized treatment plan should also be provided for relapse prevention.

6 *Family planning counseling should be provided.* This needs to include information on prenatal care, birth control options, adoption, and education on perinatal transmission of HIV.

7 *Training in parenting skills should directly involve the mother-child dyad and, whenever possible, involve other family members.* Women in treatment should be permitted and encouraged to participate in programs for their children, such as Head Start and Parent and Child Centers that incorporate parent participation.

8 *Interagency agreements should be developed with relevant child welfare agencies* to address the needs of the children whose mothers are in local correctional facilities and to help make possible regular visits from children to the mothers who do not have custody of their children.

9 *Formal linkages should be established with community providers for provision of all necessary services.* The services should include basic needs of food, clothing, housing, finances; assistance in legal matters, family planning, and vocational/educational needs; transportation; health care; mental health services; and support services.

10 *Specialized services should be provided for the children of female offenders.* Children and other family members should be included in all levels of the service delivery network—in the continuum of prevention, treatment, and recovery. The program should provide therapeutic child care and child development services, including supervision of children while their mothers are engaged in treatment and other rehabilitative activities in the community.

In working through the initial months of program startup, it was clear that the attitude, support, and resources made available by corrections administrators were absolutely crucial for success. The following are some of the most critical elements, which are discussed further throughout this *Guide*.

Issue 1. The treatment program’s special therapeutic environment needs to be understood and supported at all levels of the institution.

An AOD program is enormously benefitted when it exists in a milieu of support—when the total prison or jail staff understands the rationale and value of its special environment. Even when the corrections administration totally endorses a program, security personnel may not understand the program’s supportive, warm environment and consider it “coddling” the women. The “word-of-mouth” institutional underground, before a program has established its own record, can either greatly help or can hobble a new program.

Issue 2. Special dormitory/housing arrangements within the prison or jail are needed for women participating in intensive substance abuse treatment programs.

Isolating program participants from the general prison population is a key element for treatment, and good treatment programs try to keep their participants and graduates separated from the general population. This isolation continues to be important in the post-release period. All the CSAT-supported programs were able to gain separate facility space for their programs. However, in one case,

empty program beds began to be filled with non-program participants, which caused serious problems for programming.

Issue 3. The security personnel for treatment programs represent a vital component in the program.

Administrators can be extremely helpful to programs when they understand the program needs regarding security officers. The security officers play an important role in maintaining a program’s tone and they are important in supporting the program’s therapeutic environment. Treatment programs say they need a cadre of willing security officers who can be consistently assigned to the program and cross-trained along with treatment personnel.

Issue 4. Programs need to be allowed adequate scheduling time to provide intensive treatment.

Standardized screening shows that women offenders in the CSAT-funded programs have serious, chronic substance abuse problems. To treat such problems requires intensive full-time treatment; it is hard work for women. Prisons often require offenders to work 8 hours per day. A full work schedule means that women offenders must squeeze AOD programming into at most 4 hours per day when they are exhausted. In the CSAT programs, several prisons allowed the women’s AOD treatment to count toward their work requirement.

Issue 5. Coordinating the release of offenders with treatment needs can be critical.

Treatment programs are designed with goals and activities that mesh with the amount of time that

offenders will be incarcerated. The length of the usual sentence is critical to what type of program is planned. A jail treatment program designed to last 3 to 6 months won’t work if inmates begin to cycle through in 14-day stretches. In addition, the planning for individual program participants needs to occur in such a way that the women can be released back to the community—not to the general population—when they graduate from the program.

Issue 6. Providing space for child and family visits is an important component for women offender programs.

A comfortable area for children and families to visit helps women maintain bonds with their children. Several of the CSAT-supported programs have been able to offer areas not only for visits, but for family therapy. The observation of mother/child interactions allows skilled parenting help to the mothers.

Issue 7. Planning for post-release treatment services is vital.

The most critical period for substance-abusing women offenders is during their transition to the community. After prison or jail treatment, women offenders badly need supervised aftercare. Correctional administrators can foster the needed links to these community aftercare services. In several of the CSAT-supported jail programs, community service providers come into the facility and pre-plan with the individual woman for her post-release treatment and other services.

Chapter 3—Systems Planning for a Continuum of Care

The Center for Substance Abuse Treatment (CSAT) believes that women offenders with drug dependency problems require more services than substance abuse treatment alone, whether that treatment occurs during incarceration or in the community. These women need a range of social services within a planned continuum of care. Each woman offender should have a continuing care plan in place before she transitions between and from correctional agencies.

CSAT believes that integrating a range of substance abuse treatment services into a criminal justice treatment network will provide measurable improvements in these systems. Research supports the conclusion that outcomes for addicted women offenders will improve under a coordinated system of care, as compared to the women's receiving episodic treatment services at different points in the criminal justice process.

CSAT encourages both State and community-wide planning for a continuum of care for women offenders. Coordination and cooperation need to be set up across two major systems. One system consists of State and local

criminal justice agencies, including courts, pretrial services, jails, probation, prison, and parole agencies. The second cooperating system consists of community treatment providers involved in the supervision and treatment of substance-abusing offenders. Particularly with women, these systems also need to interact with a variety of health and social service agencies.

It needs to be recognized that systems differ. For example, the Federal prison system uses its own employees for substance abuse treatment. Many State prison systems, such as California, use contractors to provide substance abuse treatment for incarcerated women. States and communities also use many different systems for handling the post-release supervision and treatment of women offenders. These differences create a variety of both limitations and opportunities for developing a systems approach.

This *Guide* focuses on the practices of CSAT's demonstration programs in attempting to develop a continuum of care for women offenders within their existing State and local systems. In most localities, the *lack* of a coordinating system is a major hurdle in trying to provide a continuum of care for these women.

Background to Collaboration

For offenders with serious substance abuse problems, single strategies are not likely to work—whether that single strategy is an isolated episode of treatment, parole and supervision only, or case management without the leverage of criminal justice sanctions or inducements to treatment. To interrupt the cycle of substance abuse, crime, incarceration, release, and re-offense, offenders need an integrated and graduated plan that combines treatment with sanctions, supervision, and support. Strategies for monitoring and supporting each offender need to mesh at every stage across the two fields of criminal justice and treatment. And particularly for women, this continuum of care needs to encompass a multitude of other services, from housing to vocational training to strengthening and reuniting families.

The current environment for programs wanting to set up this kind of joint endeavor is quite encouraging. Over the past decade, many people in both the treatment and criminal justice fields have made concerted efforts to develop effective partnerships. The Center for Substance Abuse

Treatment has conducted an extensive review, with follow-up technical assistance, of treatment-criminal justice linkages in more than 40 States. In 1992, only 12 percent of States had significant linkages between criminal justice and substance abuse treatment. By 1995, 100 percent of States had established links between probation and parole and substance abuse treatment and were offering pretrial and pre-sentence substance abuse services.

Many States, local communities, and individual professionals have worked to set up collaborative relationships between their criminal justice and substance abuse treatment systems. As one CSAT-supported project director put it, "What we have in this community is a group of collaborators across systems with good communications. Our case manager communicates back to the judge, who is very supportive of a case management model, and the enforcement people try to guarantee success for the women by advocating for social services and treatment."

Advantages of a Systemic Approach

In designing programs for women offenders, planners—both at the State and the local level—need to assess their specific situations. In some areas, the most critical need may be to create linkages across systems and to fill in service gaps. For example, some areas have no residential treatment available for women and their children or have no supervised, safe and sober housing available for

women after their release. There may be no case management system to support women offenders who have been released to the community, whether these women are in outpatient treatment or not. Women who go from prison or jail into residential treatment may have no system of support after they voluntarily leave treatment.

Looking for Gaps in Service Delivery

For women offenders with substance abuse problems, the country has a fragmented service system. This makes it critically important to think systemically about how to design services—not just how to provide links from a single program to the community. Where are the most glaring gaps in a community's continuum of treatment, social services, and supports?

Accountability sanctions and incentives represent another area where continuity across systems is important and where a coordinated systems approach will be more effective than isolated actions. Accountability sanctions include a wide range of methods, such as incarceration, probation, and home detention. Sanctions can play a positive role in promoting recovery from addiction. Treatment itself may be used as an intermediate sanction or as an incentive. Offenders, for example, may be mandated to treatment in lieu of incarceration. As the woman successfully completes successive stages in her treatment, she can be rewarded with reduced sanctions and with incentives, such as home visits.

When a woman relapses, as evidenced by a drug-positive urine test, this regression may be addressed by increasing the intensity of an offender's participation in treatment. Alternatively, the relapsing offender may be subject to a sanction, such as a short-term jail sentence.

For male offenders, the use of intermediate sanctions in combination with AOD treatment is widely recognized and encouraged. An excellent guide on this topic is CSAT Treatment Improvement Protocol (TIP) No. 12, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* (CSAT 1994a).

For women offenders, there is almost no research on the most promising sanctions to use in conjunction with treatment. What is needed are rational, data-informed, enlightened, purposeful sanctions and sentencing practices. Treatment programs report that a system of intermediate sanctions and rewards is important as a structure for setting a client's individual behavioral guidelines during treatment and probation/parole. The tracking of frequent, random, but mandatory drug testing is useful.

Experts also believe that community-based sanctions for women, if they were available, could be used more extensively in lieu of incarceration (Owen and Bloom 1995). For women, community-based sanctions and alternatives to incarceration, such as day reporting centers, would let a woman stay in the community for mandated treatment. These alternatives would be less expensive, and often less

damaging to her family, than incarceration. We need to expand these options for women.

One serious problem for women after their release from custody is too many and conflicting requirements. Women can fail at parole if faced with multiple, conflicting sanctions from different agencies, including treatment, custody requirements, work, and probation/parole visits. For example, the child welfare agency may require actions that interfere with a woman's ability to attend mandated treatment.

A CSAT project for pregnant women and their infants found the most effective way to present sanctions to women was as a natural consequence of their behaviors. Knowing that certain behaviors would result in a referral to child protective services served to place the control more in the hands of the client. Thus the case manager's role became one of informing rather than threatening the client (Laken and Hutchins 1995, p. 9).

Creating Linkages Across Agencies

Because of the multiple problems of women offenders—and the multiple agencies that are involved in addressing those problems—drug treatment for women offenders needs to move toward a more systems-oriented approach to service delivery. This systems-oriented approach needs to emphasize

- Linkages and coordination among programs and agencies
- Joint planning and training
- Shared resource allocation

- Continuity of care for clients throughout the system

A systemic approach requires both formal and informal linkages among all the organizations—criminal justice agencies, drug treatment programs, and health and social service agencies—involved in providing treatment services to women offenders with substance abuse problems. The treatment capacity of the system, the kinds of programs and services that are available to women, and the nature of the linkages among the organiza-

tions—all will determine the structure of a given system and the ability of its organizations and officials to meet women's needs.

How best to integrate and link agencies and organizations is a separate topic, beyond the scope of this *Guide*. Table 4 lists the linkage recommendations made by the National Task Force on Correctional Substance Abuse Strategies. How to link systems, especially the criminal justice and substance abuse systems, is discussed in depth in two recent CSAT Treatment Improvement Protocols (TIPs)—TIP No. 12 on combining treatment with intermediate sanctions (CSAT 1994b) and TIP No. 17 on planning treatment for adults in the criminal justice system (CSAT 1995a).

Meeting System Needs

As more information is shared about how existing programs assess and address women's needs, it becomes possible to better meet those needs. A system's capacity and services can then be changed on the basis of information, rather than assumptions, about the unmet needs for treatment of both individual women and the women offender population in the aggregate. Having a system in place, instead of isolated programs, offers a mechanism

One serious problem for women after their release from custody is too many and conflicting requirements.

for solving many current needs. These include:

- *The need for a uniform screening and placement system*, so that women can be placed consistently in the most appropriate level of care. The Colorado correctional system, for example, has developed a screening system that assesses and matches offenders to a preferred level of treatment and has also trained counselors throughout the system in how to use it. Other State AOD agencies have adopted standardized patient placement criteria, such as the criteria developed by the American Society of Addiction Medicine (ASAM).

These standardized criteria can then be adapted for

women offenders. As one example, Pennsylvania has adapted the ASAM Patient Placement Criteria to include all levels of care available, and the Pennsylvania Criteria are now being modified to address

the special needs of women and women with children.

- *The need for continuity, comprehensiveness, and individual tracking for each woman* through each phase of her treatment and accountability to the criminal justice system.

Some metropolitan areas, particularly, are now developing centralized intake units (CIUs) and management information systems (MISs) that offer the means for this kind of tracking by all systems—corrections, treatment, and social services.

- *The need for coordination and integration of all components of the criminal justice system with each other and with community-based treatment.* The lack of an integrated approach is particularly glaring with women. For example, women with children are likely to be simultaneously involved with a group of different social service agencies, as well as probation officers; all may treat families in a different way and can set up conflicting requirements. This kind of system can set up conflicting demands that a woman cannot meet—setting her up for failure.
- *The need for management practices that create a feedback loop,* so that evaluation results can inform clinical practices and create a flow of information between units.
- *The need to identify and magnify whatever funding is available.* State needs assessments show that public funding for community treatment facilities everywhere in the country is grossly inadequate to meet treatment needs. In Delaware, for example, available community treatment slots are inadequate to meet the needs just for the offender population alone, not even counting the rest of the citizens who have substance abuse problems (Peyton 1994).

Table 4. Linkage recommendations of the National Task Force on Correctional Substance Abuse Strategies

GOAL: Provide linkages to assure effective communication across the entire correctional system, including community-based agencies, for transmitting information and coordinating services.

RECOMMENDATIONS:

- **Cumulative information** should follow the offender from the earliest impact point throughout the system.
- Relevant **assessment and treatment** information should be shared with all substance abuse treatment programs providing service to the offender.
- Offenders should have *continuing care plans* prior to transitioning between and from correctional agencies.
- **Formalized agreements** should be developed that detail areas of responsibility, services provided, and mechanisms for information exchange among State and local agencies in the correctional system and the treatment community.
- **Combined case planning** should be accomplished among correctional and treatment agencies when working with the same substance-abusing offender, when transferring the offender from one agency to another, or when transferring the offender from one part of the correctional system to another.
- Ongoing **professional forums** among correctional representatives and community treatment providers, especially at the policy-making level, should be held to address common concerns and issues.
- **Cross-training** (training across disciplines and agencies) covering a wide array of treatment techniques, case management issues, and criminal justice concerns should be conducted on an ongoing basis for professionals and paraprofessionals working with substance-abusing offenders.
- A **management information system**, preferably automated, should be established and used within and across systems to monitor the delivery of appropriate substance abuse programming to offenders, collect data for program evaluation, and establish a rationale for additional interventions and staff.

—Excerpted from National Institute of Justice, *Intervening with Substance-Abusing Offenders: A Framework for Action; The Report of the National Task Force on Correctional Substance Abuse Strategies*, Washington, DC: U.S. Department of Justice, June 1991, pp. 51-57.

A scarcity of funds for publicly funded community treatment is likely to be an increasing problem. Women offenders dependent on alcohol and other drugs, whose numbers are growing, may be adversely affected in four important ways:

- **National scarcity of women-specific community programs.** Women offenders need intensive women-specific treatment programs, including programs that also serve their children and families, and these are in particularly short supply. There is concern that, as intensive treatment programs are introduced in prisons, women will be incarcerated as the only available option for providing them with adequate substance abuse treatment.
- **Waiting lists.** Waiting lists for publicly funded community treatment slots are common across the country. When women offenders transition from a prison or jail treatment program into the community, they need *immediate* admission to a community treatment program. Being put on a waiting list for treatment is not acceptable. Institutional treatment programs report that women offenders can be lost to treatment if there is even a day's delay between release from the institution and their entry into a community program.
- **Managed care Medicaid plans.** Across the country, many States are placing their Medicaid patients under managed care arrangements. There is concern that managed care plans, designed to treat acute problems, will not cover the

type of treatment needed by women offenders with their long-term, chronic problems. Just how the ancillary services, such as vocational training and family counseling, will be paid for under managed care plans is also not apparent.

- **Loss of welfare support.** In the past, many women offenders returning to the community have received welfare support until they are employed. Such support assists a woman while she is in community substance abuse treatment. Under the recent welfare reform legislation, women convicted of a drug offense are no longer eligible for welfare support unless the State makes an exemption. Most States have not done so.

An important solution to the funding dilemma is to set up treatment funding that follows women offenders from in-custody treatment into the continuum of care in the community. More funding for community-based treatment through the correctional system is one potential and positive solution. In some States, treatment funding is now linked to offenders through the correctional system. State correctional or community supervision departments set up contracts with community substance abuse, mental health, and vocational agencies to provide services for offenders on probation. For example, the California legislature has recently allocated funds so that graduates of the Forever Free program from all parts of the State can receive community treatment after their release from prison. (Forever Free is one of the

CSAT-funded treatment programs described in this *Guide*.)

Types of Community-based Systems Models

For planners in either corrections or treatment, there are now a number of different models for setting up an integrated community system. Several of these models are demonstrations supported by funding from the Center for Substance Abuse Treatment (CSAT). Many of CSAT's recent initiatives have been designed to enhance and support the development of treatment systems, as opposed to single points of intervention.

Treatment Accountability for Safer Communities (TASC)

TASC, begun during the 1970s by the Bureau of Justice Assistance, is now a widely used model for bridging the gap between criminal justice agencies (courts and probation) and the treatment providers. TASC clients remain in treatment 6 to 7 weeks longer than other criminal justice clients, whether referred to residential or outpatient programs (Lipton 1995). National studies of TASC in the 1970s showed that the program was effective in reducing rearrest rates; only 8 percent of clients in all sites were known to have been rearrested for new offenses while in the program.

TASC incorporates the philosophies of both the criminal justice

and substance abuse treatment systems into its operating principles. This model capitalizes on the leverage of the criminal justice system to achieve maximum benefits from treatment for its clients. TASC provides supervision, but this is not equivalent to probation or correctional supervision. TASC conducts clinical screens and assessments and provides case management services, but it is not a treatment program. However, some TASC programs do provide treatment services either directly or through contracts. Although TASC can function as a program, it is perhaps most powerful when managing offenders who are moving through complex levels of criminal processing, supervision, and sanctioning, while also receiving multiple treatment interventions and modalities.

TASC programs now operate in more than 100 cities throughout the United States, and TASC is heavily represented in some States, including Florida, New York, Ohio, Pennsylvania, Illinois, Arizona, and Colorado. Besides being an effective program model, TASC has also developed a methodology for integrating the criminal justice and substance abuse treatment systems, holding offenders and both systems accountable by means of client-specific case management. The TASC methods can be used by other programs or systems that are managing substance-involved offenders, including women. These methods are essential in such efforts as developing partnerships between drug courts and the treatment delivery system and for linking institution-based treatment services with

community-based supervision, treatment services, and aftercare. TASC has particular expertise in the following service components:

- Screening and assessment
- Drug testing
- Data collection and management
- Client monitoring
- Case management
- Client advocacy
- Clinical methods
- Relapse prevention
- Staff training

TASC has developed a public domain management information system with SEARCH, Inc., called TASC-MIS. TASC has also developed a variety of monographs and guidelines, including a training curricula, manuals for trainers and participants, and monographs on urinalysis as part of a TASC program and on drug-involved female offenders.

Drug Courts

Drug courts are an important development in treating the substance-abusing offender. The National Association of Drug Court Professionals (NADCP), an organization formed several years ago, defines drug treatment courts as “a special court given the responsibility to handle cases involving less serious drug-using offenders through a supervision and treatment program. These programs include frequent drug testing, judicial and probationary supervision, drug counseling, treatment, educational opportunities, and the use of sanctions and incentives.” The NADCP has developed a set of key components for drug courts (see table 5).

Drug courts are reporting cost savings. For example, the Multnomah County, Oregon Department of Community Corrections estimated that the Portland drug court would save almost \$300,000 in costs to the criminal justice system during one fiscal year.

There is no universal model for drug courts, and not all drug courts are “diversion” models. The main types involve drug treatment and expedited case processing. The involvement of judges—and the judge’s detailed knowledge of an offender’s behavior, from attending treatment to maintaining “clean” urines to probation reports—is a significant and new factor in this approach. From modest beginnings with four or five drug courts in the early 1990s, there were now more than 400 drug courts in the United States supported by a variety of local, State, Federal, and private funds and participant fees. The 1994 Crime Act authorized the U.S. Attorney General to award and administer discretionary grant funds for drug courts. Many drug courts were started with Justice Department grants made available from 1996 through 1998. In addition, CSAT has provided modest funding and technical assistance.

Drug courts appear to offer a promising approach for managing drug-abusing women offenders. Some drug courts for women have been developed. One such example is the Brooklyn, New York, Treatment Court, which is supported by CSAT as a project in the Criminal Justice Networks demonstration program.

Table 5. Defining drug courts: The key components**The National Association of Drug Court Professionals
Drug Court Standards Committee**

Key Component No. 1:	Drug courts integrate alcohol and other drug treatment services with justice system case processing.
Key Component No. 2:	Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
Key Component No. 3:	Eligible participants are identified early and promptly placed in the drug court program.
Key Component No. 4:	Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
Key Component No. 5:	Abstinence is monitored by frequent alcohol and other drug testing.
Key Component No. 6:	A coordinated strategy governs drug court responses to participants' compliance.
Key Component No. 7:	Ongoing judicial interaction with each drug court participant is essential.
Key Component No. 8:	Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
Key Component No. 9:	Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
Key Component No. 10:	Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

From: Office of Justice Programs (OJP) Drug Courts Program Office. *Defining Drug Courts: The Key Components*, by The National Association of Drug Court Professionals Drug Court Standards Committee. Washington, DC: U.S. Department of Justice, January 1997.

Three helpful resources are shown in the box on the following page.

Integrated Management Information Systems

CSAT, through its Target Cities initiative, provides discretionary funding to develop infrastructure planning in major metropolitan areas. Criminal justice components are now part of these treatment networks in 11 cities. Two projects described in this *Guide*—the Baltimore Women's Acupuncture and Awareness Program and the

OPTIONS program in Philadelphia—are both benefiting from new comprehensive programs for women made available under this project. The Target Cities that contain criminal justice components, most of which are jail-based, include Albuquerque, Baltimore, Cleveland, Dallas, Detroit, Newark, New Orleans, Philadelphia, Portland, San Francisco, and St. Louis.

The approach of the CSAT Target Cities program is to develop an infrastructure that will support coordination, communications, and information

sharing across the network. The projects focus on developing such integrating mechanisms as centralized intake units (CIUs) and management information systems.

Community Networks

Late in 1995, CSAT awarded eight cooperative agreements to develop and implement a sophisticated new concept—criminal justice treatment networks. This demonstration program involves consortia led by a local court or community corrections agency, which also include

substance abuse treatment agencies and a range of health and mental health organizations. Four of the community networks are specifically designed to serve women—these are in Brooklyn, Philadelphia, San Francisco, and Phoenix.

This holistic approach represents an intensive effort to build and strengthen networks made up of diverse organizations and systems that have conflicting goals, varied management and operating philosophies, and differing realities. Each network is developing an automated management information tracking system to document the progress of both programs and individual offenders. The most effective models—those that expand services in a cost-effective way and show enhanced treatment outcomes in reduced drug use, lower recidivism, and improved social functioning—will be appropriate for replication. The models selected for replication will include intake screening and assessment and will provide a continuum of care that includes case management, primary health and mental health care, and other supportive services.

CSAT's Recommended Approaches for Establishing Networks

The goal of an integrated network is to provide women offenders with a systemic, unified approach where all statewide or community

Helpful resources for information about drug courts

- **CSAT Treatment Improvement Protocol TIP, No. 23**

Center for Substance Abuse Treatment. *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing*. Treatment Improvement Protocol (TIP) Series, No. 23. DHHS Pub. No. (SMA) 96-3113. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996.

- **Briefing report by the U.S. General Accounting Office**

U.S. General Accounting Office. *Drug Courts: Information on a New Approach to Address Drug-Related Crime*. Briefing Report to the Committee on the Judiciary, U.S. Senate, and the Committee on the Judiciary, House of Representatives. Washington, DC: General Accounting Office (GAO/GGD-95-159BR), May 1995.

- **Defining Drug Courts: The Key Components, by the National Association of Drug Court Professionals**

Office of Justice Programs (OJP) Drug Courts Program Office. *Defining Drug Courts: The Key Components*, by The National Association of Drug Court Professionals Drug Court Standards Committee. Washington, DC: U.S. Department of Justice, January 1997.

agencies join together to supervise, case manage, and treat offenders. CSAT expects such collaborative efforts to expand service delivery and reduce the cost of treatment to criminal justice clients, as compared with the cost of current systems that provide single points of intervention.

A network is defined as a tightly structured partnership of State and local government and criminal justice agencies, including courts, pretrial services, probation/parole, and law enforcement. Other government agencies include public and nonprofit pri-

mary health care, mental health care, substance abuse treatment, allied social services, job placement agencies, and schools. At the local network level, the primary leadership should come from the local jurisdiction's judiciary or probation/community corrections agency. The continuum of services needs to be integrated around some key intake point that can operate as a "gatekeeper" to the system. For example, a drug diversion court or a jail/detention agency could function as the central intake point. (CSAT's recommendations follow.)

Recommendations

1 The local consortium or network needs to tie together the pivotal points of referral and supervision in the courts or community supervision agencies (probation and parole agencies) with the appropriate State and local agencies responsible for offender treatment services.

2 The services provided through the consortium should include addiction treatment, public health, primary health care, mental health services, supervision/testing by courts and corrections agencies, and child welfare services.

3 The consortium should create a new infrastructure or enhance existing components for a comprehensive criminal justice network by incorporating and integrating existing Federal, State, and locally funded projects. The consortium should identify and work with projects that serve specific target populations involved with the criminal justice system.

4 The model developed by the consortium needs to include a centralized intake point of entry where offenders referred by the courts and criminal justice system can be comprehensively assessed and referred to treatment. The model needs to include intake screening, assessment, and the provision of a continuum of care that includes case management, primary health and mental health care, and other services for eligible substance-abusing women offenders.

5 The consortium should integrate culturally sensitive services as appropriate for ethnic and other minority groups in terms of both program planning and implementation.

6 A core element of the network services should be a case management system that provides appropriate supervision and tracking. This case management is expected to include assisting clients with referrals, tracking clients, frequent case review, frequently scheduled random urine testing, a schedule of regular and frequent communication with community treatment providers, and frequent reporting of client progress to the referring criminal justice agencies.

7 Case managers may be situated at numerous points within the system. These case managers should be individuals knowl-

edgeable about the criminal justice process, offender clients, substance abuse treatment, and child welfare and other women-specific services.

8 A system of intermediate sanctions and positive rewards should be implemented as a structure for client behavioral guidelines.

9 Comprehensive, women-specific treatment should be provided for women offenders with AOD abuse. This treatment should address the clinical issues related to women's substance abuse, including primary and specialty health care for infectious diseases and other physical disorders, mental health services, violence reduction and intervention, family counseling and job placement, services for victims of physical or sexual abuse, and services for families and children.

10 The public health component of the treatment regimen should involve local and/or State agencies that engage in screening and counseling for infectious diseases, as well as coordination with treatment providers. The infectious diseases of concern include HIV/AIDS, tuberculosis (TB), sexually transmitted diseases, and hepatitis B.

11 The consortium should develop an automated management information system (MIS) for rapid communication across agencies and to allow for rapid tracking and referral of clients for maximum system-wide utilization of treatment capacity. This MIS will be designed so that it continues to protect client confidentiality.

12 A goal for the system should be to expand service delivery and increase access to substance abuse, mental health, and primary care treatment for women offenders who need these services. A longer term goal should be to provide improved treatment outcomes by means of more effective treatment and recovery services. These improved outcomes can be measured through reduced drug usage and associated problems, lower criminal justice system recidivism, and improved health and social functioning.

Part II

Designing Treatment
Programs

Chapter 4—Clinical Issues in Treating Women Offenders

The women served in the CSAT-funded prison and jail programs all have severe substance abuse problems. Many are dependent on more than one drug, have a history of substance abuse extending over a number of years, and often have already undergone some substance abuse treatment.

Although women in both the prison and jail programs share serious substance abuse problems, program managers emphasize that these are distinct client populations. The CSAT prison demonstration programs stress the overall severity of their clients' problems in three areas—drug addiction, social and cognitive deficits, and criminogenic behavior. The severity of these problems must all be addressed in prison treatment programs. Women in the jail programs often have a shorter history of drug problems and of criminal behavior.

The characteristics of clients in two CSAT-supported programs suggest how prison and jail populations may differ.

- *The Forever Free prison program.* In this 6-month treatment program, a typical participant could have a 25-year daily heroin addiction, no high school diploma, no legal job

history, social and cognitive deficits, and a criminal history (typically petty theft) going back 30 years.

- *The Baltimore Detention Center program.* This 2-week Baltimore pre-trial program targets female substance abusers in the city detention center—women who have less extensive histories of drug use and crime and are therefore likely to be released back to the streets at the time of trial. The majority of women lack a high school diploma and have limited work histories. These women, like those in the State prison programs, are heavily involved with drugs. In the Baltimore program, 74 percent of the women report heroin as their primary substance problem, more than 80 percent report a secondary drug problem (most often cocaine), and 40 percent report alcohol abuse/dependence in addition to their primary drug problem(s).

For all women offenders with serious substance abuse problems, the substance abuse cannot be successfully treated in isolation from the social and psychological issues in which their addiction is embedded. Critical issues to address—for both recovery and for public health reasons—are

empowerment/self-esteem, sexual and physical abuse and violence/victimization, and health and high-risk behaviors. The Center for Substance Abuse Treatment (CSAT) required that their program grantees serving incarcerated women develop programs that address the major clinical issues affecting substance-abusing women. These major issues are listed in table 6. The following section describes each of these clinical issues in chronological order, following CSAT's list. This list is not intended to suggest any priority order. All issues are important.

Clinical Issues Affecting Substance Abuse in Women

Clinical Issue 1: The etiology of addiction, especially gender-specific issues

Women's drinking and drug abuse is different from men's. Knowledge about how and why women become addicted to alcohol and drugs has been steadily growing since the 1970s. Current research indicates that chemically dependent women differ from their male counterparts in significant ways: in their patterns of drug use, their

psychosocial characteristics, and in the physiological consequences of their drug use (Nelson-Zlupko et al. 1995). For example, unlike men, women often describe the onset of drug use as sudden and heavy rather than gradual.

Table 6. CSAT's Comprehensive Treatment Model for Women—Clinical Issues

Within the treatment program, counselors should address the following issues:

1. The etiology of addiction, especially gender-specific issues related to addiction (including social, physiological, and psychological consequences of addiction, as well as factors related to the onset of addiction)
2. Low self-esteem
3. Race, ethnicity, and cultural issues
4. Gender discrimination and harassment
5. Disability-related issues, where relevant
6. Relationships with family and significant others
7. Attachments to unhealthy interpersonal relationships
8. Interpersonal violence, including incest, rape, battering, and other abuse
9. Eating disorders
10. Sexuality, including sexual functioning and sexual orientation
11. Parenting
12. Grief related to loss: to the loss of the substance that was being abused, and the emotional losses related to the woman's children, family members, or partner
13. Work
14. Appearance and overall health and hygiene
15. Isolation related to a lack of support systems (which may or may not include family members and/or partners) and other resources
16. Life plan development
17. Child care and child custody

Source: *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs*, Center for Substance Abuse Treatment (CSAT), 1994c, pp. 178-179.

Women are more likely than men to be addicted to more than one mood-altering substance, and many addicted women report that they began using drugs after a specific traumatic event in their lives. Most importantly, for women, chemical addiction frequently represents an effort to self-medicate for depression and other mental impairments, to numb pain, and to make tolerable what is a painful and hopeless life. Women have higher rates of psychiatric comorbidity than men.

Women substance abusers often have experienced physical and sexual abuse during their childhood. More than for men, women's substance abuse is intertwined with the drug and alcohol abuse of their partners. To achieve lasting recovery from substance abuse, women need to work through issues of guilt and shame, lack of self-esteem, and feelings of disconnection and disempowerment. Substance-abusing women need to build trust, bonding, and hope as a basis for recovery.

Women's addiction is complex and embedded in psychosocial and other issues. Many clinical, developmental, and economic issues are intertwined as the framework for substance abuse in women offenders. The major issues affecting substance abuse in women fall into the following categories:

- Psychological stressors for women, including sexual and physical abuse, violence, and victimization
- Social and cultural role issues for women, which pertain to stigma, self-esteem, undereducation, and economic deficits

- Centrality of women’s relationships as an organizing principle in their lives, particularly their relationships with children and family
- Loss of self-image and personal empowerment
- Vulnerability in health and high-risk behaviors, with frequent medical problems and a high rate of HIV/AIDS and sexually transmitted diseases

Clinical Issue 2: Low self-esteem

Substance-abusing women lack self-esteem, regardless of their socioeconomic level. Addicted women offenders who serve time in jail or prison have been reported to have very low self-esteem, combined with a feeling of almost total lack of power over any aspect of their lives.

The CSAT grantees have found their women clients typically feel powerless over their lives and exhibit extremely low self-esteem. The Forever Free program, in testing for self-esteem, found that more than 70 percent of their women clients fell in the lowest 1 percent on a scale normed for the general population. As one project director pointed out, these women have experienced such powerlessness that they have no sense of self-efficacy. That is, the women truly see no cause and effect relationship between their actions and the consequences. An initial step in treatment is to develop the woman’s consequential thinking—the belief that she can affect how things happen.

Programming approaches. New psychological approaches, called “alternative approaches,” offer great promise as a framework for

helping women offenders who have serious substance abuse problems. These theories perceive women to be developing within the confines of a culturally driven society, with a “cultural mandate to be powerless” (see, for example, Miller 1986). The theorists look at the impact on women of growing up in a society whose institutions were built and designed by and for men. It is important to understand this “cultural mandate” as the backdrop to understanding why women feel powerless and may resist independence and autonomy.

The CSAT-funded grantees point out that women offenders—whose boundaries of self

Rather than being a specific intervention, the push toward empowering the women and developing their self-esteem and identity are underlying motifs throughout the entire program. This is accomplished by the program’s policies and by the many small gestures that set a program’s tone. For example, as described in chapter 5 in the section on TC models, the WCI Village program never asks a woman to face a difficult issue in group alone. A buddy is always beside her and uses either verbal reinforcement or physical touching to convey support and the belief that the woman can face this difficult issue in her life.

Substance-abusing women lack self-esteem, regardless of their socioeconomic level.

have been profoundly violated—need to face the realities of their situation without being mired in guilt and shame. These marginalized women need a program that is designed to help them become empowered, to build their self-esteem, and to find their inherent inner strengths.

Programs for incarcerated women need to provide an approach that supports and bolsters these women’s very low self-esteem. The approach needs to encourage trust, bonding, and empowerment, and to provide confrontation that is low key and supportive. Firm, but supportive, confrontation is absolutely essential for these women—a theme that will be stressed throughout this document.

Clinical Issue 3: Race, ethnicity, and cultural issues

Many incarcerated women with substance abuse problems come from minority racial and ethnic groups. Race, ethnicity, and culture are all important to a woman’s sense of identity, to her life experience, and to her personal history of drug use. The nuances of these differences need to be understood and respected.

For women of color, racism may be a central issue. Racism is a very sensitive and often uncomfortable issue to talk about. Because the topic is so difficult, racism often is not addressed in treatment programs. In addition, women of color can find it very

difficult to ask for help with such problems as substance abuse and mental health issues, because they do not trust the systems that have traditionally provided this care. Incarcerated women of color especially feel that the criminal justice system does not treat them equitably (Kanuha 1994, p. 447). These women feel that counselors and clinicians will not understand them, just as those who were supposed to help them during the judicial process did not.

Every clinician must seriously consider the intense, historical, and reality-based conflict that some battered women of color have about protecting themselves from violence vs. protecting their family or community from judgment or further stigmatization as a result of institutionalized racism. Practitioners must balance the issue of safety for the battered victim with the real and perceived experiences of battered women of color that the very institutions mandated to help them, such as the police and courts, themselves have a legacy of violence toward men and women of color (Kanuha 1994, p. 447).

Because of their own cultural experience, women of color may approach certain important issues from a different perspective than other groups. For example, women of color have a harder time than others in acknowledging abuse by the men in their lives (Rogers et al., n.d.). These women often use the excuse that their men are constantly faced with racist attitudes; the only place

where the men can express their anger is at home. In addition, women of color are also more reluctant to report abuses against themselves and their children than other women may be (White 1986). These women fear the consequences of the criminal justice system not only for themselves and for the men of color in their lives, but for their children as well (C.F. Newkirk, personal communication, 1997).

Programming approaches. The CSAT-sponsored treatment programs for women work to provide a culturally sensitive environment and, in many cases, special programming for specific ethnic and minority groups. As a base, such programs approach each woman with respect for her cultural traditions and an understanding that her acculturation exerts profound effects on how a woman views herself and others, on her feelings and what she values, and on her behavior. Designing a culturally sensitive program requires attention to at least the following two key issues:

- **Awareness of the wide differences within ethnic groups.** For example, Hispanic or Latina women come from a variety of different countries and cultural traditions. American Indian tribes represent a considerable range of cultural attitudes and values, with differences pertaining to women's traditional roles and power, child-rearing practices, and many clinical issues. An excellent overview of this diversity appears in Comas-Díaz and Greene (1994), in a seven-chapter section titled "Women of Color: A Portrait of Heterogeneity."

- **Awareness of the challenges in providing a culturally sensitive staff.** It is important to realize that all staff, regardless of their ethnicity, may need training in cultural sensitivity and knowledge. Just because a peer counselor or professional staff member comes from a particular racial or ethnic group does not mean that the person will necessarily be sensitive to specific cultural issues of that group. Staff members' life experiences may have been quite different from those of the group they are asked to counsel and treat.

One recommended strategy is to make the discussion of cultural differences a part of everyday conversations in the program, especially in process groups. This ongoing attention fosters respect for differences. Both clients and staff learn from each other what their differences and similarities are. In our society, we have learned to talk about how women and men think and act differently, based on their acculturation. Similar differences occur as a result of racial and ethnic issues, but as a society we find these issues difficult to talk about.

In substance abuse treatment, women's groups are used to focus on topics affecting special populations. Several of the CSAT-supported programs offer special counseling and process groups for culturally specific and older women's groups.

Clinical Issue 4: Gender discrimination and harassment

Programs for women need to acknowledge and explore the broad-ranging effects on women

of the sexism still encountered in American society. The differential treatment of men and women underlies many of the issues that women need to address, including self-esteem, roles, and work opportunities.

Alcoholic and addicted women suffer from the social stigma attached to women's drinking and drug use. It is widely recognized that this stigma is greater for women than for men. The shame and secrecy that surrounds this addictive behavior is one challenge. Cultural disapproval and disdain for abusing women is damaging to the women's sense of self. The vehemence of this disapproval can be seen in recent U.S. social and legal responses to women's substance abuse, such as efforts in some States to imprison substance-abusing women who are pregnant rather than to treat them. Substance-abusing women in prisons and jails must combat not only the stigma attached to being a woman with addiction problems, but also the multidimensional effects of being a woman—often a single mother—without education or job skills, with few or no legal sources of income, and living in poverty if not homelessness.

All substance-abusing women feel the effects of this social stigma and disapproval. But women in prison or jail must face this disdain on all levels. These are typically poor women, undereducated and generally without jobs. Many are women of color. Women generally have low-ranking roles in male-dominated drug-dealing, which don't net them much income. Many of these women are forced by economic need to support their

drug habits through prostitution or the barter of sex for small sums of money. Our society thinks very badly of such women. Their children have been neglected and in some cases abused. It is devastating for women to feel they have failed to be a "good woman" in so many dimensions. Women often turn the cultural disdain for this behavior inward on themselves.

Programs for women need to acknowledge and explore the broad-ranging effects on women of the sexism still encountered in American society.

The effect is to erode a woman's self-esteem and paralyze her ability to recover and build a different life.

Women are most often the victims of domestic violence, but they can also be the perpetrators of physical and sexual abuse. In our society, we have a strong social taboo regarding women who are perpetrators, particularly when they neglect or abuse their children. Because of the stigma, it is very difficult for clients and for staff, as well, to discuss these behaviors. Staff need to be aware and empathic about the fact that many women offenders are at risk for these behaviors because of their histories of physical and sexual abuse, as well as incest. This experience of abuse, combined with their present alcohol and/or other drug abuse, make these women offenders particularly vulnerable to such behaviors and to "acting out" in terms of their own stigma.

The programming approaches. Gender discrimination, com-

bined with racism and social stigma, are deep-seated currents in U.S. society that create guilt, shame, and lowered self-esteem for substance-abusing women, as well as lessening their real opportunities. Their effects on women need to be recognized within the program. For example, a woman-centered program philosophy can acknowledge the many ways

in which women in our society may be economically disadvantaged, financially dependent, and lacking in marketable job skills. This perspective lets the woman offender know she is not personally deficient because she is poor and has few job skills. These are circumstances a woman can hope to change.

An important strategy is to provide female role models who demonstrate competence and power. Aspects of this include:

- Providing female counseling staff, including women who are in recovery from substance abuse and/or are ex-offenders themselves (several of the CSAT-funded programs have all-female staffs)
- Ensuring that women staff members have administrative positions of authority (it is more common for treatment programs to have men in the key administrative and supervisory positions while women work as counselors)

- Hiring an ethnically diverse staff and bringing back successful program graduates of differing backgrounds to serve as additional role models

Clinical Issue 5: Relevant disability-related issues

Disabilities place a woman at increased risk of drug and alcohol abuse. For substance-abusing women who have disabilities, the role these disabilities may play in a woman's addiction is an important topic to pursue. For this reason, CSAT lists the presence of disabilities as an important clinical issue in treating women. This topic needs to be considered and addressed by anyone designing and setting up a treatment program.

However, the women clients in the CSAT offender demonstration programs did not present with serious physical disabilities. Since disability-related issues were not a concern among the grantees, the CSAT jail and prison programs did not develop any specific program strategies for disabled women.

Clinical Issue 6: Relationships with family and significant others

Importance of relationships in the woman's life. As described in chapter 2, the "relational model" (Covington and Surrey 1997) is useful for understanding the importance of relationships in women's lives and in the process of their recovery. This model emphasizes that relationships are central in the emotional development of women. A woman's development hinges on her relationships with others, including

serving and caring for others, and on her connections with others and feelings. These nurturing and caregiving roles are organizing principles in a woman's life, which can be a source of great strength during her recovery (CSAT 1994b).

Women offenders often develop their dependency on drugs early, frequently in early adolescence. Such adolescent drug dependency interferes both with a young woman's cognitive and emotional growth and development. These emotionally immature and dependent women need the opportunity, in a drug-free environment, to become emotionally mature adults capable of real connection with others.

Many substance-abusing women offenders have had few or no positive relationships in their lives. Such women have no models for developing healthy relationships, nor do they even have a sense of what a healthy relationship could be. For a model of a healthy relationship, one resource is *Leaving the Enchanted Forest: The Path from Relationship Addiction to Intimacy* (Covington and Beckett 1988).

Addicted women lose their sense of self. Women offenders who became dependent on alcohol and other drugs during their teen years did not have a chance to develop a deep inner sense of self and of personal identity. Without a sense of who she is, a woman is incapable of having real connections to others. Recovery from addiction is about expansion and growth of the self.

Family of origin issues. Women also need to understand how alcohol and drug problems may have affected the family in which

they grew up, including the relations between family members. Substance use patterns—and relationships—are modeled within families. Norms about drinking are "set" by family members as well as by peers. Substance abuse creates a dysfunctional family structure, even for mainstream families. Both this family dysfunction, and problems with chemical dependency, tend to be passed on from generation to generation. In some cases, there is a genetic predisposition to alcohol or drug dependence. But substance abuse is also learned. Children and codependent adults develop family roles and behavior patterns that help them survive in this environment. These dysfunctional patterns persist and limit the family members' ability to connect with others and to live a full and satisfying life.

Women alcoholics are more likely than male alcoholics to have a family history of alcoholism (Blume 1992). In State prisons, 32 percent of women inmates have a parent who abused alcohol and 7 percent have a parent who used drugs (BJS 1994). In New Jersey, 43 percent of the women in State prisons lived with alcoholic relatives while they were growing up and 45 percent lived with drug-using relatives (Gonzalez 1996). Among these women's siblings, 39 percent have an alcohol problem and 50 percent have a drug problem.

Programming approaches. A good treatment program needs to establish an environment in which women are encouraged to grow in maturity and to connect with others. Issues of trust, inti-

macy, and bonding are all central, and the program approach should encourage sharing of feelings and bonding among the women. Staff members can be important role models for how to connect and relate to others in healthy, caring relationships.

Programs also need to make women aware of the emotional dynamics in substance-abusing families. These dynamics affect not only the attitudes that a woman develops while growing up with a substance-abusing parent, but also the woman's life with her children.

Nearly half of female inmates report that at least one member of their immediate family has been incarcerated (BJS 1994). These women need to look at what effect their family environment may have had on their attitudes, values, and behavior, and on how they connect with others.

Several of the CSAT-supported women's programs provide education on the effects of family addiction, and one has a group for adult children of alcoholic families (ACoA). A number of communities have ACoA groups that could provide post-release support for women and their families.

Clinical Issue 7: Attachment to unhealthy relationships

Women who abuse alcohol and other drugs tend to have relationships characterized by unhealthy dependencies and poor communication skills (Bepko 1985). Substance-abusing women offenders often have unhealthy, illusory, or unequal relationships with spouses, partners, friends, and family members (Covington, in press). Some drug-dependent women use addictive substances

to mask the inadequacies and pain of their relationships—to help them maintain relationships with drug-using partners, to fill up the void of what is missing in the relationship, or to deny the pain of being abused (Covington, in press).

Problems connected with drug-using male partners. Having a drug-using male partner is a particularly critical problem for the incarcerated woman with substance abuse problems. Many women say a man introduced them to drugs, while men more often began using drugs with male peers. In one study, 33 percent of female heroin addicts said a male friend, spouse, or partner influenced their decision to use narcotics. Only 2 percent of male

The woman may be part of a drug-using environment in which not only her partner, but also her siblings and parent(s), are involved with drugs. Incarcerated women need to build the strength to break their unhealthy dependency bonds on their partners, not only as a step toward substance abuse recovery but to prevent recidivism to criminal activities through the partner's influence.

Programming approaches. Programs for incarcerated women need to place an emphasis on overcoming disempowerment and disconnection from others as a basis for recovery. This approach looks at a woman's relationships in terms of her own needs, her sense of self, and the

A good treatment program needs to establish an environment in which women are encouraged to grow in maturity and to connect with others.

addicts said that a woman influenced their decision (CASA 1996).

It is accurate to say that some of these women are addicted both to the substance and to a man who is addicted. A man introduces them to drugs, and they depend on the man for their supply. In many cases, the woman's criminal activities can result from dependent acquiescence in responding to the wants of an addicted male partner.

Lack of awareness of exploitation. The woman may not recognize that she has a history of being exploited by the addicted partner. Physical, sexual, and emotional abuse often go hand-in-hand with these relationships.

responsibility she owes to herself. The woman needs first to understand what a healthy relationship entails, so she is able to assess her own relationships. Before entering treatment programs, many women do not see how they are being exploited or even realize that they are being abused.

Through an effective treatment program, the woman finds that she can care about others, while also making responsible choices in her own behavior. She learns that she has a responsibility to set boundaries and take care of her own needs (Beattie 1989, 1990). For a woman to break her pattern of unhealthy relationships, she needs help to:

- Recognize intimacy and friendship, as distinct from sexuality
- Develop trust in herself as a way of developing trust in others
- Attend to her own needs and identify how these needs could be met through friendship and support from others, especially from other women
- Develop actual relationships of trust and support with others
- Understand the different qualities of dependence, independence, and interdependence
- Identify and deal with any codependent behaviors in which the woman represses her own feelings, neglects herself, and doesn't set her own boundaries

Many drug-dependent women, when they leave prison or jail, will face the necessity of cutting

Incarcerated women, particularly those with substance abuse problems, have almost universally suffered some form of violence, including sexual abuse as children.

themselves off from the significant people in their lives. To maintain recovery, the woman needs to live in a safe and drug-free environment. She needs to be independent from addicted family members—whether a partner, a brother or sister, or a parent. Treatment programs need to prepare women to make this kind of emotional break, and also to help the woman find safe and drug-free housing and a network of support.

Clinical Issue 8: Interpersonal violence, including incest, rape, battering, and other abuse

Research shows that a high proportion of both alcoholic women and those addicted to drugs have a history of being physically or sexually abused. Incarcerated women, particularly those with substance abuse problems, have almost universally suffered some form of violence, including sexual abuse as children.

Two of every three women offenders ran away from home at some time as children (a frequent reaction to abuse at home); about one in every four have attempted suicide; and nearly seven of every 10 offenders were victims of severe and prolonged physical and sexual abuse primarily as children, but continuing into adulthood for many (Lord 1995, p. 261). At Forever Free and WCI

Village—both CSAT-supported prison programs—the project directors estimate that 90 percent of their clients have suffered some form of abuse from an early age, and 90 percent of that is sexual abuse.

Sexual abuse during childhood is particularly devastating, since it can lead to distrust, depression, anxiety, shame, and poor self-image, all of which can hinder recovery from addiction (Harvey et al. 1994). Violence has a psy-

chological impact on women that is manifested in such disorders as depression, post-traumatic stress disorder, and low self-esteem. Among pretrial jail detainees in the large-scale study in Chicago, fully one-third (34 percent) met the criteria for post-traumatic stress disorder (Teplin et al. 1996).

Many studies have shown the correlations between domestic violence and substance abuse. Because so many substance-abusing women offenders are involved in relationships with substance-abusing men, the women suffer a high level of verbal/physical abuse and victimization. Both victimization and post-traumatic stress disorder are related to relapse in women (Root 1989).

Over the past decade, a good deal has been learned about the etiology of domestic violence and battering and about strategies for helping women to avoid and escape such relationships. Most researchers now view violence against women in a broad social and cultural context, not solely as a mental health problem resulting from individual pathology. The psychological model explains violence as a manifestation of both individual psychopathology and learned behavior, with roots in early childhood abuse, family dysfunction, drug abuse, or disorders of personality, thought, or impulse control (Thorne-Finch 1992). In accord with this view, intervention strategies for women need to be comprehensive in approach.

The programming approaches. Treatment programs for incarcerated women need to start with the recognition that many of the

Resources

Treatment Protocol: Domestic Violence and Substance Abuse

For an introduction and recommendations on treating substance-abusing clients who are the survivors or perpetrators of domestic violence, order CSAT's recent guidelines produced by a panel made up primarily of domestic violence experts. The book is *Substance Abuse Treatment and Domestic Violence*, Center for Substance Abuse Treatment (CSAT), Treatment Improvement Protocol (TIP) Series, No. 25, DHHS Pub. No. (SMA) 97-3163. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997b. This guide includes an overview of female survivors and male batterers; and covers screening and referral of survivors and batterers in substance abuse treatment programs; legal issues; community linkages and coordination; Federal confidentiality regulations; assessment instruments in English and Spanish; a sample personalized safety plan for survivors; and resources and services. All TIPs are available free through the National Clearinghouse for Alcohol and Drug Information (NCADI), 1-800-729-6686.

Bibliography: Women, Violence, and Substance Abuse Treatment

To learn more about women, violence, and substance abuse treatment, order CSAT's selected bibliography of articles and books published on this topic since 1990, as well as other resources. The report is titled *Women, Violence, and Substance Abuse: Selected Bibliographies, 1990-1998*. It was prepared for the Center for Substance Abuse Treatment by the National Evaluation Data and Technical Assistance Center (NEDTAC), April 1998. The report is available on the Internet at: [<http://neds.calib.com>].

participants have suffered from physical, verbal, psychological, and sexual mistreatment (Miller 1991, Mondanaro et al. 1982). For many, this abuse is a central factor in their addiction and in their inability to maintain recovery. Women who return to violent relationships tend to relapse (Miller et al. 1989).

Establishing an environment for recovery. According to Herman (1992), in her book *Trauma and Recovery*, "Survivors feel unsafe in their bodies. Their emotions

and their thinking feel out of control. They also feel unsafe in relation to other people" (p. 160).

In the early stages of recovery from trauma, the essential element is safety (Herman 1992). A woman must feel that she is in a safe environment, both physically and emotionally. Successfully establishing such an environment within the prison or jail setting is primary.

Working through feelings about abuse. The second essential element is to help the woman con-

front and deal with her feelings about the emotional and physical trauma she has endured. As one of the CSAT program directors stated, "The abuse these women have suffered is at the core of their substance abuse. If women don't have a chance to work through their rage, they soon relapse and end up right back in prison." For women, the issue of abuse is a sensitive, emotionally charged issue. Project staffs recommend addressing this issue in various ways, depending on the stage in the treatment process and the length and intensity of the program.

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How deeply to probe about feelings about abuse during screening is discussed in chapter 6, in "Stage 1: Screening and Assessment." The most effective ways to handle issues of sexual and physical abuse in short and longer term programs are also discussed in chapter 6.

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How best to introduce these sensitive issues will depend on the woman's readiness to acknowledge the abuse and to process her feelings. For some women, the preferred way to handle issues of abuse is in women's process groups. Other women may fare better with individual therapy.

Within their process groups, the CSAT-supported programs have chosen to deal with these sensitive issues in two different ways. Some programs consider violence, victimization, and abuse to be so pervasive that it is a subject which emerges throughout all the group work.

This avoids any stigma attached to a special group on the topic. Other programs utilize a variety of specific groups, such as: Domestic Violence and Abuse, and Surviving Sexual Abuse.

Staff need to be aware that many of these women have been so violated since childhood that they don't even recognize they have been abused. It is important to raise their awareness about their personal rights and boundaries, and about what constitutes verbal, physical, and emotional abuse. Only then can the women set their own personal boundaries.

Racial and cultural differences. The patterns and outcomes associated with violence do vary, depending on the woman's racial, ethnic, and cultural background. Most researchers now agree that domestic violence does exist in a social and cultural context (Kanuha 1994, p. 430). Research is beginning to show what the differences are across cultural lines on this issue, and providers need to be sensitive and knowledgeable about these complex cultural differences (Comas-Díaz and Greene 1994). For a review of the primary literature sources discussing cultural patterns in domestic violence, see Kanuha (1994).

Kanuha (1994, pp. 446-449) discusses intervention strategies with women of color in battering relationships, both in terms of individual clinical interventions as well as organizational development activities. Studies suggest that having social supports available, such as social networks and extended family, is a positive factor in helping women of color perceive options

for leaving their battering partners (Coley and Beckett 1988). Kanuha (1994) recommends comprehensive approaches. She suggests that, for women of color, individual therapy can be a helpful tool but it needs to be incorporated with "group work, educational sessions about the etiology of violence against women ... family therapy, and most importantly, culturally specific healing regimens and ceremonies."

Battering in lesbian relationships. Battering and domestic violence may be present in lesbian as well as heterosexual relationships, and is often related to drug abuse. The isolation and invisibility that is enforced by society makes this a difficult issue for any woman, and this difficulty is compounded for women of color. Separate groups for lesbian women are desirable, since these women may not feel comfortable in support groups for battered heterosexual women (Kanuha 1994).

Clinical Issue 9: Eating disorders

The culturally driven urge to be slender is widespread among women in the United States. On any given day, from 33 to 40 percent of American women are trying to lose weight (NIH 1992). Substance-abusing women are particularly prone to eating disorders. In part, this is because cocaine, heroin, and tobacco are all linked to being thin. Women who give up these substances are likely to gain weight. Bulimia and anorexia occur more frequently among alcoholic women than other women.

Among the women offenders in the CSAT demonstration programs, eating disorders are not a major problem. Some information suggests that the cultural pressures to be thin may not be as strong for women of color as for other groups. In the CSAT programs, nutrition is the more important concern. Incarcerated women demonstrate a number of issues around eating. One of these is cultural: the fact that women and mothers are equated with nurturing and food. Addiction, recovery, and relapse are associated with drastic fluctuations in weight loss and gain. Women in institutional settings may be rewarded for gaining weight because of the perception that extra weight signifies a woman is not using drugs. Weight gain may be rewarded because of the perception that extra weight signifies no drug use. In prison, women who have been heavy cocaine or heroin users will tend to gain weight. Obesity can also result from the heavy prison diet, often designed for men.

Good nutrition is a problem. Many of the women have never had a well balanced, nutritional diet. The women tend not to have knowledge about nutrition and good eating habits. Establishing good nutrition, and reducing food cravings from nutritional imbalances, is important for preventing relapse.

Although the CSAT-supported programs did not focus on nicotine addiction, this can be an important issue in prisons and jails. The current information about nicotine addiction suggests that, particularly in the case of young white women, nicotine addiction is on

the rise. Smoking is used to control weight gain. However, the same information suggests that smoking is on the decline among African American teenage girls because the cultural pressures to be thin are not as strong.

Women in prisons and jails may actually be heavier smokers than male inmates. An increasing number of prisons and jails are becoming smoke-free environments, and nicotine addiction then becomes a necessary treatment issue. The OPTIONS Program in Philadelphia is one model that addresses this issue.

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For program descriptions and contact information on eating disorders, see chapter 8.

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The programming approaches. Because of the high rate of malnutrition among substance-abusing women offenders, programs need to educate the women about proper nutrition. In prison TC settings, it may be possible for the women to plan and cook their own meals, which gives practical benefits. The women need to know how to prepare nutritious, well-balanced meals on a low budget. Many of the CSAT-supported programs provide educational sessions on nutrition.

In general, prisons and jails often do not provide the types of foods most appropriate and desirable for women. Treatment programs may not be able to influence their institution's food. However, the kinds of concerns expressed by the CSAT advisory group were that (1) institutional

food tends to be too heavy on meat, cheeses, and starches, so the women gain weight, (2) women who are vegetarian have difficulty achieving a balanced diet, and (3) meals may not be nutritionally adequate for pregnant women.

The most desirable physical arrangement is for incarcerated women's treatment programs to be located in their own separate space. The women eat together in their unit rather than with the overall jail or prison population.

and drugs will aggravate, not help, a woman's sexual dysfunction.

Developing a sense of healthy sexuality is tied to a person's sense of self-worth. It represents the integration of the biological, emotional, social, and spiritual aspects of who the woman is and how she relates to others (Covington 1991a). A woman's sense of her sexuality is a developmental process that occurs over time. For women offenders, this normal developmental

Developing a sense of healthy sexuality is tied to a person's sense of self-worth.

Under these conditions, program providers may be able to provide meals that demonstrate good nutrition for women.

Clinical Issue 10: Sexuality, including sexual functioning and sexual orientation

Women often go through substance abuse treatment without ever addressing issues of sexuality and intimacy. Yet sexual dysfunction is very common among women with substance abuse problems, often predating their problem drug use. It has been reported that only 55 percent of women recovering from alcohol abuse report satisfaction with their sexual functioning, compared with 85 percent of nonalcoholic women (Covington 1991a). Contrary to social stereotypes, alcohol depresses a woman's interest in sex. There is also a lack of sexual desire among heroin-addicted women. Alcohol

process has often been interrupted by addiction and distorted by her personal experiences. She may never have experienced sexuality without being under the influence of alcohol or other drugs.

Few women in prison have a positive view of sex. Some have been prostitutes, many have been sexually abused, and most connect sex with shame and guilt (Covington, in press). Even women who have been the most sexually active may have little accurate information about sex.

Incarcerated women have a number of other issues around sexuality. Women with substance-abuse problems are frequently confused about the difference between intimacy and sex. These women may never have experienced intimacy with another person, so they have difficulty in achieving intimacy in their relationships. It is common for these

women to confuse sexuality with the intimacy they really seek, on the assumption that sex and intimacy are the same.

Sexual identity and self-acceptance may be an issue for some lesbian and bisexual women. Older women have their own issues. The many women with severe addiction problems can experience physiological consequences, such as hormonal changes and liver damage, that affect their sexual functioning. One CSAT-supported program reports that many of the women in the program, as a result of severe substance abuse, are starting menopause very early—in their late 30s and early 40s.

The programming approaches. Sexuality is an essential area for addiction treatment programs to address, because issues around

sexual desire and sexual functioning.

- **Common concerns among recovering women.** The program should also help women understand that they share many concerns common to women offenders entering the early stages of recovery. These include concerns about sexual dysfunction, shame and guilt, sexual identity, prostitution, sexual abuse, and the fear of having sex “clean and sober.”
- **The relationship of substance abuse to physical and sexual abuse.** The women should understand that substance abuse is related to physical and sexual abuse. Alcohol consumption, for example, has been linked to assault, rape, spouse and child abuse, and fight-related homicide. Many

ties in dealing with three sources of stigma—their sex, their race or ethnicity, and their sexual preference. Special groups for lesbian and bisexual women are one programmatic approach.

- **Prostitution.** Many of the women have either been prostitutes or have exchanged sex for drugs. These bartering conditions, especially in “crack houses,” may be degrading and demeaning for teenage girls and women. Substance-abusing women involved in this kind of “sex for survival” have issues on many levels, from shame to concerns about intimacy and self. The women need help in exploring their lifestyle and they also need the practical tools to change that lifestyle. Either a group or individual counseling approach, or both, is helpful. The SISTER program offers specific counseling for prostitutes in a group called the “Ex-Sex Workers Group.”

Many disadvantaged women with substance abuse problems have grown up in families where they experienced parental neglect or abuse.

sexuality are a major cause of relapse among women. Approaches need to help women work through their sexuality issues on a number of dimensions. One helpful resource is the document, *Awakening Your Sexuality: A Guide for Recovering Women and Their Partners* (Covington 1991a). Treatment needs to help women understand such issues as:

- **Basic information about drugs and sexuality.** As a first step, all the women need to know about the role that alcohol and drugs can play in diminishing

women in this population will not be able to separate sexuality from issues of incest, rape, or sexual abuse. These are often the core problems that underlie sexual dysfunction in these women. Both individual and group counseling are helpful approaches. Several of the CSAT programs offer groups on “surviving sexual abuse.”

- **Sexual identity and self-acceptance.** Women who are lesbian or bisexual may feel shame and stigma, which can be a factor in relapse. Women of color face particular difficul-

Many disadvantaged women with substance abuse problems have grown up in families where they experienced parental neglect or abuse. These women do not know how to be nurturing parents because they never experienced nurturing as children. The women often have no role model for consistent, positive parenting. In addition, experts who treat poor, substance-using women report that disadvantaged women often do not know what normal child behavior is. They tend to have unrealistically high expectations about how their children should behave,

Clinical Issue 11: Parenting

combined with harsh disciplinary practices.

Incarcerated, substance-abusing women have an acute need for help with mothering behavior. When mothers have been imprisoned, their children are likely to feel abandoned and to demonstrate both behavioral and emotional problems. If the mother used drugs during her pregnancies, her children may also have subtle behavioral or cognitive problems that create a need for special tolerance and parenting skills.

It can be emotionally difficult for treatment staff to accept the fact that some women will not be reunited with their children or may not want to have custody. In some cases, reunification will not be practically possible or in the best interests of the children. Whatever the outcome regarding eventual custody, these are difficult, painful parenting issues for women to handle. Treatment staff can help incarcerated women assume—and plan for—as great a role as possible in the decisions about their children. But staff need to be sensitive and self-aware, so they do not inadvertently increase the guilt these women clients already feel about their children and their inadequacies as mothers.

The programming approaches. Relationships with her children are almost always a central focus in a woman's sense of self and her emotional life. Parenting and mothering are important issues. Many addicted women offenders need to learn what positive parenting entails. The longer term treatment programs offer the chance for women to observe

and practice how to nurture themselves and their children. These longer women's programs (2 months or more) address parenting issues through a variety of education, skills-building, counseling, and child visiting/observation efforts.

When the child visits, skilled observation of the interaction between mother and child can give a concrete basis for therapy with the mother. As an example, at WCI Village, one mother was observed to be functioning as a sister to her visiting children, rather than as a parent; she was then helped to understand and assume a parental role.

The CSAT grantees suggest the following topics are important to cover in parenting programs:

- **Education on child development.** This education needs to focus on normal patterns of child development and what is reasonable to expect in terms of behavior at different ages. Incarcerated mothers need special help concerning the feelings and behavior of children after the separation from her. Their behavior may be very difficult for a parent to handle.
- **Family communication.** Among the skills needed are listening skills, confrontation, resolving conflicts, handling stress, expressing emotions, redirecting children's misbehavior, building self-esteem, and effective discipline.
- **Fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), and drug exposure in utero.** The women need to be aware of possible effects on their children from the mother's use of alcohol and drugs during preg-

nancy. Such children are often not identified by the schools, although the children may be experiencing learning disorders, attention deficit disorder, and other problems. These children may be fussy and hard to console as infants, and later may be nervous and distractible with subtle behavior problems. Women need to know what to look for and what help is available for the children.

The types of interventions offered by the CSAT-supported women's programs are parenting education groups, parenting counseling groups, counseling and therapy for the individual woman as a parent and for the entire family, and a group dealing with mother/daughter issues.

Clinical Issue 12: Grief

Clinical evidence suggests that women will experience a sense of acute grief and loss in acknowledging their drug use and need to sustain sobriety (Zankowski 1987). Incarcerated addicted women are also faced with almost overwhelming grief and loss as the result of their past lives. To recover from addiction, women need to work through their feelings of guilt and shame, as well as loss. Several of the CSAT women's programs report that it is difficult for their women clients to recover and maintain sobriety if they do not go through a grieving process first.

There is the loss of the substance itself, which has been serving some critical function for the woman. By the time a woman is incarcerated, she has suffered overwhelming losses—her children, her partner, her self-

respect, often her health and appearance. The many women who have been in abusive relationships with substance-abusing partners will come to understand that their lives must start over. They must give up the people who have been important to them and build other, positive relationships. Women with parents or siblings who abuse drugs will have to distance themselves from their families in the interest of recovery.

Women also experience grief, shame, and guilt associated with the real damage they have done to those they love, particularly their children, and to themselves. Several of the CSAT grantees have stressed how important it is to have some spirituality component in work with women. If

either a modified 12-Step model or a TC that includes 12-Step principles. They believe that the spirituality embedded in the 12-Step model is an important advantage for treating women. *A Woman's Way Through the Twelve Steps* is one resource that illustrates the different ways in which women can connect to a spiritual source and acknowledge their responsibility and grief, while also growing in terms of self (Covington 1994).

Many of the CSAT grantees stressed that helping women to connect to their own definition of the spiritual is critical to their recovery process. Religion and spirituality are not the same, although for some women they are connected. Religion rests with institutions, and is based on

ing for women to realize that they are part of a long history in which females have been revered as “birthers, growers, and caregivers.”

Clinical Issue 13: Work

Both low levels of education and unemployment are correlated with substance abuse for women. Incarcerated substance-abusing women are extremely vulnerable to recidivism and to relapse if they cannot sustain themselves (and their families) economically through lawful employment. This factor has become critical since passage of the Federal welfare-to-work legislation. Women formerly sustained through welfare programs will find this to be only a temporary help, if they are eligible at all. The legislation requires, unless the State opts out or modifies the requirement, that anyone convicted of a drug-related felony after August 22, 1996 will not be eligible for cash benefits or food stamps. Women in the CSAT-supported programs present the following issues:

- **Education.** The low educational level of women offenders in the CSAT prison demonstration programs adversely affects their ability to sustain themselves and their families economically and legally. Among the CSAT programs, the Oregon Recovery In Focus program has the highest average educational level of women clients—11th grade. The Baltimore pre-detention program is typical, with 65 percent of clients not graduated from high school. All the CSAT programs encourage education, especially acquiring a GED, as a base for achieving self-sufficiency.

Spirituality can be important in providing a sense of purpose [for their grief and pain].

women are to endure and rise above all this grief and pain, then there must be the sense that it has all been for some reason. Spirituality can be important in providing this sense of purpose.

The programming approaches. Programs designed for women use a philosophy that focuses on the strength of each individual and uses her experience, both past and present, as learning tools rather than as sources of grief and shame (Walker et al. 1991). The women need to take responsibility for the harm they have done to others, while also learning to value themselves.

The CSAT-supported programs described in this *Guide* use

forms, dogma, and rituals. Spirituality, for women, is about “transformation, connection, wholeness, meaning, and depth” (Covington, in press).

Women connect to their inner sense of spirituality in many ways. Those who have rejected religion must find a different path; others may be drawn back to the religion of their childhood. Covington (in press) reports that she has found it useful to give art history books to women in recovery groups. Women connect with the energy of the prehistoric earth goddesses, worshipped in apparently all cultures for thousands of years before patriarchal religions developed. It is affirm-

- **Employment.** In prison studies, incarcerated women in general often mention substance abuse as a reason for their unemployment. Few women in the CSAT programs have had any specialized vocational training and most are unemployed. As an example, the Baltimore pre-trial program reports that more than 70 percent of their clients are aged 26-40 years and only 8 percent state that wages/salary were their primary income source before incarceration; just 12 percent report working full- or part-time in the past year. Some 32 percent of the women receive public assistance and 65 percent report being unemployed.

The programming approaches. Substance abuse treatment programs do not generally provide vocational training for women during incarceration or after their release. Actual training is done as part of the institutional programming, in work-release programs, or through community referrals.

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The coordination of treatment with prison work programs is discussed in chapter 5.

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The treatment program's role is to provide the planning, outreach, and advocacy needed to equip their women with necessary job skills. Women suffer from a dearth of the well-paying, unskilled labor jobs available for men. Since women often support a family, not just themselves, there needs to be a real focus on preparing women for jobs that pay a decent living wage. In the CSAT-supported programs, the

following types of help are provided:

- GED testing and assessment and adult basic education to pass the GED (graduate equivalency diploma)
- Vocational testing for training programs
- Job hunting skills, including writing resumes, interviewing
- Vocational planning

Clinical Issue 14: Appearance and overall health and hygiene

Physical and dental health. Typically, indigent drug-abusing women do not seek treatment for physical ailments until their conditions are serious (Prendergast et al. 1995). Women come into prison with more medical needs than do men (Lord 1995). Drug-abusing women enter incarceration with a host of untreated mental and physical health problems. All drug users, and cocaine users in particular, are at increased risk for a range of physical problems, including extreme weight loss, dehydration, digestive disorders, skin problems, dental problems, gynecological and venereal infections, tuberculosis, hepatitis B, hypertension, seizures, respiratory arrest, and cardiac failure (Daley and Przybycin 1989).

For drug-abusing women offenders, medical treatment is important not only for reasons of health but to increase their self-esteem. For women, body image is tied to self-esteem. The CSAT grantees report that women offenders who have used crack cocaine heavily often present with disfiguring facial sores, missing teeth, and other physical evidence of neglect. Because of

the prison diet, women may have gained considerable weight and consequently feel obese and unattractive. CSAT's advisory panel stressed that resolving these types of problems is important, because it bolsters the women's sense of self-worth.

The programming approaches. Medical services need to be provided for incarcerated women with substance abuse problems. Many jails and some prisons lack the facilities to provide women with the level and type of care they need. For treatment programs for incarcerated women, the approach is threefold:

- The program needs to arrange for adequate medical and dental services. Staff may need to advocate on behalf of the women for adequate medical and dental care. It is important to help women gain access to the services available within the jail or prison setting.
- The program should help women understand how substance abuse has affected their health and underscore their responsibility for the health of their own bodies.
- The program should stress that it is important whether the women's teeth are fixed and their physical problems are treated. This kind of attitude says, "you are a worthy person and it matters how you look and feel."

Pregnant women offenders. Most of the pregnant women coming into prison are young first offenders in need of intensive drug treatment (Lord 1995). Alcohol- and drug-abusing women who are pregnant when they enter prison face severe, multiple problems. The outcome

of the pregnancy is often complicated not only by the mother's substance abuse, but by her general ill health, poor nourishment, sexually transmitted diseases, battering, and late or no medical attention. These are high-risk pregnancies. Especially in jails, the women may receive no medical care at all or inadequate prenatal care. The detoxification process can be hazardous for the fetus.

The programming approaches. Substance-abusing women who are pregnant when they enter custody need specialized obstetrical care for their high-risk pregnancies. The CSAT Treatment Improvement Protocol (TIP 2), *Pregnant Substance-Using Women* (CSAT 1993b), offers guidelines for handling detoxification from heroin and other drugs. The consensus panel, in developing TIP 2, found that many protocols used for detoxification did not address the special cautions required for pregnant women.

It is particularly important to identify and treat pregnant women who are HIV positive. Transmission from the mother is the foremost cause of pediatric AIDS in the United States. Medical treatment with pharmacotherapy of HIV-infected pregnant women can now cut by 68 percent the chance that the mother will transmit the virus to the fetus (CDC 1994).

Most institutions automatically remove the baby after birth from mothers who are pregnant when they enter prison. Among CSAT-supported programs described in this *Guide*, both the WCI Village TC and the Recovery In Focus programs have special compo-

nents designed to help new mothers. WCI Village helps a pregnant woman prepare for loss of the baby and lets her help choose the baby's caregiver, if possible. The In Focus program operates a volunteer foster parent program for the babies. These volunteer parents bring babies for visits to the mother.

AIDS and other sexually transmitted diseases. Women who inject drugs or who have drug-injecting sex partners face increased risk of contracting HIV/AIDS. An appreciable number of drug-abusing women already have HIV infection or untreated sexually transmitted diseases (STDs) when they enter prison. The costs of medical care in prison have risen dramatically with the advent of the AIDS epidemic. Among State prison inmates nationwide, a higher percentage of women than men test positive for the human immunodeficiency virus (HIV) (BJS 1994). In New York, one out of every five women entering the State prison system is HIV positive (Lord 1995).

In addition, women who smoke crack are emerging as a population at equal or greater risk than intravenous drug users for HIV and other STD infections (Inciardi et al. 1991). This is because of high-risk sexual behaviors, particularly the barter of unprotected sex for crack or money with numerous sex partners. A three-city study by the Centers for Disease Control and Prevention found that the overall prevalence of HIV among crack users was 15.7 percent, with women having higher rates of infection than men (Edlin et al.

1994). In New York City, where rates of HIV infection are high, the available data suggest that the rate of infection is between 12 and 20 percent for crack users who do not have other risk behaviors (Fullilove and Inciardi 1995).

Rural women who use crack cocaine seem to be at as great a risk for HIV infection and transmission as inner-city women. A study of 60 crack-using women in rural Georgia and Miami showed that of those tested for HIV, 15 percent of the Miami women and 11 percent of the rural Georgia women were HIV-positive (Forney et al. 1992).

The programming approaches. CSAT grantees are required to make testing and screening for infectious diseases, including HIV, available for all clients. Such testing involves a number of confidentiality issues, which programs need to understand and be prepared to explain to women offenders. Pre-test counseling is required for all participants who elect to be tested. Programs that screen for HIV also need to be sure to provide counseling for those who test HIV-positive.

All the CSAT-funded women's prison programs provide education and counseling on HIV and other high-risk health behaviors. Even the 2-week Baltimore pre-trial program addresses the prevention of HIV and sexually transmitted diseases (STDs); medical screening to identify women with STDs is available through the detention center medical services program.

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This issue is covered further in chapter 7, in the section on working with the medical staff.

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Clinical Issue 15: Isolation related to a lack of support systems

Having a network of people to turn to is a critical element for women in recovery. Because substance abuse is a chronic disorder, recovery is punctuated for most individuals by “slips,” or periods of relapse. It is important for a recovering woman to have people who will support her at these times. The families of many incarcerated women cannot provide this support. For these women, their families may be one source of their substance abuse problem, rather than a support in recovery.

Who is in a woman’s personal network of associates is absolutely critical after the woman leaves prison or jail. Her prior associations will mainly be other substance-abusing individuals. If the woman does not cut herself off from these associations and step into a new network of nonabusing people, she is likely to relapse.

Programming approaches. All the CSAT-supported treatment programs consider it vital for addicted women offenders to have a support system after they leave the institution. Incarcerated substance-abusing women can benefit from help aimed at developing this support. First, trust is a real issue. Many women offenders will need the experience of

connecting with other women and learning to trust them before they will become able to utilize peer support. Second, women offenders may find it hard to believe that success is possible for women in their situation—in trouble with the law and with severe substance abuse. Successful role models—women who have themselves been substance-abusing offenders—can provide both understanding support and the proof that success is possible.

The CSAT programs use two different approaches. First, several jail and prison programs have developed their own alumna groups to offer support to the women after release. The second approach is to encourage program participants to become involved in community mutual-help groups. These groups sometimes meet in

women are successful role models recruited through professional and community organizations

- Several support groups made up of women ex-offenders who have graduated from the treatment program
- A Winners Circles mutual-help group, part of a new national mutual-help organization for people who are addicted ex-offenders

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Chapter 6 provides information about support groups developed and sponsored by the CSAT women’s programs.

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Twelve-step and other mutual-help groups. All of the CSAT-supported programs described in this *Guide* utilize 12-Step study

All the CSAT-supported treatment programs consider it vital for addicted women offenders to have a support system after they leave the institution.

jails, so that program participants have already made personal contacts before they leave the institution.

Program-sponsored groups. Support groups are an integral part of the intensive program efforts to keep women offenders involved in treatment after their release from jail or prison. Some of these groups include:

- A mentor program that matches each individual offender with a trained woman volunteer in her community; these

groups within their treatment programs. All the programs also encourage women to participate in mutual-help support groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), and Women for Sobriety. Very strong efforts go into making arrangements to connect women after custody with support groups in their local communities. These groups offer many advantages for women—the groups are free, available at a variety of day and evening

hours, and provide a nonusing peer support group.

Women-only groups are especially important during the early stages of recovery for women who have a history of abusive relationships with men. The women-only support groups have been important for women for the following reasons:

- *Their spiritual component.* Addicted women offenders need not only hope but a sense that their lives, and the pain and suffering they have endured, have meaning. The 12-Step groups offer women a spiritually sustaining process for change.
- *Their chance for bonding with other women.* The 12-Step groups, by providing peer support and bonding, provide one key way to keep women involved and committed to recovery after release from custody.
- *Their opportunity for peer modeling.* Women offenders get both encouragement and practical help from women like themselves who have struggled with a range of obstacles and are now recovering.

Although not treatment per se, the great value of these mutual-help groups lies in their capacity to supply support at all stages in the recovery process. These groups fit into a woman's life after her self-discovery and recognition of an addiction problem. The groups work by giving women a process for maintaining their motivation and commitment to recovery.

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For a helpful resource on how mutual-help groups contribute to recovery for women, see Stephanie Covington's "Sororities of Helping and Healing" (1991b).

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Clinical Issue 16: Life plan development

The woman with a severe substance abuse problem tends to be living hopelessly in the present, without any long-range goals or plans for her life. The CSAT grantees point out that incarcerated women enter their programs without the planning and coping skills needed to make life plans. The women first need to grow in terms of self-esteem, self-assertion, and in their sense of empowerment. These are the sources of hope that a woman will need to change her life. Then these women need help in acquiring the practical skills, such as education and vocational training, that form building blocks for a life plan.

In addition, the ability to cope with stress is an important factor in avoiding relapse to drug use. According to the CSAT grantees, their women clients face extreme levels of stress in their lives, combined with poor coping skills. They need ways to cope with both internal stressors, such as lack of self-esteem, depression, and separating self from abusive relationships, and such external stressors as finding a job and managing on a small income. Those working with substance-abusing women suggest that it is important to introduce the women to drug-free recreational

activities as well as to a host of other coping mechanisms for handling stress.

Programming approaches. The substance-abusing woman offender needs to develop a vision for her future and to create a life plan. For addicted women offenders, the goal is comprehensive: to help the woman remake her life. The CSAT programs provide the scope to help a woman develop and integrate the necessary pieces to build a sober, self-sustaining life for herself and possibly also for her children.

Individualized treatment plan. All the CSAT women's programs develop an individualized treatment plan for each woman. In the longer treatment programs, this plan evolves as the woman works through the treatment process. The plan helps a woman think through not only her goals and the steps toward recovery from substance abuse, but also the goals for her life. These would include her hopes and steps for reunification with her children, her education, job goals, and plans for housing.

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Chapter 6 describes the individualized treatment planning done by CSAT programs.

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Life skills. An important piece of the habilitation process is to help women offenders develop the life skills required to overcome the multiple problems they will face upon leaving the institution. Many of these women lack the basic skills to meet the demands of day-to-day living. Among the topics covered by the

CSAT demonstration projects are budgeting, grocery shopping, cooking, practical problem solving, and assertive communication skills.

Recreational activity and stress management. Another important area is stress reduction. The director of WCI Village says the women are eager to learn skills for controlling and reducing stress, including meditation. How to manage anger as well as stress is also a component in six of the CSAT-supported programs. Among the interventions used by the CSAT programs are:

- Exercise classes
- Meditation
- Yoga classes
- Relaxation techniques
- Acupuncture
- Art therapy

Many of the women don't know how to nurture themselves or to have a good time. Leisure-time activities—including those with children—help sustain women in recovery. The women also need to learn self-soothing techniques in order to deal with the many painful feelings that surface when they are abstinent.

The CHOICES TC program in Arkansas offers an unusual and highly popular alternative—a Ropes Course. The course, which costs \$25,000-\$35,000 to install, has poles that are 45 to 50 feet high, combined with harnesses and a zipline the length of a baseball field. Some of the treatment staff and correctional officers are certified instructors. The women use the course in teams; it is a tool that builds self-esteem, confidence, and trust among the women as well as teaching responsibility for self and others.

There are many different problem-solving scenarios (obstacles) that teams must work together to solve. The course experience gives women a chance to share an experience and talk afterwards about their feelings, as well as providing them with a tremendous sense of pride and accomplishment.

Clinical Issue 17: Child care and child custody

For mothers confined to prison, their families are broken apart. Two-thirds of women in State prison have children under age 18 and, before being incarcerated, 72 percent of these women lived with their dependent children (BJS 1994). When these mothers enter prison, their children are placed in foster homes or with relatives and friends; for these women, separation from their children is one of the most damaging aspects of a prison sentence (Berkowitz et al. 1996).

always separated from their infants soon after birth. The infants go to foster care or to a relative, and the mother has no opportunity to bond with the baby. Many of these women are themselves products of the foster care system, and fear what will happen to their children.

Since the early 1980s, advocates for women prisoners have pressed for services to assist incarcerated women in strengthening and sustaining bonds with their children. Child visitation and other contacts are critical for maintaining a mother-child bond. Without institutional and program support, these visits tend not to happen. Although nearly all State prisons allow child visits, more than half of women inmates never receive a visit from their children (BJS 1994). Fewer than 40 percent of jails nationwide permit contact between women and their children during visits, and only 15

The women are eager to learn skills for controlling and reducing stress.

Imprisonment compromises the incarcerated woman's ability to maintain relationships with her children, thus adding to family difficulties following her release (Bloom et al. 1994). The psychological stress of incarceration related to separation from family and loss of control over their lives may also exacerbate existing depression or induce other mental health problems (Fogel 1993).

Family reunification issues. Women who are pregnant when they enter prison are nearly

percent allow extended visits between women inmates and their children (ACA 1990, p. 45).

Advocacy. Many of the women also need legal advocacy to regain custody of their children. A national project of Child Custody Advocacy Services found that 80 percent of the women seeking help with legal custody problems had been incarcerated for drug offenses or drug-related crimes (Johnston 1995). This project found a dramatic correlation between mother-child reunifica-

tion and post-release residential drug treatment for mothers. More than 90 percent of clients released to residential drug treatment achieved reunification with their children.

Programming approaches. One of the most significant deficits of male-oriented programs is that they pay little or no attention to the inmate's role as the caretaker of children. Approaches for women offenders need to help them cope with the concrete and

Organizing visits between children and their mothers is one important way of maintaining the bond among families. A few advanced programs across the country use these family visits as an opportunity to offer therapy for families and for the children. Engaging sentenced mothers and their children in treatment together is most easily accomplished in community alternatives to incarceration or in local jails. However, involving the children is possible

Organizing visits between children and their mothers is one important way of maintaining the bond among families.

excruciating difficulties they will face as the primary financial and emotional support of their families. Planning should begin from the woman's first entry into the program about her goals and what kind of help she will need. Even non-substance-abusing women who are poor and single can find the problems and challenges of being a single parent almost overwhelming in our society. We should not minimize how difficult this role is. The mother in prison or jail is often concerned about losing custody of her children. If she does have custody, then she must be prepared to support and manage her children after her release. Programs need to focus on the woman's role as mother, on her expectations and skills as a parent, and on improving her parenting skills.

in prison settings and is a promising strategy for helping incarcerated women. Several of the CSAT women's demonstration programs have strong family support and reunification components. This strategy is important for a number of reasons.

- At least three-quarters of the women will resume custody of their children after release. Their children are the most important factor in their lives; most women with children want to be good mothers and to be reunited with their children. This factor can be a major motivation for women in seeking and staying in treatment.
- Parenting education and therapy can also help women meet court-mandated requirements and regain custody of their children.

The CHOICES program has a playground for children visiting

their mothers. At the Recovery In Focus program, children come for visits and a family therapist conducts play therapy sessions with the children. New mothers receive education on bathing babies and other care. In Focus works with a church volunteer program dedicated to helping the women resume custody of their children upon release. The volunteers serve as foster parents and legal guardians until the women are released. The social services department is usually not involved. The volunteer foster parents bring the babies to visit once a week.

In terms of legal advocacy, the CSAT demonstration programs have a number of strategies that combine parent education with family reunification efforts. In addition to the parenting component, the SISTER project provides a legal advocate who helps the women with custody and other legal issues. An advantage of a family reunification component is that it can realistically, and professionally, address whether a woman is ready to resume custody of her children. When necessary, counselors can help a woman face and cope with the fact that she is not at this point able to care for her children. The program can then help the woman assume some control in the decisions about what is best for her and her children.

One CSAT grantee points out that the drive toward family reunification should not obscure a tragic reality—up to 25 percent of these women will not get their children back. The staff must also assist women to live with this reality. Several of the CSAT

grantees pointed out how essential spirituality is for women in these circumstances. The women need comfort and support in coming to terms with their emotions, which include not only guilt and grief, but relief as well. This is a difficult issue not only for the women but for the program staff to handle. Staffs tend to project their own values on women who don't get their children back.

Additional Clinical Issues

The clinical issues shown in table 6, p. 40, which are part of CSAT's comprehensive treatment model, are important issues for all substance-abusing women regardless of socioeconomic level. These issues simply tend to be more intense for the substance-abusing woman who is disadvantaged and incarcerated.

In addition, women being treated within the criminal justice system present other serious issues. These issues pertain to coexisting psychiatric disorders and criminogenic characteristics.

Clinical Issue 18: Coexisting psychiatric disorders, including depression

Alcohol- and drug-abusing women have high rates of depression and a number of other psychiatric disorders. The coexistence of major mental illness, as defined by the DSM-IV criteria, can complicate both the diagnosis and treatment of substance abuse. Prisons and jails contain many women who have coexist-

ing psychiatric disorders along with substance abuse problems.

In the past few years, ever greater numbers of women appear to be entering correctional systems who have prior histories of psychiatric hospitalization and/or suicide attempts (Lord 1995, p. 264). Economically marginalized women with serious mental illness, once institutionalized, are now living in the community, where they may fail to seek help from mental health clinics or may discontinue their medication and treatment. Those leaving mental institutions may find little support from family or community and then become homeless. As these women make their way from the streets to shelters, they frequently stop taking prescribed medications and self-medicate with street drugs that are easily accessible. It is only a matter of time before they become caught up in the criminal justice system.

Programming approaches. A good treatment program for women in the criminal justice system will conduct mental health screens to look for underlying mental disorders. With women, the focus will be on identifying co-occurring mental disorders, including depression, in addition to identifying criminogenic traits.

Traditionally, substance abuse programs have not admitted women with diagnoses of schizophrenia and similar psychotic disorders. There is an overwhelming need within the criminal justice system for programs that serve incarcerated women who have coexisting psychotic

disorders and substance abuse problems.

The CSAT-supported programs for incarcerated women have made a concerted effort to admit such women to their programs, provided that the women are stabilized on appropriate psychiatric medications and are able to handle the intensity and interpersonal demands of the program. Their experience is that these women may need extra time in the program and the understanding help of skilled staff, but they can be successful. This approach requires close coordination with the mental health staff of the institution. Institutional barriers often make such cooperation difficult.

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The experience of CSAT's grantees with treating women who have co-occurring mental disorders is summarized briefly in chapter 7. See "Relationships With the Medical and Psychiatric Staffs."

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Ideally, treatment approaches for substance abuse should be designed to deal with a range of women who may also exhibit antisocial and other personality disorders. It is important to be aware that a subset of women may have organic brain damage and impairments resulting from abuse and seizures. Some will have low intelligence quotients.

Clinical Issue 19: Criminogenic characteristics

An important area where women offenders differ from men is in their level of sociopathy. A major subset of male offenders meet

DSM-IV criteria for having antisocial personality disorders. These male offenders have personality patterns that are basically unsocialized, bringing them constantly into conflict with other people and society. Drug treatment programs for male offenders are designed to deal with a high rate of sociopathy and criminal thinking. One of the most sophisticated criminal justice screening systems—that used by Colorado—classifies

and of 2 percent for women aged 45-64. Antisocial personality disorder was highest among those with the least education and those from urban areas (Jordan et al. 1996).

The experience of CSAT's grantees supports these statistics. For example, the director of the North Rehabilitation Facility says she has found that these women are not "sociopaths" in the commonly accepted sense. That is, the women are not callous, nar-

It is important for the women to understand that they can, and should, take on the responsibility for the decisions in their lives.

offenders for treatment by a scale that measures their risk for criminality in combination with their level of drug addiction.

Criminal thinking is also a factor with women offenders, but experts suggest that—for women—the context is different. First, recent studies suggest that a relatively small percentage of women offenders can be classified as having antisocial personality disorders. The study of pretrial female detainees in Chicago's Cook County jail found a lifetime prevalence rate of only 14 percent for antisocial personality according to DSM-III-R criteria (Teplin et al. 1996). Among convicted female felons entering prison in North Carolina, 12 percent had a diagnosis of antisocial personality disorder, with a rate of 17 percent for young women aged 18-24, 11 percent for women aged 25-44,

cistic, antisocial people with no sense of guilt, no loyalty, and no mainstream social values. Instead, as this CSAT grantee points out, these are alienated and marginalized women with an extreme lack of self-efficacy. The women feel so powerless that they can't learn from their mistakes, because they perceive no relationship between their behavior and its consequences. These self-esteem issues are frequently tied to their history of victimization and dependence on a male criminal partner.

Many women do, however, engage in such criminal behavior as prostitution and robbery to support their drug habits. Some experts suggest that a woman's tendency toward antisocial behavior is often based on codependency. She is not the perpetrator of a crime, but a codependent in this behavior and this lifestyle.

Her lifestyle depends on the relationships the woman enters into, and being dependent on a drug-using male may lead her into antisocial and criminal behavior to please him and supply her habit. The women need to address any criminal thinking regarding such behavior from the perspective of a woman's emotions and motives.

All the women need to look at taking responsibility for their own behavior and at the alternative choices they actually have. This requires changing from an acquiescent, passive role to a more active, assertive one. The CSAT grantees suggest that many of these women have a very traditional and limited view of women's roles. It is important for the women to understand that they can, and should, take on the responsibility for the decisions in their lives.

The CSAT grantees report that some subgroups of women do have sociopathic tendencies and attitudes similar to those found among many male substance-abusing offenders. These subgroups include:

- Younger women (primarily in gangs) who show violence, criminality, and predatory behavior; this is a disturbing recent phenomenon. One criminal expert suggests this does not signify a radical change for women. The rising violence among women is simply proportional to the extraordinary, unprecedented level of violence being shown today by certain subgroups of young males in large cities.
- Young women who have a variety of cognitive deficits and are developmentally very

delayed. These young women may form unhealthy emotional attachments. As a program director pointed out, some young hangers-on in gangs—actually sweet, gentle people—can do horrible things to gain a sense of belonging, inclusion, and support from gang members. Because of some recent State laws, women as young as 18 or 19 (“really adolescents,” points out the program director) are now being incarcerated in the criminal justice system for drug-related offenses.

- Women whose drug addiction is not severe, but who seem willing to commit crimes with ease when they do use. For these women, drug use may serve to disinhibit their behavior and increase their risk of crime.
- Women whose drug addiction is not severe, but who may be prone to criminal activity because of their values. For these women, criminal behavior may reflect a family systems/family values problem. This type of problem seems likely to be most prevalent among women offenders from families that have a record of incarceration. Nearly half (47 percent) of women in State prisons report having an immediate family member who has been in jail or prison (BJS 1994). In the New Jersey State correctional system, 75 percent of the women report having a relative who has been incarcerated (Gonzalez 1996).

The programming approaches. Learning to take responsibility for one’s own behavior and to abide by society’s rules are two essential elements in a treatment

program for incarcerated women. A program needs to have rules that are clearly stated, understood by all the participants, and consistently applied. The sanctions that will apply if the rules are broken should also be clear and consistent.

In treatment programs, sanctions are in essence “calling people out” for not going by the rules; that is, a pre-announced penalty is enacted when a program participant does not abide by the rules of the program. One example of a sanction might be that the woman must leave a program and go back into the general prison population for a period of time. In therapeutic communities (TCs), people may lose privileges for transgressing rules. Generally, programs use a series of graduated sanctions, with the sanction becoming more severe with each transgression.

In-Program Sanctions and Strategies

Programs for incarcerated women set up their own sets of program rules and sanctions. These sanctions may have some overlap with sanctions imposed by the institution itself. Urine testing for drugs, usually on a random basis, is done to verify that program participants are remaining drug-free. This urine testing can be done by either the program, the institution, or both. Typically, a positive urine results in the imposition of sanctions. The ideal is to work out how best to handle such situations. Sanctions are most effective if

they operate not as punishment but as a trigger to motivate more help or another step in treatment for the woman.

Within male AOD treatment programs, authoritatively applied sanctions are often thought necessary to instill and reinforce a different mind set about the men’s antisocial behaviors. For women, in-program sanctions may operate somewhat differently: not as a coercive force for change, but as a way for women to gain personal empowerment and responsibility. It is important for women to feel personally capable of judging and making amends for their own behavior.

The Recovery In Focus program, a 6-month TC in Oregon, uses a structured system of participant-enforced sanctions. The In Focus system is based on guidelines developed at another Oregon facility, the Powder River Institution. In Focus staff reports that many correctional officers question the inmate-to-inmate sanction rule that governs the In Focus treatment community. However, the Powder River treatment community has had excellent results with this method, including fewer disciplinary reports, better conduct, and increased accountability of the inmates. The In Focus program has experienced similar positive results. The system works as follows:

- *Color-coded living groups.* The In Focus dormitory for program participants is divided into four color-coded areas—orange, blue, green, and yellow. Seven women are housed within each color-coded section. Each color group has one designated “Crew Chief.”

- **Crew Chief selection and role.** The assignment as Crew Chief lasts for 1 month. It is an earned position based on positive accomplishments made by the individual woman while in treatment. This position gives the individual positive recognition, but also enhances her leadership abilities. Each Crew Chief’s job is to monitor the other six women in her color group. Being a “leader” is a hard job when the person has to interface with other women who manifest criminal thinking errors, defiance, manipulation, and anger.
- **Leadership Group for Crew Chiefs.** Every week all the Crew Chiefs come to a support group called the Leadership Group. This group helps the women to solve problems and to gain the support of others who are in the same position.
- **Community Representatives.** Each Crew Chief is supported by a Community Representative. These four representatives, one for each color group, are elected by the residents of the In Focus program, and they may stay in this position until they are released from the program or resign. Their primary function is to support the particular Crew Chief and help her remain calm, clear, rational, and fair. To be eligible for election as a Community Representative, a woman must have participated in the program for 30 days or more and have at least 30 days remaining in the program. She may not have had any disciplinary reports (DRs) in the last month or have any DRs pending. If a woman receives a DR during her assignment as Community Representative, she must resign the position.
- **Resident responsibilities.** Each resident in the program is responsible for following the rules. When a woman breaks the rules, she must use a “three-step process” (see table 7). In other words, the Crew Chiefs are not expected to manage every rule violation. Each individual is responsible for following the rules and *for holding anyone they see violating the rules accountable by using the three-step process.* The Crew Chiefs and the Community Representatives are by no means excused if they are rule violators. They too will be sanctioned.

Interventions by CSAT-supported Programs

The CSAT grantees have developed a wide variety of specific program interventions to address the women’s clinical issues. Table 8 shows the types of interventions carried out by the nine CSAT-supported programs described in this *Guide*.

In all programs, the overall mix of interventions was designed to ensure that the women would receive a full range of comprehensive services, from medical care and health risk assessment to education and job skills training. Several of the programs also provide extensive aftercare services once the woman offender returns to the community. Safe and drug-free housing after release is particularly critical for these women.

Table 7. Recovery In Focus inmate-enforced sanctions

The three-step process

1. If an individual is breaking rules and is not in your color group, always go to the individual first and ask that person, in a thoughtful, caring way, to hold herself accountable.
2. If the individual is not receptive to your feedback, has an attitude, or responds in a negative verbal way, go to the Crew Chief of her color group and explain what has happened. Now you are to let it go and have faith in the Crew Chief to handle the matter.
3. If the individual continues to be nonreceptive to the feedback or to accepting the sanction, the Crew Chief will then go to a Community Representative. The Crew Chief and the Community Representative will then inform the individual that she must attend the Monday leadership meeting. The sanction will be stapled to the board and the subject is then to be dropped until it can be discussed in the presence of a counselor.

Table 8. Interventions of the CSAT Demonstration Programs for Women Offenders (continued)

Interventions	Prison programs				Jail programs				
	Residential		TC		TC			Intensive outpatient	
	1	2	3	4	5	6	7	8	9
Family reunification <ul style="list-style-type: none"> • Parent education/groups • Parent/family educational counseling/therapy • Child visits • Legal advocacy/foster care program • Mother/daughter issues 	X	X	X	X	X	X		X	
Educational/vocational assessment/planning <ul style="list-style-type: none"> • GED testing/preparation (adult basic education) • Job hunting skills • Vocational training • Community college 		X			X	X	X		X

Code: 1 Forever Free 4 Choices 7 Stepping Out Project
 2 WCI Village 5 OPTIONS 8 North Rehabilitation Facility
 3 Recovery in Focus 6 SISTER Program 9 Baltimore Detention Center

Interventions	Prison programs					Jail programs				
	Residential		TC			TC			Intensive outpatient	
	1	2	3	4	5	6	7	8	9	
Medical/health services <ul style="list-style-type: none"> • Screening for STDs • Health/nutrition education • HIV/other medical treatment • Pregnancy services 		X		X	X		X	X		
				X	X		X	X		
			X	X	X	X		X	X	
		X		X	X			X	X	
12-step study groups <ul style="list-style-type: none"> • Spanish-speaking 12-step groups 	X	X	X	X	X		X	X	X	
						X				
Relapse prevention skills	X	X	X	X	X			X	X	
Stress management <ul style="list-style-type: none"> • Anger management • Exercise class • Meditation/yoga/relaxation 	X	X	X	X	X			X	X	
		X	X	X	X		X	X	X	
		X	X	X	X	X		X	X	
		X								

Code: 1 Forever Free 4 Choices 7 Stepping Out Project
 2 WCI Village 5 OPTIONS 8 North Rehabilitation Facility
 3 Recovery in Focus 6 SISTER Program 9 Baltimore Detention Center

Table 8. Interventions of the CSAT Demonstration Programs for Women Offenders (continued)

Interventions	Prison programs					Jail programs								
	Residential		TC Mid/long-term		TC Mid/short-term	Intensive outpatient								
	1	2	3	4		5	6	7	8	9				
Non-traditional therapies														
• Acupuncture														
• Art therapy														
• Ropes course				X										
• Spirituality		X												
• Video therapy group														
Life skills training														
• Communication/assertiveness	X	X	X	X										
• Practical issues (budgeting, etc.)	X	X	X	X										
Psychiatric services														
Criminal thinking/cognitive restructuring														
• Retail theft (“Boosters”)	X	X	X	X										
• Prostitute group (Ex-Sex workers)														

Code: 1 Forever Free 4 Choices 7 Stepping Out Project
 2 WCI Village 5 OPTIONS 8 North Rehabilitation Facility
 3 Recovery in Focus 6 SISTER Program 9 Baltimore Detention Center

Interventions	Prison programs				Jail programs					
	Residential		TC		TC			Intensive outpatient		
	1	2	3	4	5	6	7	8	9	
Accountability interventions/training										
• Drug testing by program	X	X	X	X	X	X		X		X
• Drug testing by institution	X	X	X	X		X		X		
Continuing care planning										
• Post-release treatment funding	X	X	X	X	X	X	X	X	X	X
• Housing placement				X		X		X		X
Aftercare services		X	X	X	X	X	X			X

Code: 1 Forever Free
 2 WCI Village
 3 Recovery in Focus
 4 Choices
 5 OPTIONS
 6 SISTER Program
 7 Stepping Out Project
 8 North Rehabilitation Facility
 9 Baltimore Detention Center

Chapter 5—Program Design

Since there is no universal model for treating addicted women offenders, how does a planner choose which model to use? A variety of possible treatment models, therapeutic interventions, and other interventions are widely accepted.

Selecting the Appropriate Model

Women can recover in many types of programs, but the goal should be to develop a program model designed to give the best recovery chances to the majority of women in the program. According to one director, “too many programs have just put a dress on a male model.” Some decisions will be based on practical realities and will depend on such factors as:

- *Average length of time available for program participation.* Pre-sentence detention centers may plan on programming for only 2 weeks, while jail programs may be able to offer 2- to 6-month programs and prisons can provide long-term 6- to 18-month programs prior to a woman’s release. Obviously, program goals must be tied to the time available. For example, a 2-week

prerelease program needs to focus on motivating women into community-based treatment and arranging for a continuum of care after release, while a 6-month program can undertake intensive treatment.

- *Type of model typically used in a State and/or stipulated in State legislation.* Illinois, for example, has a strong therapeutic community (TC) tradition, while in Washington State, treatment programs have traditionally been structured on 12-Step models that do not include the strong behavior modification component typical of TCs. (In Washington State, the correctional institution may provide behavioral modification components for inmates.)
- *Type of women primarily being served in the program.* As one example, the Arkansas community corrections program serves young first-time offenders who usually return to their families. Being removed from their families is often a shock and a “wake-up call” for these young women. Their programming needs will be somewhat different from those of more typical prison populations, who tend to be women offend-

ers in their 20s and 30s with severe and long-standing substance abuse problems, repeat criminal justice records, and prior treatment attempts.

- *Availability of physical space.* Adequate space for treatment programs is a problem under the current crowded conditions in prisons and jails. An intensive residential program requires the space to separate participants physically from the general prison or jail population. The residential treatment community, usually a TC, needs separate space large enough for living, eating, meetings, and program activities. Other programs need adequate space so that participants can meet for individual and group work in privacy.

Treatment Modalities in Criminal Justice Settings

The choice of a program model also depends on the modality—whether a program will be outpatient, residential, or in a transitional setting. Table 3 shows the CSAT-supported programs discussed in this *Guide* according to

their type and length of treatment. The major categories of programs used in jails and prisons are described briefly below.

Detoxification

Detoxification is an important first step in the treatment of substance abuse for women who are experiencing acute effects from drugs or alcohol. This first step involves stabilizing the person and managing withdrawal symptoms while toxic substances are eliminated from the body. Although most larger jails provide detoxification, nonviolent offenders are often referred to community agencies for these services (Peters 1993). The Task Force on the Female Offender, convened by the American Correctional Association (ACA), recommended that separate detoxification units be established in local facilities for female offenders (ACA 1990, p. 42). These units should provide for detoxification, medical and mental health screening, counseling, and community referrals as part of the booking and intake process.

Although methadone is most commonly used to detoxify individuals from opiates in the community, methadone is rarely used in prison settings. Some correctional systems force offenders to detoxify “cold turkey”—a practice that is dangerous with pregnant women because it can harm or kill a fetus. According to CSAT’s Treatment Improvement Protocol (TIP 2) on pregnant, substance using women, clonidine has also been used effectively for detoxification, but its safety

for pregnant women is not known (CSAT 1993b). TIP 2 suggests that agents that may be used to reduce extreme agitation during withdrawal among pregnant cocaine addicts include low doses of diazepam (Valium), chlordiazepoxide (Librium), desipramine (Norpramin), doxepin (Sinequan), and phenobarbital. Another useful CSAT TIP is No. 19, *Detoxification from Alcohol and Other Drugs*.

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CSAT TIPs are available through the National Clearinghouse for Alcohol and Drug Information. See “Drug-Related Federal Clearinghouses” in the Resource List.

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Drug Education

Drug education should not be considered treatment, but it can be an effective tool to inform inmates about alcohol and other drug issues. Some prisons provide drug education for their general populations, but only 14 percent of jails provide such services, according to a recent survey (Peters et al. 1992). At times, women offenders may attend drug education classes while waiting for an opening in a drug treatment program. In some cases, drug education may cause a woman to recognize that she has a drug problem and needs to become involved in treatment.

Drug education may also be useful at an early stage in a jail or prison substance abuse treatment program. In this case, the content would focus on developing the woman’s motivation for treat-

ment and encouraging her to remain in treatment.

Outpatient Treatment

Outpatient treatment can be either standard or intensive. In a jail or prison setting, inmates involved in outpatient treatment live in the general population and work and interact with other inmates. However, the preferable situation for those in intensive outpatient programs is to be segregated from the general population.

- **Standard outpatient programs.** In standard outpatient programs, the women typically receive services about three times per week, including group therapy once or twice a week and individual counseling about once a week. The kind of topics covered would be an introduction to the 12-Step model, identifying triggers to relapse, and counseling on HIV/AIDS prevention. These low-intensity programs are suitable for women who typically have a short history of substance abuse, have had minimum to moderate drug use prior to incarceration, and have relatively strong motivation or support for recovery. None of the CSAT-supported women’s models described in this *Guide* are low-intensity outpatient models.
- **Intensive outpatient programs.** Intensive outpatient services are in-custody treatment that is part of a continuum of care and is adjacent to a community aftercare component. Intensive outpatient programs are appropriate for women with longer and more severe drug

abuse histories, who are likely to have had previous treatment and may also be recidivists. The programs are effective for incarcerated women or for women in detention centers who may be released into the community instead of being incarcerated. Women receive services for a minimum of 3 to 5 hours per day, three to five times per week.

In this type of program, the women receive a variety of diagnostic, clinical, didactic, and counseling services. Motivating women to enter residential or outpatient treatment in the community after their release is a major goal. Treatment is most effective just prior to the woman's release date.

Two of the programs described in this Guide are intensive outpatient programs—the Incarcerated Women's Recovery Program at North Rehabilitation Facility and the Baltimore Detention Center program. Services provided at North Rehabilitation Facility include group counseling for substance abuse, chemical dependency education, relapse prevention, 12-Step groups, anger management, STD testing and treatment, family counseling, adult basic education and GED testing, general medical services, acupuncture, mental health counseling, and assistance with housing.

Residential Treatment

Residential programs in prisons and jails refer to programs where the participants live together in a

facility separate from the general prison population. The level of substance abuse treatment can vary in intensity. For example, Forever Free, at the California Institution for Women, provides alcohol and other drug (AOD) treatment for 20 hours per week over a minimum of 6 months; participants also spend at least 20 hours per week on work assignments with the rest of the prison population.

Therapeutic communities (TCs), which are the most common residential modality in prison and jail settings, offer the most intensive level of programming available. The participants live and eat together without

mingling with the general population and they spend full work days in their AOD treatment program. Women appropriate for TC treatment will have a longer history of substance abuse than those in less intensive programs, will often have had repeated failed attempts at treatment, will have used high levels of multiple drugs prior to incarceration, and will continue to have chronic or severe use despite adverse consequences. Like intensive outpatient programs, TCs are most effective just before the woman is released from custody, so treatment needs to be scheduled in tandem with a woman's release date. The types of TC programs

in criminal justice institutions may be categorized as follows:

- **Traditional 9-18 month TC programs.** The traditional long-term model TC is an appropriate model for prisons, where sentences are at least a year in length. The WCI Village TC in Delaware, where participants' length of stay ranges from 6 to 18 months, fits this model.
- **Modified 3-12 month TC programs.** This shorter TC model is also appropriate for prison populations. The CHOICES community punishment facility in Arkansas operates a co-educational program where the length of stay varies from a

Therapeutic communities, which are the most common residential modality in prison and jail settings, offer the most intensive level of programming available.

minimum of 90 days to 24 months. The Recovery In Focus program at the Oregon Women's Correctional Center, Salem, is a 6-month pre-release day treatment program. This program has a special focus on family and life skills, with a goal to reunite women with their children.

- **Short-term 2-6 month TC programs.** Short-term TCs can be used in correctional settings where sentences are of shorter length. Among the CSAT grantees, there are three short-term women's TCs. The longest is the OPTIONS county jail system program in Philadelphia, where women

stay an average of 6 months. Two are 2-month programs—the SISTER jail program in San Francisco and the Stepping Out jail project in San Diego.

As the OPTIONS director points out, the length of a program is not as important as the program's process and support for healing. Rather than "residential treatment," it may be more appropriate to call such supportive programs a "therapeutic center" or a "therapeutic living environment."

After their release into the community, some women will enter community residential treatment programs. These residential rehabilitation programs require full-time participation in treatment activities and programs. Table 9 shows a chart matching type of treatment to appropriate populations.

Transitional Programs

Several types of facilities may be available for women in their transition back to the community. Some of the more common include work-release centers, day treatment programs (sometimes called day reporting centers), and halfway houses. These types of transitional facilities are described in chapter 6 in "Various Paths for Women Upon Release."

Types of Approaches and Program Components

For treating women's addiction, the CSAT grantees emphasize how important it is to use a com-

bination of methods. Even the shorter programs use varied techniques.

* * * * *

Training materials that may be helpful for program designers are listed in the Resource List. Some of these materials, such as new training materials by Stephanie Covington, "Helping Women in the Criminal Justice System," may be useful for all types of alcohol and drug (AOD) treatment programs.

* * * * *

Stepping Out, a program for inmates with a minimum of 50 days remaining to serve, expects in that short time period to give women an introduction to treatment concepts, knowledge about what to expect in long-term treatment, and a level of comfort with the treatment process. The program uses a combination of TC principles, 12-Step principles, and cognitive therapy. This program finds that, for some women, the combination of cognitive therapy—to understand why the woman uses drugs—plus behavior modification is a better option than 12-Step programs. Following are some of the major types of interventions and approaches used by CSAT grantees for women offenders with substance abuse problems.

Psychoeducation

Psychoeducational approaches are frequently used in treating jail inmates who are incarcerated for relatively brief periods of time, often using "closed" groups of inmates who enter and leave

at the same time. Program staff may include professional counselors and ex-addicts. This approach is based on the premise that substance abuse disorders develop as a result of multiple biopsychosocial factors. The goal is to help individuals recognize their own individual predisposition to substance use, their personal risk factors, and to develop coping skills and strategies to enable them to attain long-term abstinence. Program components usually include (1) developing motivation and commitment through understanding addiction history, stages of recovery, and the adverse effects of addiction on all phases of life; (2) enhancing life and communication skills; (3) education to prevent HIV infection; (4) relapse prevention skills, including identification of relapse triggers and strategies to manage lapses; and (5) developing an individualized aftercare plan. The longer programs supplement the psychoeducational material with a range of adjunct activities, such as mutual-help groups, GED classes, vocational training, mental health counseling, and work assignments.

Psychoeducational approaches have primarily been used with male inmates, so the approach needs to be modified for women. The primary didactic practices—lectures, group exercises, homework, and instructional materials—need to be augmented with a focus on process groups that discuss women's issues, as well as individual and group counseling. A fundamental clinical service for effective women's treatment is widely recognized to be the

Table 9. Matching substance-abusing offender subgroups to treatment models

Substance-abusing offender subgroups	Self-Help	Educational	Outpatient	Intensive outpatient	Residential TC	Transition/case management
Early stage	+	+	+	+ / -	+ / -	+
Addict	+	+ / -	-	+	+	+
Co-occurring disorders	+ / -	+ / - (careful screening)	-	+	+ / - (screening, special services)	+
Criminogenic	-	+ / - (focus on cause-effect)	-	+ / - (need for structure, conditions, sanctions)	+	+

Code:

Co-occurring disorders—Individual with mental illness and substance abuse problems

TC—Therapeutic community

+ Highly effective
 + / - Somewhat effective
 - Minimally effective

Adapted from: Bureau of Justice Assistance, *Design and Implementation Issues for Drug Treatment in the Jail Setting*. Washington, DC: U.S. Department of Justice, 1991.

women-only counseling or therapy group. These groups need to focus on the issues that are the source of enormous emotional pain for women, such as sexuality and sexual behavior; incest, rape, and other sexual abuse; family violence; and relationships with alcohol and drug-using partners, spouses, parents, and other family members. Motivation to treatment—using a really positive, upbeat approach—is needed to buoy up the participants and to promote optimism and the desire to be involved in community-based treatment after release.

Pharmacological Treatment

Methadone treatment has been researched extensively and has been shown to be effective in reducing withdrawal symptoms and drug cravings for opiate-dependent patients (Anglin and Hser 1990). The most recent major study—a follow-up of 3,000 clients 1 year after drug abuse treatment conducted by the National Institute on Drug Abuse (NIDA)—found that 69 percent of outpatient methadone clients had effectively reduced their heroin use and 48 percent had reduced their cocaine use (Hubbard et al. 1997). Illegal activity declined by 52 percent, while the number of clients jailed dropped from 63 percent in the year before treatment to 21 percent in the year after treatment. In this Drug Abuse Treatment Outcome Study (DATOS), 39 percent of patients admitted to the outpatient methadone programs were women.

Methadone treatment is usually used for people who have not been able to achieve abstinence in drug-free programs. Methadone is used infrequently in jail settings, partly because administrators are reluctant to provide narcotics to inmates and because of concerns regarding medical supervision and institutional security (Magura et al. 1992). In 1997, a National Institutes of Health Consensus Development Panel on effective medical treatment of heroin addiction recommended that all opiate-addicted persons under U.S. legal supervision have access to methadone maintenance treatment (NIH 1997). According to testimony at that conference, only one U.S. prison currently provides methadone treatment for inmates.

Methadone treatment is an important intervention for pregnant women offenders who are addicted to opiates. Detoxification from opiates is a danger to the unborn fetus. For this reason, CSAT TIP No. 2, *Pregnant, Substance-Using Women* (CSAT 1993b) recommends methadone maintenance for pregnant opioid users. Pregnant women are usually the only population eligible for methadone maintenance in U.S. jails and prisons.

Psychosocial Treatment

Psychosocial treatment includes an array of techniques, including role plays and psychological counseling that may involve the client and her children and significant others. The short-term Baltimore detention center program, for example, is designed to provide intense, short-term psy-

chosocial rehabilitation services, mostly in a group setting. The program uses a combination educational, skills building, and motivational model. The women participate in group therapy sessions to process women's issues and have individual counseling sessions with a therapist. In addition, the educational groups use a cognitive/behavioral substance abuse treatment curriculum that focuses on developing relapse prevention skills (Mattson 1995). Topics covered include anger management, assertive communication, drug refusal skills, and daily planning.

Important components include:

- **Individual/group counseling and targeted counseling.** Women offenders respond well to both guidance and counseling (ACA 1990, p. 43). Some of the issues that therapy groups may address include family issues, incest, domestic violence, prostitution and survival sex, and shoplifting. For those with HIV/AIDS, individual counseling, group therapy, and peer support groups with other HIV-positive women are all appropriate interventions. Depression, sexual abuse, and physical abuse are so prevalent among this population that these issues are often treated as an underlying theme in all the work, rather than as special group topics.
- **Interactive process groups.** Process-oriented groups, led by either peers or staff, create a sense of connection among the participants. The research suggests that connectedness with others is critical to women's growth and development, and

that substance-abusing women may lack this sense of connection. Interactive process groups, which help women develop this sense of connection and relatedness to each other, are therefore an important and therapeutic approach for women.

- **Emotional healing.** The women need to understand their feelings and work through their emotions. Because women often report that they became dependent on drugs in order to seek relief from painful emotional states, it is imperative that there be an emphasis on affect as well as cognitive work. The CSAT-supported TC models take advantage of a wide variety of peer and group therapy techniques.

WCI Village, for example, uses transactional analysis, psychodrama, and branch groups—a type of group in which clients meet regularly to share in-depth thoughts and feelings as a basis for understanding themselves and developing better coping skills (Inciardi 1996). The Recovery In Focus program uses such methods as transactional analysis, gestalt therapy, and role plays.

Nontraditional Therapies

Acupuncture, meditation, yoga, stress management, relaxation techniques—these therapies are important because all help the women “own” their own recuperative efforts. Many AOD treatment programs report that acupuncture helps their clients in the early stages of withdrawal

and recovery. Acupuncture has been used in treating various types of drug abuse, including alcohol, heroin, methadone, barbiturates, diazepam, phencyclidine (PCP), cocaine, and nicotine. Unfortunately, research on acupuncture for drug treatment is sparse and there are only isolated reports of well-controlled clinical trials.

Three of the programs described in this *Guide*—the SISTER project, Baltimore Detention Center, and North Rehabilitation Facility—use acupuncture up to five times per week. One of these program directors states that, after acupuncture, most clients

Cognitive therapy is used to help women recognize errors and fallacies in their thinking.

report experiencing an overall sensation of relaxation and peace of mind that lasts approximately 24 hours. This program suggests that acupuncture be repeated with consistency during the first 10 days and then be gradually reduced.

Criminal Thinking Interventions

Some addicted women offenders, like men, have long-standing criminal thinking patterns and values. Cognitive therapy is used to help women recognize errors and fallacies in their thinking. The women tend to be manipulative, and often see their criminal behavior as the result of drug use to which the individual has fallen

victim (Yochelson and Samenow 1986). To change behavior, the person’s underlying beliefs and value systems must also be changed. Treatment interventions designed for women are at an early stage of development. Some of the CSAT program directors have used materials developed by Koerner, Fawcett, Inc. and by Gorski and Miller (1988). (For more information about materials and available training, see the Resource List.)

These criminal thinking materials can usually fit into any program design. Research suggests that criminal thinking patterns are the same for both men and

women. However, the context of women’s lives, including the very real victimization that many women offenders experience, needs to be addressed. Some of these materials are designed to start from the women’s existing beliefs and values, to help them understand their own aberrant thinking, and then to open up their minds to new information and a change in beliefs.

In the criminal thinking construct, for women the crime itself may be immaterial; it is the circumstances that matter. Women’s crimes are often done in conjunction with men, so it is important for a woman to look at her relationships prior to the crime. The In Focus program looks at women-specific thinking errors

in such areas as prostitution, low self-worth, relationship addiction, and codependence.

Preventing Relapse and Recidivism

Relapse prevention components are a critical element in programs treating substance-abusing women offenders. Relapse to substance use is a common problem for all recovering individuals—this is one of the symptoms of alcohol and drug dependence. Offenders are particularly vulnerable to relapse during the initial period after their return to the community (Peters 1993). Substance abuse is often a method of coping with stress,

Clearly, reducing relapse to alcohol and drug use is critical for reducing recidivism. For women offenders, relapse prevention needs to be broad in scope. Some of the factors implicated in relapse for women are mental illness, including depression, bipolar disorder, and post-traumatic stress disorder resulting from physical and mental abuse. Another key factor in relapse for women offenders is that most lack the skills to cope with the stressful situations in which they live. Their relationships are central: when their primary attachments—whether mother and siblings or male partner—are part of the drug-using scene, women may need to make the

the skills needed to prevent relapse. Such skills include strategies to recognize and handle the individual's recurrent thoughts, cravings, or physical desires to use drugs; strategies to deal with positive expectations about the initial effects of drug use; and strategies to monitor the woman's relapse warning signs, to handle high-risk situations, to build drug-free friendships, and to adopt a more balanced lifestyle (Peters 1993).

Important Programmatic Factors

Certain key factors need to be built into any treatment program for substance-abusing women offenders, regardless of the type of program model used. These are elements that the research has shown are important for the recovery of offenders who have severe, long-term patterns of substance abuse. These elements include providing longer time in treatment, a graduated series of intermediate sanctions through the criminal justice system, clear sanctions and rules within the treatment program, comprehensive services, and a continuum of care after release.

Length of Time in Treatment

For both men and women offenders with drug problems, spending longer lengths of time in treatment is a critical factor in preventing recidivism. Repeated research demonstrates that the

Relapse prevention approaches help offenders recognize their own “triggers” to relapse and develop the skills needed to prevent relapse.

and the stress is very high for offenders as they leave a structured setting for life outside the institution.

The research points to the value of drug treatment in preventing criminal recidivism. The findings show that successfully reducing drug use does dramatically reduce further criminality. For example, follow-up studies of career addicts in Baltimore have found high rates of criminality among heroin users during those periods when the users are addicted and markedly lower rates during periods of nonaddiction (Inciardi et al. 1993a).

difficult choice of divorcing themselves from these attachments. To avoid relapse, many of these women must build completely new lives, with new sources of support in the community.

Several relapse prevention approaches have been designed specifically for criminal justice populations. The materials used by the CSAT-supported women's programs described in this *Guide* are in the Resource List under “Program Materials.” Relapse prevention approaches help offenders recognize their own “triggers” to relapse and develop

longer a substance-abusing offender stays in treatment, whether that treatment is in a TC or outpatient facility, the better the outcome in terms of declines in drug use and criminality (De Leon 1984; Anglin and Hser 1990; Hubbard et al. 1989). Statistics from the CSAT women's programs demonstrate the important effects of time in institutional treatment, combined with community aftercare following release. Findings include:

- Only 30 percent of women who completed the Recovery In Focus prison program had a new subsequent arrest, compared with 44 percent of those who did not complete the program and 65 percent among those who did not participate in the program at all (see page 147).
- Some 90 percent of Forever Free graduates who subsequently stayed for 5 months or longer in community residential treatment programs were successful on parole, compared with 38 percent of program dropouts and 62 percent of program graduates (see page 147).
- Among participants in both the SISTERS and the Stepping Out jail TC programs, those who continued into community aftercare after release were significantly less likely to be arrested (see pages 148-149).
- Stepping Out graduates provided only with aftercare stayed in treatment an average of 33 days; those receiving aftercare plus safe and sober housing stayed in treatment for more than 80 days—more than double the time for aftercare alone (see page 149).

Coordinating With the Criminal Justice System

Offenders in treatment programs often do better, remaining longer in treatment, when the treatment is mandated and coordinated as an intermediate sanction within the criminal justice system. Treatment can be constructively used as one sanction within a graduated series of intermediate sanctions. In an increasing number of jurisdictions, the courts, correctional system, and treatment programs are being coordinated to provide this kind of synergy. In Baltimore, for example, the judges and detention center officials are all committed to rehabilitation for addicted women and are attempting to match women with appropriate treatment services. Coordinating treatment with sanctions takes communication, and often training for all personnel involved. The CSAT grantees suggest that certain types of coordinated actions are important, including the following:

- Judges need to be encouraged to refer addicted offenders to treatment, but the particular type of treatment should not be specified; that should be determined by the screening and assessment process.
- The sentencing to treatment should be time-neutral. That is, because of treatment, the length of the sentence should not be extended beyond the normal length for that offense. Offenders should not be kept on waiting lists for treatment while in custody, so that the treatment actually extends their time in custody.

- Sentencing needs to be tied into the successful completion of treatment phases so that, as a woman completes her in-custody treatment program, she is allowed to start the post-custody release and treatment phase immediately. Creating a hiatus in her treatment, with a return to the general population, may cause the woman to regress and lose ground.
- A series of graduated sanctions is most effective for ensuring that women stay in treatment after their release. In some programs described in this *Guide*, a program graduate is allowed to leave the prison or jail only if she will be participating in treatment or in a treatment plus work release program.

Less restrictive measures than incarceration, such as house arrest or electronic monitoring, would seem to offer promise as a method of supervising women in the community. However, these types of options have not been relevant for the CSAT-supported programs, which are based in facilities. For example, both house arrest and electronic monitoring are available in Baltimore, but these options are not directly relevant to the facility-based Baltimore pretrial program.

Coordinating Program Rules and Institutional Sanctions

Learning to be personally accountable is a major component of all the CSAT-supported women's programs. Rules form the backbone of a program. The program's rules will be an additional layer on top of the jail or

prison's rules and sanctions. How the institution's rules and the program rules will mesh needs to be worked out individually for each program.

The issue of urinalysis is one important sanction to be considered. There is no one answer to this. Staff of each program must decide whether to collect urines, and if so, what the consequences will be for a "dirty urine." Among the CSAT women's prison programs, urines are collected by the institutions in some cases, by the programs in others, and by both in one case. CSAT's expert panel on women's programming sug-

the urinalysis, the institution will set the punishment. At the SISTER project, for example, the sheriff's department does the urinalysis; a woman with a drug-positive urine test will receive 5 days in the lockup or could have her prison time extended.

- **Treatment program policies.** The longer term TCs try to be flexible about readmitting a woman who has had a drug-positive urine test. In the SISTER project, on an individual basis, a woman may be permitted to return to the treatment program.

Incarcerated women tend to be very eager to take advantage of education and other programming.

gested that important factors to consider include the following:

- **Effect of use on others in the program.** In a short-term, intensive program, drug use by one participant could contaminate the program for the others. The 2-week program at the Baltimore detention center does urinalysis for therapeutic reasons. If a woman uses, she is out of the program. However, results are coded so that the jail authorities do not know which participant tests positive. In a longer term community program, it would be possible to work with a woman, to allow a new attempt, without jeopardizing the recovery of others.
- **Tolerance level of the institution.** In correctional settings, there will be zero tolerance for drug use. If the institution does

However, she must first demonstrate her commitment by attending substance abuse support groups in another housing unit. At WCI Village, women are removed from the program for 90 days and then return to the program.

The experience of the CSAT-supported programs is that very few women test positive for psychoactive drugs while in the programs. For example, in over 2 years of program operation at the Baltimore detention center, only one woman has tested positive.

Continued collecting of urines during the post-release period is done in some jurisdictions as part of a continuum of graduated sanctions. For example, in the Delaware three-stage system of custody, work release, and after-

care, urine monitoring continues for 6 months in the aftercare phase.

Provision of Comprehensive Services

As the earlier chapters make clear, the vast majority of female offenders with drug abuse problems have multiple and long-standing psychosocial problems. Substance-abusing offenders often exhibit some form of cognitive problem, psychological dysfunction, unrealistic or disorganized thinking, misshapen values, and frequent deficits in educational and employment skills (Inciardi and Scarpitti 1992). For these individuals, drug abuse may be complicated by social and psychological problems. Thus, the goal of treatment is "habilitation"—which involves socializing the person for the first time into a responsible way of life, rather than rehabilitation—which implies the return to a previous way of life.

CSAT recommends that treatment programs for incarcerated women provide interventions in the clinical areas discussed in chapter 4. In addition, there are two important areas of programming that need to be available for women offenders, either through the criminal justice system or community programs. These areas pertain to higher education and vocational training.

Education

Incarcerated women tend to be very eager to take advantage of education and other programming. During one study of jail programming for women, a jail

manager observed that women in his jail, unlike many of the men he had supervised in other facilities, were “very receptive to learning, improvement, and a variety of programming opportunities” (Gray et al. 1995). In this study, inmates rated work training as the single most needed program, followed by college courses, ranked third, and vocational courses, which tied for fourth. The chance to take college courses is particularly important for women who have enough prerequisites.

Vocational Skills Training

Economic self-sufficiency is a cornerstone to success after imprisonment. Undereducated women have a particularly tough time in the job market, because there are virtually no traditionally female jobs that pay well for unskilled or semiskilled labor. Treatment programs for women offenders need to take whatever actions they can to expand vocational opportunities. There are two problem areas:

- *Opportunities for training in the better paying male jobs are not made available.* A 1980 General Accounting Office study found that, within the Bureau of Prisons, women had access to only 13 prison industry jobs while men had access to 84 (Miller 1990). Work programs for women are sex-stereotyped, with much emphasis on cosmetology, clerical skills, and food service (Glick and Neto 1982, pp. 141-154).
- *Prison security needs for women can limit their opportunities.* At coed institutions, security needs (such as requir-

ing a guard to take the woman to and from a program) can severely restrict the number of job training opportunities for women.

Although various nontraditional women’s vocational programs are being increasingly introduced into women’s prisons (Owen and Horwitz 1991), the CSAT demonstration projects found their women had very limited access to vocational training opportunities. As one CSAT program director pointed out, many of these women clients do not have skills that suit them for office work—which is what the training programs for women tend to emphasize. Women can benefit from training in nontraditional work that pays well—such as welding, auto body repair, auto mechanics, electrical work, bricklaying, and computer maintenance.

An additional caveat is important. The division of time between a woman offender’s work and her substance abuse treatment can be a problem. Women who have severe and long-standing addiction problems need to be focusing full time on their treatment. This can create scheduling tensions with the criminal justice institution. In two of the CSAT-supported prison treatment programs, women were initially required to work for 8 hours per day. This meant the treatment had to be sandwiched into early morning hours and then into the evening, when the women were exhausted. It is far preferable for the women’s time in treatment to count toward the work requirement.

Continuum of Care

In-prison treatment programs for incarcerated women are not sufficient for most of this population. It is essential that the women receive a continuum of care that extends to community treatment and other support after their release. As one prison AOD program director put it, “The majority of women who leave the institution ‘cold turkey’ need further help. If they don’t get it, most of them will be back inside within a month.”

The goal should be to extend supervision and treatment until the woman is in full recovery, with a safe, drug-free place to live, a support system in place, and the means for self-sufficiency. For prison and jail AOD programs, “time in treatment” needs to encompass the whole continuum of care, not just the institutional segment.

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Chapter 6 describes the many strategies used by the CSAT grantees to provide this continuum of care for their women clients.

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Just how managed care may affect this continuum of care for ex-offenders is not now known. Many States are now moving toward managed care plans as a way of managing their publicly funded AOD clients. Offenders returning to the community generally receive any treatment through the publicly funded providers. Managed care plans usually limit the number of AOD treatment sessions that a client

may receive, often in terms of both annual and lifetime benefits. Ex-offenders are likely to need more intensive treatment for longer periods than the standards allowed by their State's managed care plan.

Adapting Models to Women's Needs

Traditional models for treating substance abuse were all designed for men. Because women's addiction is different from men's, women need models adapted to their psychology and addressing the causes of their substance abuse. The accumulated experience in women-specific programs is making this task easier than in the past.

Recommendations of CSAT Women's Programs

In setting up a model specifically for women offenders, the CSAT women's prison programs offer the following recommendations:

- **Use a woman-centered model and staff approach.** Look carefully at the underlying assumptions of the basic model, and adjust the curriculum and design to match women's psychology and developmental needs. Just adding women-specific topics to a male model program does not do enough. The fact that women counselors are used also does not guarantee a woman-centered approach, since their work experience may be with the more typical male-oriented models (New

York State Division of Alcohol Abuse and Alcoholism 1990).

- **Use a model matched to the population being served.** Look at the population to be served, construct a model that incorporates the latest thinking about women's emotional development and addiction, and build a program that meshes with the needs of that population. A rehabilitation model is appropriate when addiction is seen as just one piece in a constellation of biopsychosocial problems.

Other models are possible, depending on the population being served and the program's basic theory about addiction. Examples would be: (1) for young women, an adolescent developmental model emphasizing tasks in developmental growth could be appropriate; (2) when addiction is seen as a primary disease, then a model that stresses spirituality and how to overcome craving may be appropriate (e.g., a 12-Step model); and (3) if lifestyle is seen as the driving problem, then a resocialization model, such as a TC model, is appropriate.

- **Use a stages-of-change model.** Based on the addiction theory chosen, then a stages-of-change model needs to be adopted and staff need to be trained to understand and use it. (See, for example, Miller and Hester [1986], Gorski [1991], and Prochaska and DiClemente [1986].) The stages-of-change concept then undergirds the program, as staff continue to assess each woman and develop individual treatment plans

according to where each woman is on the continuum of awareness, motivation to change, and readiness to take positive action. The Prochaska and DiClemente model, recommended by one of the CSAT grantees, involves six stages: (1) precontemplation (the person sees no need to curtail the habit), (2) contemplation (the person sees the negative results of addiction), (3) determination (the person begins to examine the best treatment methods), (4) action (the trial with abstinence begins), (5) maintenance (the focus shifts to relapse prevention), and (6) termination (the person is in stable, long-term recovery) (Prochaska 1996).

- **Build in a premotivation stage.** Build in a premotivation process. Treatment starts under artificial circumstances in a custody setting. In the community, a long process of motivation often occurs before people voluntarily enter treatment or mutual-help support groups. Women offenders frequently need rehabilitative work, focused on issues underlying their addiction, before they can commit to their recovery. The North Rehabilitation Facility in Seattle recommends three initial process goals for women during this pre-readiness phase:

- (1) To develop some meaningful awareness of the addiction problem, based on their own values.
- (2) To resolve their feelings of ambivalence about substance use, and to develop some intrinsic motivation to change.

- (3) To take some positive action.
- **Plan for cultural and ethnic diversity.** Look at the racial and ethnic mix of the program population and plan to provide appropriate, sensitive programming (and staff) for special groups.
 - **Develop flexible programming.** Provide as much program flexibility as possible to meet varying needs of the women. Research and experience show that women want and do better with an individualized response to their problems. In addition, because of their greater numbers, male offenders tend to have more varied treatment programming available to them. Programs for women, because there are fewer of them, need to be flexible enough to serve a range of clients.

Modifying the Common Male Treatment Models

The two most widely used treatment models for incarcerated men and women are those based on 12-Step principles and therapeutic communities (TCs). As these models have evolved, current criminal justice treatment programs tend to blend philosophies; for example, many prison TCs incorporate 12-Step principles.

The underlying reason why both these models need adaptation for women is the same: both models were initially developed for men. Before planning a program for women, it is important to look at the basic assumptions underlying these male-oriented

models and adapt them to be more effective for women. Essentially, both the 12-Step and TC models operate on assumptions about male power, as perceived by male clients. Both models offer powerful features, particularly when adapted to meet the needs of women.

The 12-Step Model

Alcoholics Anonymous (AA), the original 12-Step model, was founded in 1935 and was initially designed for men. As late as 1968, only 22 percent of AA members were female. During the 1970s and 1980s, the number of women

Those designing their programs on an AA model need to be aware of its major advantages, and its limitations, as a model for healing women offenders.

in AA mushroomed and women-only groups spread across the country. By 1992, at least 35 percent of all AA members were women. According to Covington (1991b):

It is impossible to describe the variety of AA meetings and members that exist at this time. There are specialized meetings for women, lesbians, Native Americans, nurses, non-smokers, people who are HIV-positive, and scores of others who may share some other characteristic in addition to their desire to stop drinking.

At the time AA was founded, it represented several radical concepts (Covington, in press). The 12-Step programs are free, they are nonhierarchical, and they are

spiritual in a nonspiritual society. There is still no involvement by professionals or experts in 12-Step groups. Twelve-step groups stress face-to-face interactions and encourage their members to accept personal responsibility for themselves. Members receive social support and a sense of connection to others through the creation of a caring community.

Today, the 12-Step AA model is a basic component in nearly all treatment for offenders—particularly the ongoing groups that offer peer support in institutions and in the community after release. All the CSAT-supported programs described in this *Guide*

have 12-Step study groups. The North Rehabilitation Facility uses an AA model modified for women for its program design.

Those designing their programs on an AA model need to be aware of its major advantages, and its limitations, as a model for healing women offenders. The AA principles work well for women—but the language and principles need to be interpreted in ways appropriate for women. Among the 12-Step principles that are important for women's healing are the steps to restore the person's sense of integrity and belief in self and to help her atone, using bonding, fellowship, and sharing with others.

In designing a model for women offenders, these modifications are important:

- Expand the early interpretation of the 12-Step disease model, in which alcoholism is perceived as a primary disease of the individual. Chapter 2 explains how many practitioners today perceive the medical model of disease in a broader holistic context, taking into consideration such issues as genetic vulnerability, environmental influences, and lifestyle choices.
- Adapt and reinterpret the language of some of the literature, which was written as much as 50 years ago, to eliminate overtly sexist content and connotations. *A Woman's Way Through the Twelve Steps* (Covington 1994) is particularly helpful in illustrating the numerous ways in which women may individually interpret and learn from the 12 Steps.
- Develop a premotivation component. Programs based on variations of the 12-Step model tend to start at the point of motivation to treatment, after ambivalence about substance use has been resolved. The focus is on moving toward recovery. Models designed for women offenders need to step back to a prior phase. The model should assume the woman is *not* initially motivated to stop her substance abuse and that the program needs to help the woman acquire the motivation she needs for change to occur. Motivation requires introspection, a sense of self-efficacy, and a sense of self. A lot of work goes on before a person becomes moti-

vated into treatment. Programs that don't help women go through these initial steps may just be "skimming off" and reaching only those women who have already done the hard work of motivation on their own.

Those designing women's programs need to be aware of the body of feminist literature that critiques the 12 Steps and criticizes their language as being simplistic, sexist, and reductionist (Bepko 1991; Berenson 1991; Kasl 1992; and Rapping 1996). Feminists are particularly concerned about the 12 Steps emphasis on powerlessness and on the call for "submission," which some feminists confuse with surrender. The concern is that the 12 Steps may demand giving up control and power over one's life and encourage submission—neither of which would be productive for women.

It is important to keep in mind the dynamic operating with female offenders. These women have not felt social pressures to achieve control and dominance, as men have. Their experience often is to be profoundly violated as people, to be subjected to physical and sexual abuse, to lack personal boundaries. These women feel powerless over almost everything in their lives. For marginalized women, the recovery process is different than for men. These women need to *acquire* control. They need to recognize and be responsible for their own personal boundaries and to gain a sense of self

and of their own identity as individuals.

At this point, there is also a considerable body of helpful literature from people who have successfully adapted the 12 Steps in work with substance-abusing women. They point out that the masculine "power over" is what the 12 Steps ask to be relinquished. Instead, the 12 Steps favor the feminine "power with" and the "power to be able," which fosters a sense of empowerment (Miller 1982). Recovery encourages surrender and giving up the *need for and the illusion of control*. "The process of recovery from addiction is a process of recovering a different, more feminine, sense of power and will" (Berenson 1991, p. 74). Covington (1994) has found that women are able to interpret the Steps in ways that are distinctly personal, meaningful, and useful to themselves.

The 12-Step, mutual help model is a holistic approach that provides the major factors women need for recovery. Most important, the model fosters personal growth within the context of connections and relationships. Herman (1992) points out that 12-Step programs can create the safe environment for women that is essential for recovery from trauma. As Covington (1994, p. 192) states:

Working with the 12 Steps from a woman's perspective empowers us and helps us change our lives. Creating a strong inner place and believing there is something in the universe supporting us helps us to know we are

not alone. Then we may be surprised to find that the power and healing revealed in the Steps allows an ease in living, an acceptance and serenity, that can transform the way we experience self, relationship, sexuality, and spirituality—which are at the heart of life.

* * * * *

One excellent resource explaining how the 12-Step model operates is “Sororities of Helping and Healing: Women and Mutual Support Groups” (Covington 1991*b*). For programs wishing to adapt the 12-Step model, materials developed by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) can serve as a resource; one such product is the NIAAA Project MATCH manual on 12-Step facilitation therapy (Nowinski et al. 1995).

* * * * *

Therapeutic Community (TC) Model

TC models, developed originally for men as a mutual-help model for heroin addiction, focus heavily on developing responsibility and conformity in criminogenic, antisocial men who have severe drug dependency. Many practitioners believe it is the most appropriate form of drug abuse treatment in correctional settings (Hooper et al. 1993).

TCs have been in existence for decades, and their successes have been well documented (De Leon 1990, pp. 115-138). Correctional system TCs grew out of convincing evidence of success from

such programs as Stay ‘N Out, established in the New York State correctional system in 1974. Stay ‘N Out follow-up studies showed that treatment in a prison-based TC could significantly reduce recidivism rates for both men and women offenders with histories of severe drug dependence (Wexler and Williams 1986; Wexler et al. 1990). Women who

backgrounds. Some staff will be certified AOD counselors who may have been through a TC themselves and may be in recovery; other staff will be counselors with a social work or psychology background and special training in AOD treatment. This type of staff mix tends to expand the scope and capacities of a program.

The underlying treatment principle in TCs is that drug abuse is a disorder of the whole person—that the problem is the person and not the drug; that addiction is a symptom and not the essence of the disorder.

stayed in the program for 9 to 12 months did even better than the men, with 92 percent completing their parole successfully.

The underlying treatment principle in TCs is that drug abuse is a disorder of the whole person—that the problem is the person and not the drug; that addiction is a symptom and not the essence of the disorder. The primary goal is to change the negative patterns of behavior, thinking, and feeling that predispose to drug use (Hooper et al. 1993).

The original TCs for men used an authoritarian and aggressive confrontational approach and peer pressure to encourage the development of prosocial behaviors and commitment to a drug-free lifestyle. Staff within the early TCs were often ex-offenders and graduates of the program. Today, TCs usually combine staff who have a variety of

TCs have a highly structured treatment approach, in which strict community norms govern appropriate participant behavior, with an elaborate system of rewards and punishments regarding community behavior. Participants learn responsibility through a system of graduated responsibilities and roles. TCs provide intense residential treatment, with participants living in a unit isolated from the general population. This fosters a strong sense of community and reduces the negative peer pressure from other inmates.

The TC model can offer an ideal environment of support and help to incarcerated, substance abusing women, with a depth of nurturance and support never before known by these women. The women in these TCs learn to trust and bond with others, to find hope and opportunity for change. Many clients have

never experienced a structured environment or someone who cares. The CSAT women's TCs are designed to provide such an environment. As one program director put it, "We want the women to feel like part of a supportive family."

The major change from a male-model TC to a program for women is the de-escalation in the intensity and level of confrontation. Men's programs often have an intense, in-your-face confrontational style that can be loud and aggressive, and these apply overt, coercive pressure to change an individual's unsatisfactory behavior.

In successful women's programs, confrontation is used as a technique but in a context that also stresses the power of the woman to make her own decisions. The women's programs confront but do so in a supportive way for the woman. At WCI Village, a peer is always designated to be a woman's support when she must face a group. This rotating support person gives active reinforcement—either verbally or by touching, according to what is most reassuring for the particular woman. Another example: women are socialized to please others. This often means that a woman feels she cannot speak bluntly about unpleasant realities or her own feelings. Being confronted to speak the truth can be a freeing

experience—a form of empowerment for women.

Setting up a TC requires some staff who have personal experience with this modality. For those who have not experienced a TC, it can be hard to gain a sense of how the TC milieu operates. Some articles that can provide insight about this modality include works by Hooper et al. (1993), De Leon and Ziegenfuss (1986), Yablonsky (1989), Inciardi (1996), and Pan et al. (1993). Nielsen and Scarpitti (1995) offer a look at how language reflects and defines the subculture of a work release TC, becoming a change factor in the thought processes of the men and women clients.

An interesting recent article describes the challenges and principles involved in moving from a traditional TC model to a TC model that serves women and children (Brown et al. 1996). The article describes adaptations made in three categories: structural design issues, treatment issues, and staff and training issues.

Male counselors who come out of male-oriented TC experiences may have difficulty in adapting to a women's TC model. This problem is discussed in chapter 7 under Selection and Training of Substance Abuse Treatment Staff.

Examples of Modification by CSAT Programs

Six of the nine women's prison and jail programs described in this *Guide* are TC models. These programs demonstrate the different types of TCs, depending on the length of client participation. These types include the traditional TC (usually 9 to 15 months in duration), the modified TC (6 to 9 months), and the short-term TC (2 to 6 months) (see table 3).

In adapting their TC models for women, the CSAT demonstration programs have made numerous adjustments. Selected examples include the following:

- **TC program structure.** The OPTIONS TC program in Philadelphia does not use a traditional hierarchical structure. Instead, this TC employs a communal, noncompetitive approach. Rather than a graduated process for individual leaders, this program uses program committees as a mechanism for exercising leadership, cooperation, and responsibility.
- **TC components designed to answer women's needs.** WCI Village focuses on family issues, provides a supportive and nurturing environment for working on relationship issues, and sets up a structure that gives women empowerment through their job functions and earns them rewards for appropriate behavior.

Part III

Stages of Treatment Planning: The Action Steps

Chapter 6—Stages in the Treatment/Accountability Continuum of Care

For a woman offender with severe substance abuse problems, the most promising continuum of treatment and accountability will include four critical stages as she moves from initial screening through custody into the post-release period. See table 6 for a list of clinical issues that need to be addressed, and table 10 for steps in the continuum of treatment. The following sections describe promising practices at each of these stages: (1) screening and assessment, (2) in-custody treatment, (3) transition/pre-release planning, and (4) post-release treatment and continuing care. This chapter reflects the practical knowledge and experience gained by the CSAT grantees as they planned and carried out their treatment activities.

Stage 1: Screening and Assessment

Screening and assessment represent the first stage in the continuum of care for substance abusing offenders. This initial stage is critical in providing the framework and the “road map” for treating each individual woman. For treatment programs within correctional settings, the screening

and assessment process serves these purposes:

- To identify, select, and engage women who would benefit from the in-custody treatment program
- To provide an objective basis for assessing the severity of the woman’s substance abuse problems and working with the woman to develop an individualized treatment plan
- To provide a framework for reassessing the woman’s treatment readiness, progress, and her next-step goals over the course of the treatment program
- To define the most appropriate level and type of treatment

Table 10. Continuum of treatment

In terms of coordination between treatment and corrections, the most effective continuum of treatment currently identified includes the following steps:

- Identify the offender as a substance abuser as soon as possible after entry into the criminal justice system.
- Screen for diversion into treatment as an alternative to custody (as is done by the Treatment Alternatives for Safer Communities [TASC] model) or in-custody treatment for those not eligible for diversion.
- Prior to the offender’s release, link (through case management) reentry treatment planning services with appropriate community treatment providers; ensure the availability of community treatment to avoid gaps in care.
- Provide early release to the community conditioned upon a commitment to fulfill a treatment plan negotiated voluntarily by the offender and counselor with concurrence of the releasing authority (probation, county parole, the court).
- Provide monitoring of the treatment plan by probation or county parole in close cooperation with the case manager and community treatment provider.
- Make a series of clear and rapidly implemented intermediate sanctions available to the supervising authority as alternatives to returning the offender to custody if she violates probation/parole conditions.

—Adapted from Bureau of Justice Assistance, *Design and Implementation Issues for Drug Treatment in the Jail Setting*. Washington, DC: U.S. Department of Justice, 1991.

and other services that the woman will need when she is released back into the community.

In the past few years, this topic has become a high-priority issue for both the corrections and treatment fields. It is being recognized that treating addicted offenders saves society enormous sums in reduced crime and other social benefits ... and that the most cost-effective way to provide that treatment is through appropriate matching. Women need to be matched to the level and type of treatment most likely to benefit them—based on the severity of their substance abuse problem, their criminal record, their prior treatment, their family support, personal resources, and other factors. To provide low-level services to a woman who needs residential treatment wastes money and resources, besides discouraging the woman. To provide residential care to a woman who can benefit from less intensive outpatient treatment also wastes resources. Since the early 1990s, the field has become increasingly concerned, and knowledgeable, about using screening instruments to help guide these clinical judgments.

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This section highlights screening and assessment issues pertinent to women, based on the experiences of the CSAT-supported programs described in this *Guide*. For an in-depth discussion of screening and assessment issues, as well as descriptions and lists of widely used screening instruments, see TIP 7, *Screening and Assessment for Alcohol and Other*

Drug Abuse Among Adults in the Criminal Justice System (CSAT 1994a).

* * * * *

Pre-Screening for Treatment

Pretrial Screening and Court-Ordered Treatment

In some jurisdictions, screening may be done by the criminal justice system at the pretrial or sentencing stage. In Arkansas, for example, judges may transfer first-time, nonviolent offenders with substance abuse problems to the Department of Community Punishment (DCP). Sentenced offenders go to the Department of Community Punishment Facility in lieu of prison. These women are court-ordered to have 90 days of substance abuse treatment. Women who enter the CHOICES program come through this mechanism. For this type of screening and decision-making process, the CHOICES staff recommends the following:

- The court may order treatment, but should not specify the type of treatment program. That decision should be made through a thorough screening assessment by persons trained to do this screening—often the treatment providers. In Arkansas, the sentenced women may volunteer for the Choices program. Based on the assessment and the availability of program space, treatment staff selects women appropriate for their program.
- Judges and court administrators need training on substance abuse and treatment in order

to make informed sentencing decisions involving treatment. Choices staff spent about 1 year in carrying out such training in Arkansas.

Role of the Classification System

Classification is the process by which a jail, prison, probation, parole, or other part of the criminal justice system assesses both the security risk represented by an individual offender and, ideally, the individual's need for health, mental health, or other special services. In both jail and prison programs, this initial classification is often used as a pre-screening for the substance abuse treatment program. Both the booking screen and the medical screen give an opportunity to ask about alcohol and other drug (AOD) issues.

Since the classification system is so often used for treatment pre-screening, it is important to know how adequately these systems deal with women. Classification systems were initially set up for male offenders and take a male perspective. Consequently, most prison and jail systems have totally inadequate classification systems for women; there is a lack of classification models for women. The Federal prison system, for example, does not have a separate classification system for women.

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For a thorough discussion concerning the problems of current classification systems for women, see "Institutional Classification of Females: Problems and Some Proposals for Reform," a chapter in the recent book *Female*

Offenders: Critical Perspectives and Effective Interventions (Brennan 1998). This chapter aims to help managers of correctional agencies, classification directors, treatment providers, and researchers in designing or considering new approaches to classifying female detainees. Brennan concludes that most of the current gender-neutral systems are not well aligned with either a policy goal of risk assessment for female detainees, or with the policy goals of needs assessment, treatment, and rehabilitation. The book as a whole (Zaplin 1998) offers a broad-based perspective on female offenders, including theoretical models, treatment considerations and strategies, and program approaches. Among the topics covered by a number of experts are the relational theory of women's psychological development, treatment in a systems perspective, mental health issues and treatment, childhood maltreatment and surviving violence, and programs that work in helping mothers and prostitutes.

* * * * *

Classification issues may be very different for women, since a lower percentage require close custody and supervision. In comparison to men, women inmates are less of a threat to each other, staff, or property. According to Lord (1995), "it is almost unknown to create classification systems for women ... [so] we simply use instruments designed to assess the dangerousness of men and overbuild or oversecure for women at significant cost but little real gain in increased safe-

ty." A survey by the American Correctional Association (ACA 1990) showed that:

- Only 20 percent of U.S. jails and 39 percent of State prisons have a separate reception or diagnostic center for women.
- Only 26 percent of jails and 51 percent of State prisons have full-time classification officers assigned exclusively for female offenders.
- Only 26 percent of jails and 22 percent of State prisons recognize the differences between men and women and have a classification system especially designed for female offenders.

The classification instruments used to pre-screen for any woman's treatment program will probably have been designed for men. These instruments need to be reviewed and possibly modified to reflect issues pertinent for addicted women offenders. In modifying the pre-screening instrument, it is important to keep in mind that the pre-screening process can be significant in introducing and interesting women in the program. The pre-screen is thus an opportunity to help the woman look at her drug problem and also an opportunity to encourage her to change it.

The pre-screening and staging into treatment should be a partnership arrangement between the correctional and treatment staffs. This is an area in which some of the CSAT grantees have encountered resistance. Correctional staffs may want to control the decisions about who enters treatment or, in many cases, the institution's classification system is simply set up to make these decisions and any change is resisted.

A variety of screening scenarios is possible, but the important principle is to assure that treatment staff are comfortable with which women are admitted for treatment.

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Chapter 7, "Critical Issues in Implementing Programs," offers some suggestions for forging mutual arrangements between corrections and treatment staffs.

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Instruments for Screening

A nationwide survey of community and corrections programs that treat women offenders found these programs seldom use standardized screening instruments. Instead, the programs tend to assess need on the basis of a client intake interview supplemented by observation and by information from client records (Prendergast et al. 1995, p. 245). The researchers concluded that the failure of many programs to use a standardized assessment protocol—that is, a published, validated instrument—suggests there is likely to be considerable variation in the kind and quality of information obtained on clients for various areas of need. The researchers also concluded that these programs may have an insufficient information base on which to develop needed services and to match clients to appropriate services.

Standardized screening and assessment instruments designed and validated for women are not available. What is recommended

for women's treatment programs is the following:

- **Use standardized instruments** that, if possible, have been normed for the offender population. The validated instrument can form the backbone of the assessment process. These standardized instruments offer certain advantages: training tools, supplementary resources, and a common database.
- **Add specific questions** that relate to women, such as questions pertaining to physical and sexual abuse and mental health.
- **Choose instruments that match up with program goals.** The program context will affect the choice of instrument. Using a validated instrument as a base, many programs like to develop their own individualized

forms. WCI Village, for example, has developed its own screening form. The SISTER project uses forms developed by Walden House, Inc. SISTER graduates are transferred to Walden House facilities after their release from jail.

Many instruments are available that perform similar functions. Some of the substance abuse screening instruments used by the programs described in this *Guide* include:

- **Simple Screening Instrument for Alcohol and Other Drug Abuse (SSI):** A 16-item public domain instrument adapted from 13 validated instruments; administered with pencil and paper.
- **Substance Abuse Subtle Screening Inventory (SASSI),**

developed by SASSI Institute: An 88-item self-administered screening tool (used by North Rehabilitation Facility, Seattle).

- **Offender Profile Index (OPI):** A public domain screening instrument that requires a 30-minute face-to-face interview and is appropriate for determining the type of treatment to be used by the correctional system. Interviewers must be trained to use the OPI.

Screening for Admission to Programs

Men and women respond very differently to the screening process. Several of the CSAT-supported projects operate parallel programs for women and men. Staffs point out that men respond to screening in a concrete, factual way, answering questions with a word or two. Women have a more individualized response; women want to talk about their answers. Screening for women can therefore be a therapeutic experience and a first opportunity for bonding with staff.

The CSAT programs recommend that more time be allocated for screening women into substance abuse treatment programs than is provided for men.

Screening for Admission to Jail/Detention Center Programs

For jail programs, where time is often limited, it makes sense to use the classification process as a pre-screen gatekeeper to the program. This gets women into the program as quickly as possible. The principle is to have classification staff make the first cut and to send a selected list of names to

Screening Recommendations

1 The screening of women for institutional drug treatment programs needs to reflect a mutual, collaborative effort between the correctional classification staff and the treatment program staff.

2 It is desirable to have the substance abuse screening done as part of an institution's medical screen, where the screening can be done by a nurse or by some person with a background in public health. This screening needs to be done by a person who has had experience and/or training in substance abuse. Some nurses have such training.

The CSAT expert panel on women's correctional treatment also recommends:

- Review and carefully evaluate the process that correctional counselors will use in pre-screening for the treatment program. The pre-screen should not cull out women who are appropriate for the program.
- Provide orientation to the program and training for the correctional counselors who will do the pre-screen.
- If possible, have a treatment staff person involved on the classification board to reflect the treatment program's perspectives and interests.
- Stay in touch with the correctional counselors' priorities concerning treatment. Changes in sentencing or security priorities can affect how much effort these counselors make to interest and sign up women for treatment.

the treatment staff. It is helpful if the pre-screen can flag women who may have program difficulties because of medical, mental health, or management problems (for example, women who are going through detoxification). Examples of how this process works for the CSAT-supported programs include:

- ***Baltimore 2-week Acupuncture and Awareness jail-based treatment readiness program.*** Classification staff at the Baltimore City Detention Center send the program a selected list of women identified with AOD problems. The program director then chooses women to assess for possible admission, based on security and trial date status, the nature of the offense, and slot availability. This program serves women awaiting trial, primarily for drug-related offenses, who have less extensive histories of drug use and crime and are likely therefore to be released back to the community at the time of trial.

Pre-screening is based on the woman's self-reported alcohol and other drug use history and/or on information about her criminal history.

- ***Stepping Out TC program, San Diego.*** Jail counselors, trained by Stepping Out staff, do the pre-screening. Counselors look at (1) the number of days left (sentenced inmates must have at least 50 days remaining to serve), and (2) the severity of the substance abuse problem. If eligible, the counselors explain the treatment program to the woman and, if she is interested, place her name on a

list of prospective participants. From this list, the Stepping Out treatment staff screen women into the program.

For screening into the program, treatment staff use two scales of the Adult Substance Use Survey (ASUS), which takes 7 to 10 minutes to complete. This survey measures substance abuse severity by two scales: involvement with drugs and disruption to the woman's life related to substance use. The two scales should be "in sync" with each other. Inmates on psychotropic medications are admitted on a case-by-case basis. Criteria for admission into the program include the following:

- Minimum 50 days remaining to serve
- Custody level appropriate for programming (general population)
- No holds (i.e., Immigration and Naturalization Service, parole)
- Sentenced, no cases pending
- Apparent substance abuse problem, based on the scale scores
- Willing to participate in program

Screening for Admission to Prison Programs

Screening for prison programs does not have to be elaborate. The concept of matching the client to a particular type of treatment does not usually pertain in this context because, in many cases, there will be only one program available for women in the criminal justice setting. The screening is more an issue of determining whether a given

woman is appropriate for the available program rather than of matching (which implies that multiple treatment options are available). While matching inmates to the appropriate intervention is important, field experience suggests that prison programs do not need to use elaborate diagnostic and matching procedures (CSAT 1993a). This is because:

- Inmate populations tend to be quite homogeneous in their drug use histories and need patterns. As an example, assessment shows that fully 70 percent of women in Delaware prisons need either short-term or long-term residential treatment (Peyton 1994, p.12).
- Often, treatment alternatives are limited in the particular prison or in the entire correctional system.
- External factors such as the expected time of release are often more important than a detailed treatment needs assessment in determining whether a woman is eligible for the program.

As with the jail programs, pre-screening is usually done by the classifications staff. A medical examination may also be done when the woman enters prison. At Forever Free, a Corrections Counselor III provides project oversight and is responsible for the screening and selection of program participants. At the other CSAT-supported programs described in this *Guide*, treatment staff conduct the screening and selection of participants. The screening process is usually simple. For example, the Recovery In Focus program, a 6-month TC in

Oregon, uses a brief screening tool that addresses the following eligibility criteria:

- Adult woman aged 18 years or older with children aged newborn to 18 years
- Alcohol/drug use causing problems in two or more life areas: social, mental, emotional, legal, educational, vocational, marital/family, spiritual, physical, or with avocational activities
- Remaining sentence time of 4-6 months before release
- Willingness to participate in the program; overtly hostile, disruptive, or combative inmates are not eligible
- No record of being a sex offender (because children are involved in the program)
- Ability to participate in treatment sessions (i.e., not actively psychotic or severely cognitively impaired)

Criteria for Selecting Program Participants

In addition to the admission criteria listed above, program staffs mentioned other important factors they look for. These include:

- **Interest from the woman.** Does the woman agree to participate in the program? An “I won’t go” response weeds a woman out of most of these programs, which are voluntary.
- **History of violent behavior.** Programs tend to screen out women with a history of violent behavior. The director of WCI Village, however, has reassessed this and now admits women on a case-by-case basis who are classified as committing a “violent crime.” Some of these women commit-

ted assaults during robberies to get money for drugs, and such women may be appropriate for the program.

- **Ability to participate in a mixed cultural group.** Within the program, previous gang membership may affect the selection of individuals for certain groups. The West Coast programs in particular are confronting a situation of women participants who come from hostile ethnic gangs. A treatment staff person has to be aware of this factor during screening and identify candidates who cannot be added to certain groups because of the gang affiliations of other group members. Senior residents in TC programs can be very helpful in identifying gang members and possible conflicts. TC communities also need to work to disengage participants from this gang mentality.

Staffs recommend that the initial screening not probe into such sensitive issues as physical and sexual abuse. This issue is discussed further in the next section, *Stage 2: In-Custody Treatment.*

The CSAT-supported prison and jail programs suggest that staff have access to the correctional and mental health records of potential participants. These records should be reviewed prior to selection of participants.

Including Women With Co-Occurring Disorders in Drug Treatment Programs

Almost no correctional treatment programs are available to help women who have the co-occur-

ring disorders of major mental illness combined with substance abuse. As was discussed earlier, research shows that an increasing number of women with serious mental illness, who are often homeless, are being institutionalized in prisons and jails. Such women may use alcohol and drugs to self-medicate their mental illness, and these women badly need treatment for both substance abuse and their mental illness.

Both historical and structural factors help explain why so few treatment programs are available for offenders with co-occurring mental and substance abuse disorders. Historically, substance abuse programs have been reluctant to admit those who have a dual diagnosis. Substance abuse counselors are likely to have no experience in working with such patients and so feel insecure about treating them. Institutional barriers are also significant. Within correctional institutions, the substance abuse and psychiatry departments are usually separate entities and are not administratively housed together. This institutional separation tends to segregate clients into separate tracks. When the psychiatry department “owns” a given inmate, then that inmate is likely to be diagnosed as mentally ill and the substance abuse problem may not be considered.

The CSAT-supported women’s programs described in this *Guide* understood this dearth in available treatment for women with co-occurring disorders, and have been willing to take on stabilized psychiatric patients in their programs. However, several pro-

grams have run into institutional barriers with the mental health divisions in their institutions. The mental health professionals have not been willing to refer their clients to the substance abuse treatment program. Against this kind of background, substance abuse programs need to be prepared to develop strong working relationships with the mental health departments and psychiatrists in their institutions, so individuals from both disciplines work together as a team. This issue is discussed further in chapter 7, “Critical Issues in Implementing Programs.”

The CSAT-supported women offender programs have found that many of these women with a dual diagnosis can handle a substance abuse program, even an intense TC experience, successfully. Several programs initially followed the traditional approach and screened out women with major mental illness. But, by admitting these women on a case-by-case basis, these programs have been able to identify which women will be able to benefit from their programs. Key factors affecting whether a program should admit a particular woman with co-occurring disorders include the length of the program, severity of symptoms from the mental disorder, and intensity of the program. The stigma surrounding mental illness is a factor that needs to be addressed by staff members who will be working in these special programs with women who have co-occurring disorders.

Length of the Program

Short-term programs can be more inclusive of women with co-occurring disorders than longer programs. A woman will be less disruptive to the group during shorter time periods. Longer term treatment program staffs may have to pay more attention to the effects one individual can have on group dynamics and to make decisions based on the greater good of the group over a single individual's needs.

The director of the 2-week Baltimore detention center program says that as many as one-third of their women participants have an additional psychiatric diagnosis. These women are stabilized on psychotropic medications as needed and, as long as the women are not disruptive and get some benefit, they stay in the program. The two CSAT-supported jail programs that average 2 months in length (the Stepping Out TC jail program and the SISTER jail TC program) also admit women with co-occurring disorders on a case-by-case basis. The Stepping Out staff believes that about 15 to 20 percent of their participants have co-occurring disorders. These programs will accept a woman if she volunteers to participate, is on medication for major mental disorders, including depression, and is able to do the program and function. If a woman in the program needs a full psychiatric evaluation, she can be sent for a 3-day, in-jail evaluation with a psychiatrist.

Longer programs, especially TCs, have to be more cautious about admitting women with co-occurring disorders. In programs

involving milieu therapy, a single disruptive individual can undermine the environment for the whole group. Experience at the Recovery In Focus prison TC is that many of the women have personality disorders.

Severity of the Woman's Symptoms

What counts is whether the woman is able to participate meaningfully in the program and receive some benefit from participating. It is also important that the woman not prove disruptive to others.

Women with a range of psychiatric disorders can participate successfully, as long as their acute symptoms are under control. The Recovery In Focus TC, for example, admits women with such co-occurring disorders as bipolar disorder, post-traumatic stress disorder, fetal alcohol effects, and fetal alcohol syndrome. Staff members have a background in mental health. They understand women with dual disorders and expect that they may have a more difficult time than others in abiding by the rules of the program. Women with co-occurring disorders are also likely to take a little longer to complete the program than others. Staff hold many consultations with a psychiatric nurse. If a woman is unable to manage in the program, she can be referred to the prison's Mental and Emotional Disturbance (MED) program.

Intensity of the Program

For TC programs, the women need to be able to handle the intensity of the program without

being overstimulated. TCs rely on confrontational methods, which may not work well with women who have serious mental illness.

The issue of psychiatric medications is a serious concern with substance-abusing women. Those in the AOD treatment community are acutely aware that certain medications can reinforce addiction. The issue is that certain medications are addictive and are associated with the development of drug dependencies. Such medications are primarily

they are not receiving treatment for a core issue—the symptoms that are secondary to physical and sexual abuse in their lives. Once these issues begin to be addressed, the symptoms often decrease and the medications can be decreased. Overmedication also frequently results when women are misdiagnosed as having a major psychotic disorder, when in fact they are suffering from other disorders that manifest similar symptoms—either Dissociative Disorders and/or

The CSAT-supported programs stress how important and therapeutic the assessment process can be for their women clients.

the minor tranquilizers (benzodiazepines). Today, these minor tranquilizers are *not* commonly used for psychiatric management, as they were in the past.

This issue should not obscure the importance of psychotropic medications for women who have major mental disorders in addition to their drug abuse. Prescribed medications, including antidepressants, are important for women with major mental disorders and the use of these medications should be encouraged. For such women, psychotropic medications that address the underlying mental illness may be critical for supporting the woman's recovery from substance abuse.

In practice, there is a delicate balance between medicating for real mental illness, while not reinforcing the addiction. Women with major mental illnesses are often overmedicated because

Post-Traumatic Stress Disorder. The mental health caregiver increases dosages to relieve symptoms, but to no avail because of the incorrect medication. Overmedication then becomes an issue.

The CSAT-supported women's programs have experienced two distinct types of problems with medications. In jail programs, many of the women come into detention with major mental illnesses; they require but are not receiving any prescribed medication. Women with dual disorders need to be stabilized on medication before beginning substance abuse treatment.

The prison programs have found a different challenge. In prison, women tend to be overmedicated and the medication can be supporting their substance abuse. The WCI Village TC, which originally excluded

women on any medication, found that many women were being overmedicated in prison. WCI Village staff are now working with the medical department to sort out which women really need medications.

Assessment Process for Jail and Prison Programs

The CSAT-supported programs stress how important and therapeutic the assessment process can be for their women clients. For some women, especially if it is their first time in prison or in treatment, assessment can be a vulnerable time. It is a time when women start to bond with staff members; this is often their first chance to talk about themselves. Many women feel that this is the first time anyone has ever addressed them seriously, one-on-one, as though their lives matter. It may also be the first time anyone has addressed their problems in a nonjudgmental way. The programs recommend using the assessment process as a tool—the beginning of the therapeutic experience.

Recommendations on the process include:

- Incorporate the assessment as a tool for developing each woman's treatment plan and for guiding the treatment process.
- Involve each woman actively in discussing the results of the tests, what the tests mean, and what the results suggest about suitable goals for her. Women are very interested in finding out what the tests show about themselves and in talking about this.

- Provide training for staff who will do the assessments; staff need good, nonjudgmental interview skills. Staff need to know how to phrase questions (for example, “Where do you live” is likely to elicit a richer response than “What’s your address?”). Staff also need to be informed about confidentiality issues. Women offenders have a right to privacy and the confidential handling of any information they provide.
- Help staff understand the effect that culture and ethnicity can have on all the significant issues in a woman’s life. Staff involved in screening, assessment, and treatment planning need to be sensitive about how their own culture, ethnicity, and life experiences affect their perceptions and attitudes.
- Inform and train staff about the limitations on the exchange of confidential information. Those limitations are not negotiable. There is a form, “Limitations of Confidentiality,” used in TASC programs, which notifies the offender about the information that will accompany her through the system. Also, it is important for clients to be informed that any information representing a threat to institutional security will be communicated to prison officials. Information protected by the Federal confidentiality laws and regulations may always be disclosed to the correctional institution after the offender has signed a proper consent form.

* * * * *

For a discussion of Federal regulations, consent, the offenders’ right to revoke consent, and sample forms, refer to CSAT’s TIP No. 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT 1995a, pp. 73–89).

* * * * *

- Develop efficient forms and systematic procedures, so that each woman’s complete assessment record, summary, individualized treatment plans, relapse prevention plan and prognosis, and aftercare plan can be passed on to those who will be supervising the client during the post-release period, including treatment providers, caseworkers, and probation/parole officers.
- Plan to devote adequate resources to assessment.

Although the screening process may be simple, the assessment process is more in depth and provides the core framework for treatment. The assessment may not begin until after the woman has been admitted to the program and may take up to 30 days to complete.

The CSAT-supported women’s programs use a battery of assessment instruments and interviews. These assessment instruments and interviews form the base for developing, and then monitoring, each woman’s individualized treatment plan. This plan will be revised and updated as the woman progresses throughout the course of treatment. Especially in short-term programs, one of the most critical functions of assessment has

to do with planning for continuing care. The assessment process helps guide the decisions about what type of treatment and services will be most appropriate for a woman after her release.

Table 11 lists the areas that should be investigated in the assessment process, as well as special areas of assessment for women offenders. These lists are adapted from CSAT’s TIP 7 on screening and assessment (CSAT 1994a).

Assessment Instruments

The following instruments were utilized as part of an assessment battery by the CSAT-supported women’s programs described in this *Guide*:

- **Substance abuse severity, psychopathic personality disorder, and recommended levels of treatment:** Adult Substance Use Survey (ASUS) combined with Level of Service Inventory-Revised (LSI-R). The Stepping Out staff received training in these instruments, using a process developed through the Colorado Department of Corrections.
- **Substance abuse severity; psychosocial history, assessment, and treatment planning:** (1) Addiction Severity Index (ASI), which now includes more questions relevant to women, as well as sections on living arrangements and relationships. A shorter instrument is specifically designed for follow-up. The ASI has been normed for criminal justice offenders but not for women. (2) The Multidimensional Addictions and Personality

Profile (MAPP), by John Craig, is an assessment tool for addictions and a screening tool for life skills and psychological issues.

- **Psychiatric screening (co-occurring disorders):** (1) Symptom Checklist (SCL-90-R), (2) Minnesota Multiphasic Personality Inventory (MMPI) abbrev-

viated form, (3) Brief Symptom Inventory, (4) Beck Depression Inventory or (5) assessment by mental health clinician.

- **Motivation and treatment readiness:** (1) Stages of Change Readiness and Eagerness Scale (SOCRATES) (40 items) or (2) the Circumstances, Motivation, Readiness, and Suitability (CMRS) scale (42 items); a brief 14-item version of the CMRS is available. The SOCRATES instrument corresponds to the five conceptual stages of change in the Prochaska and DiClemente model (Prochaska and DiClemente 1986).
- **Patient placement in community continuing care:** (1) American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Several States have adapted these criteria for publicly funded AOD clients. In Focus uses the Oregon patient placement criteria.
- (2) Level of Care Index (LOCI), developed by CATOR/New Standards, Inc., a checklist compatible with the ASAM criteria.
- **Post-release social services:** Individually developed program forms.

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See the Resource List, Screening and Assessment Instruments, for ordering information on many of these instruments.

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Table 11. Components of assessment

Areas that should be investigated with all substance abusing offenders

- Archival data on the client, including—but not limited to—prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records
- Patterns of AOD use
- Whether the woman is in withdrawal from alcohol and/or other drugs
- Impact of AOD use on major life areas, such as marriage, family, employment record, and self-concept
- Risk factors for continued AOD abuse, such as family history of AOD abuse and social problems
- Available health and medical findings, including emergency medical needs
- Psychological test findings
- Educational and vocational background
- Suicide, health, or other crisis risk appraisal, including HIV risk behaviors
- Client motivation and readiness for treatment
- Client attitudes and behavior during assessment

Additional components in assessing women offenders

- Child care; status of the woman’s children
- History of physical and sexual abuse
- Underemployment, limited income, and poor and hazardous working patterns (such as prostitution or selling drugs)
- Factors limiting opportunities for education and intellectual growth
- Poor health care, inadequate birth control, lack of prenatal care, and lack of other medical services
- Responsibility and availability of support for care of children, aging parents, and other dependents
- Guilt associated with a woman’s self-concept as a “bad mother”
- Specific issues for older women: alcoholism, isolation, and fear of violence
- Special issues for lesbian women: feelings of oppression, effects of discrimination

—Adapted from Center for Substance Abuse Treatment, *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*. Treatment Improvement Protocol (TIP) Series, No. 7. DHHS Pub. No. (SMA) 94-2076. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994a, pp. 16, 30.

Promising Assessment Practices

As the descriptions throughout this chapter make clear, the CSAT-supported programs—particularly the jail programs—make impressive efforts to identify and provide for the range of their clients' needs before release. This type of approach—a focus on the multidimensional problems of women offenders—is typical of the “most promising” women's community programs identified in a national search (Austin et al. 1992).

It is important to note that this “best practice” is not typical of most women's programs for offenders. A nationwide survey of 234 community and in-custody treatment programs for women offenders found that while nearly all assessed the drug use and drug treatment histories of women entering the programs, it was less common for them to assess other areas of possible need, such as health care, psychological status, vocational skills, and difficulties in coping with problems (Prendergast et al. 1995).

Assessment in Short-Term Programs

In short-term programs, where the aim is to motivate women into community treatment, the assessment is a major program component. What is needed is to match the woman to the appropriate level of care in the community. When few treatment options are available in the community, then it becomes even more critical to identify other supportive services, such as

drug-free and safe housing. Critical areas to assess include vocational training, child care, transportation, the woman's familial responsibilities, and the role the woman played in the criminal offense (was she the primary actor in the crime or was she acting at the direction of her significant other?).

North Rehabilitation Facility in Seattle, a short-term program, uses a 5-day triage process, with a four-person triage team that meets every day, to assess all admissions. This team includes three chemical dependency counselors and an employment development specialist. The team looks at chemical dependency and vocational, educational, and mental health issues, among others. At intake, the women fill out a self-assessment form and have a biopsychosocial interview with staff. Based on the self-assessment and interview, additional in-depth assessments are done in specific identified areas of need.

At the Stepping Out TC project in San Diego, women average 62 days in the program but have stayed as long as 6 months. For both treatment planning and for matching clients to community treatment, this program is using an assessment system developed by the Colorado Department of Corrections. The staff received training in how to use the instruments, which result in recommendations to these specific levels of treatment: (1) no treatment; (2) increased urinalyses, drug and alcohol education; (3) weekly therapy; (4) intensive outpatient; (5) intensive residential treatment; (6) TC; or (7) assess

for psychotherapy. This type of process, using objective means to assess a person's progress and level of treatment need, is very different from the intuitive assessment that most counselors are accustomed to using. It took the staff more than a year to come to trust the objective test results.

This program points to the increasing refinements being made in the treatment-matching process. The Stepping Out staff consider their system to be a “third generation” level assessment, capable of giving accurate risk and needs assessments along with recommended treatment modalities. In the future will be “fourth generation” methods, that will allow matching clients, based on their needs, to a particular treatment provider and possibly even to the most appropriate therapist.

Assessment in Longer Programs

For longer programs, such as TCs, assessment is an ongoing process tied to developing an individualized treatment plan. The CSAT-supported programs suggest the following practices:

- *Provide for orientation before doing in-depth assessment.* At WCI Village, women fill out an initial assessment form; this takes 1-2 hours depending on the woman's educational level. Over the next 30 days, the woman is oriented to the program, learning about TCs and her job functions. The assessment cycle continues during the month. At the In Focus program, women start with an orientation by a senior resident on the program's rules and

regulations; a week later, the woman goes through the intake process and develops a treatment plan.

- **Continue to assess throughout the treatment period.** Ongoing assessment is needed, so that clients move to the appropriate next stage of their treatment in a timely manner. Also, as women move through the program, their levels of trust, their ability to introspect, and the way the women perceive past experiences may all change. It is important to reassess the woman's situation, because her original responses during screening can change. The treatment team also needs to do a regular assessment of how the woman is progressing in terms of her needs and goals. One program, for example, does a staff team review of each woman at each level in the program (about every 3 to 4 months).
- **Start assessing for needed services well in advance of discharge.** Programs bring in outreach coordinators or case managers long before the woman is released to the community. At In Focus, for example, this component begins 90 days before the woman's release. Some elements—such as family support and reunification components, education, and vocational training—are addressed throughout the treatment program.

Each woman's screening and assessment record, along with the treatment plan and prognosis, needs to be summarized and made available for the continuing care treatment providers,

case managers, and probation officers who will work with the offender in the community. The summary and transfer of a woman's records should be done with the woman's consent to release of information. Assessment results also need to be compiled to assist in program evaluation and research.

Stage 2: In-Custody Treatment

Once the screening process is over, appropriate women should enter the treatment program as quickly as possible. According to the CSAT grantees, keeping the women on waiting lists is counterproductive and should be avoided if at all possible. Waiting lists are particularly unsatisfactory when women are mandated to treatment by the court and then must wait to enter the program, so that treatment actually extends their period of incarceration.

In planning and operating their in-custody programs for women offenders, the CSAT grantees have encountered a number of common challenges. Although the programs differ in length and type, the problems they have faced, and the strategies they recommend, reflect a set of shared common perceptions about who these women are and how the women can be helped. All these programs—whether in detention centers or State prisons—serve women offenders who have long-term, severe alcohol and drug abuse problems.

Planning the Program

In initially planning the program with corrections administrators, certain issues are critical. These pertain to:

- **Desired physical environment.** Whenever possible, a separate pod to house the women in treatment is a tremendous advantage for every type of program. Living together is a kind of base for developing a supportive, family-type environment among participants and it insulates the women from the general population. In the CSAT-supported programs described in this *Guide*, all have been provided with separate housing for their program participants; the programs also have a separate area for their program activities. A few, such as WCI Village, have a completely separate facility for their residents so that the women do not mix with the general population for meals, recreation, and other events. This type of separation is important for long-term TCs.
To have their own facility, projects may have to make some compromises. For example, one CSAT project agreed to house pregnant addicted women in their program facility. The women needed this separate housing and the program has adapted to having some women who will be able to remain, even if these women violate the rules. (Normally, a woman who violates the rules could be expelled from a TC.)
- **Space needs.** Space is a great problem under current crowded conditions in the correction-

al system. Programs need adequate room for meetings and other activities. The Forever Free program uses a large trailer set up in the yard for their activities—this inexpensive strategy provides room for four offices plus classrooms. A second urgent need tends to be space that offers a friendly and inviting environment where child and family visits can take place.

- **Scheduling issues.** In some States, such as California and Oregon, vocational rehabilitation is required for prisoners for up to 8 hours per day. However, intensive substance abuse treatment is a full-time activity. Full-time vocational schedules conflict with intensive treatment needs. TCs provide a full schedule of events throughout the day. Some programs have been able to arrange for treatment hours to count toward the vocational requirement, so that adequate treatment time is available. Part-time treatment schedules are less desirable than longer treatment hours, since the fewer hours may not be intense enough for the population of incarcerated women with severe substance abuse problems.
- **Sufficient resources.** Outside providers are often brought in under contract to manage treatment programs in correctional settings. Planners in correctional settings need to involve these providers at an early stage. In some cases reported in the literature, programs have initially had to struggle with inadequate

resources because of budgets that didn't include basic supplies needed by a treatment program. These supplies include paper, pens, videotapes, curriculum materials, workbooks, photocopying, and training resources.

Setting Appropriate Goals

It is important to be realistic about what a treatment program can achieve. There are several

dimensions to this realism. First, substance abuse is a chronic condition, and lapses and relapses must be expected. Success is measured in many ways besides abstinence. Second, addicted women offenders are difficult clients who need to make fundamental changes in many areas—not just in their substance use. Many must learn to trust and bond with others; to grow in self-esteem and in their ability to perceive, establish, and defend their own personal boundaries; to learn basic coping skills; and to learn the vocational skills for self-sufficiency. Such fundamental change is not easy—it takes enormous work and commitment by the individual, and it takes time.

Time is the essential driver in limiting what a program can realistically achieve. As a general guide, the CSAT-supported programs suggest what would be realistic goals for three types of programs: (1) intensive short-

term, often pretrial, programs in detention centers or jails (about 2 weeks), (2) mid-length programs in jails, community punishment facilities, or prisons (such as 2-3 month TCs or 4-6 month less intensive programs), and (3) mid-to long-term full-time residential and TC programs in prisons (3-18 months).

(1) *Short-term programs*, usually held in detention centers or jails, need to focus on the goal of motivating women into treat-

It is important to be realistic about what a treatment program can achieve.

ment and on their reentry to the community. The women need an upbeat, enthusiastic boost about how much treatment can help them. As one project director put it, "This is the rah-rah type of approach." In this short time frame, women need to feel accepted, to feel hope, and to be introduced to the concept that treatment can help them with their lives. The program at the Baltimore Detention Center uses therapeutic motivation that focuses on life consequences from substance abuse. This therapeutic style is based on William Miller's motivational interviewing techniques (Miller and Rollnick 1991). Using an empathic counseling approach, the counselor gives the woman feedback on the life consequences of her behavior. Using this theory of "reflection and mirroring back," the counselor connects the consequences of addiction to the events happening in a woman's

life and helps the woman to see those connections and consequences. This feedback serves to provide enlightenment about her opportunities for change. At the end of the 2-week program, as many women as possible will be connected up with community treatment programs. The major elements in such brief programs will be:

- **Stabilization** (the woman will be drug free, detoxified, oriented, and her medical needs will be determined; methadone treatment placement in the community should be considered)
- **Needs assessment process** (one project director called this “screening the woman and reaching out to engage her in treatment during this brief window of opportunity”)
- (Desirable option) **Acupuncture** to help provide withdrawal symptom relief during the detoxification process
- **Therapeutic motivation to treatment** (this intervention may include education and a therapeutic component, as well as relapse prevention concepts and skills)
- **Case management** directed at the woman’s immediate treatment needs and ancillary needed services, such as child care
- **Health screening**, especially for sexually transmitted diseases (STDs), and risk education about HIV and other STDs
- **Community resources and referrals** for the woman’s identified needs, including safe and sober housing

In these short programs, women are often still in drug withdrawal when they arrive. It

is a treatment *readiness* situation. As the director of the North Rehabilitation Facility’s program points out, the more sophisticated the assessment process, the better. Since staff have so little time to work with the women, it is important to understand the stages of change model and to be skillful in using and interpreting screening tools. Staff can then identify where the woman is in terms of her motivation to change, and place her in the most appropriate community treatment setting.

(2) **Mid-length programs (2-3 months)**, often held in jails and community punishment facilities, also need to focus on pretreatment and treatment readiness issues. Especially in intensive TC programs, the women can get a glimpse of what residential treatment will be like, including the support and bonding that is possible. The CSAT grantees recommend that these programs aim to bring women along through the pre-stages of treatment. These pre-stages include the following:

- **Developing problem awareness.** The woman needs to develop an awareness that she has a real problem: that substance abuse is having a significant adverse impact on her life and the lives of her family, especially her children.
- **Resolving ambivalence.** The woman needs to work through her ambivalence about giving up substances, and deal with grief and loss issues and with how her relationships fit into her substance abuse and criminality patterns.
- **Identifying barriers to recovery and action steps.** The behavior of each woman will be individ-

ual. Therefore her barriers and steps will also be individual. It is when the woman is ready to take action that treatment can really begin.

Women offenders cannot move through these stages of change until they resolve certain developmental and emotional issues. The women must be able to be introspective. Initially, women offenders with a history of addiction do not respect their own feelings and may not be in touch with their feelings. As previously mentioned, they often feel victimized and so powerless they do not understand the cause and effect relationship between their behavior and its consequences. And most importantly, the women need to feel hope that it is in their power to change.

The shorter 2-3 month treatment programs need to establish a rhythm that acknowledges and reflects the woman’s emotional state. For at least the first week after she enters the program, the woman will be in crisis. She will again be in crisis for about 2 weeks just before she leaves. It is critical to get the women comfortable and stabilized, since people in crisis do not learn.

It represents a great step forward if, by the end of these programs, the woman has developed an internalized motivation for treatment. This type of motivation is demonstrated by an evaluation of Forever Free program graduates who subsequently entered community residential treatment (Prendergast et al. 1996). When asked why they entered treatment, the most common response given (16 of 20 women) had to do with being “tired,” “disgusted,” “wanting to change,” or to “save”

self. Three women mentioned getting or keeping a job or parenting issues (being a better parent or getting children back) as their motivation. External pressures from all sources—from the criminal justice system, attorneys, or family members—were mentioned as a factor by only three women.

Major elements in these 2-3 month full-time residential (or 4-6 month less intensive programs, such as Forever Free) may include the following:

- **Stabilization** (detoxification if needed, with medication needs stabilized)
 - **Psychoeducation** (including both educational components and therapeutic interventions and groups)
 - **Process groups** dealing with women's issues
 - **Individualized relapse prevention** skills development and planning
 - **Orientation and participation in 12-Step and other support groups**
 - (Optional) **Family reunification and parenting components**
 - **Work on criminogenic thinking patterns and behavior modification** (in some States, this element will be provided by the institution instead of the treatment program)
 - **Individualized treatment planning** (since women will need ongoing treatment and supervision in the community, matching of the woman to the appropriate level of post-release care is very important)
 - **Medical, dental, and psychiatric screening and treatment** (education/counseling about high-risk behaviors regarding STDs and HIV/AIDs is critical)
- **Case management** to identify post-release needs and resources for women who will not be entering residential treatment; this will include the areas of safe and drug-free housing, connections to local mutual-help groups, financial aid, vocational skills, and child care/custody issues

(3) **Mid- and long-term full-time residential programs (3-18 months)**. The goal of these intensive residential programs, particularly TCs, is to provide the woman with her primary treatment base. The TCs, as described previously, also aim to make fundamental changes in the negative patterns of behavior, thinking, and feeling that predispose to drug use. The TCs work through all stages, from pretreatment readiness and motivation through actual treatment. Drug treatment is combined with a structured increase in the person's personal growth and responsibility. Participation in a TC represents a major commitment by the woman.

For offenders, the prison TC provides the base for reducing recidivism and relapse. However, it should not stand as end-stage treatment. Based on a large body of literature in the fields of both treatment and corrections, it appears that the most effective strategy involves a three-stage intervention process (Inciardi et al. 1994). The regime is adapted to the client's changing correctional status: incarceration, work release, and parole or other forms of community-based corrections. For example, the women participants at WCI Village move through the following stages:

from (1) orientation, to (2) primary TC prison treatment at WCI Village, to (3) a secondary transitional work-release TC in the community, to (4) a tertiary stage of living in the community under the supervision of parole or some other surveillance program (TASC), with outpatient counseling and group therapy continued at the work-release TC.

A prison TC needs to be organized in phases or levels, so that the woman progresses through the program at her own pace. The woman also needs to take responsibility for her own progress. At WCI Village, the orientation phase is devoted to helping the woman commit to treatment. There are five subsequent levels. Progression through the program's levels depends on the amount of time spent in the TC and on the completion of requirements within each level. The fifth, highest level is senior resident, and is earned by those who have been in the program for at least 18 months. Progression from one level to the next is seen as a reward for appropriate behavior, and each level brings new privileges. To move to the next level, a woman must give a presentation to staff describing why she feels ready for the higher level; staff then make the determination. From level five, women progress to the next stage—the transitional work-release TC in the community.

Developing an Individualized Treatment Plan

For each woman client, the assessment process needs to be ongoing. The woman should meet regularly with her counselor about her plan, helping to

set her goals and to discuss her progress. The treatment team also should have regular meetings with the counselor to assess how the woman is progressing toward her goals. The goals should be very concrete and specific, so they can be measured. “Increasing self-esteem” is too vague. Goals should be specific to the individual and have a target date. For example, a goal might be for a woman, within 1 month, to stop retreating to her room instead of facing issues in group.

Treatment Recommendations and Strategies

The CSAT-supported women’s treatment programs have encountered a number of challenges as they have implemented their programs. Their recommendations and strategies for dealing with these issues are described below.

Issue 1: Uncertain client schedules and assignments

Programs in detention centers particularly face complex scheduling problems. Some of these include periodic disruptions to the program schedule caused by lock-downs and other security needs; patients being relocated or transferred during a treatment cycle because of overcrowding; and the difficulty of scheduling treatment because of the initial quarantine and impending trial dates. In county jails, the population is characterized by rapid turnover.

The CSAT grantees suggest both adopting a creative and flexible attitude and, if possible,

designing the treatment program for flexibility. This is an advantage for handling the uncertainties, but it also promotes a more individualized approach. Since the number of women involved in these programs is generally small, the more individual and flexible approach will serve the women better. Some strategies used by the women’s programs include:

- At the OPTIONS TC program in a county system, the program is designed in 8-week cycles; some topics are consistent across all cycles, but each cycle addresses the specific topics that fit the needs of the particular women in the group. In this system, new inmates can enter at any time in any cycle.
- Admission to the OPTIONS program is continual; a Newcomers group is used to orient new clients to the program. The Newcomers group permits staff to assess each new client’s needs, to assess potential adjustment problems, and to confer with other group leaders about appropriate client placement.

The WCI Village prison project director also points out that flexibility is important, because the models for treating incarcerated women are new. This is an underserved population. Experience and emerging research findings will suggest what is working well and what could possibly be modified. If staffs keep an open mind as they work with the women, they may come up with many new ideas for improving the program process.

Issue 2: Attracting clients to the treatment program

The women’s programs supported by CSAT have had few difficulties in attracting women to participate. At the Recovery In Focus prison program, for example, virtually 100 percent of the inmates volunteer to participate. At Forever Free, there are more applicants than program slots. One exception is a program where untrue rumors were circulated among the general prison population. This initial “bad press” has been overcome by orientation sessions when new inmates arrive, presentations in the living units, and by inmates’ observation of the program’s actual performance. A second program found their applicant pool was reduced when the corrections counselors, who were responsible for recruiting participants at the classification pre-screen, began to have different priorities.

Both Stepping Out, a jail program, and WCI Village, a prison program, consider it important to recruit the women into treatment immediately after their sentencing. Both programs hope to avoid having new inmates get negative messages about the program and other adverse effects from other inmates in the women’s living environment. Both these programs have also begun doing active recruitment within the living units.

The CSAT grantees report some of the major reasons women come to their programs include:

- The positive way they’re treated: Inmates see that the women are treated with

respect and caring in these programs—something that many have rarely experienced.

- **Curiosity about themselves:** In the Stepping Out program, the director said the women are very interested in the intensive assessment process and in discussing and finding out how they compare with other women.
- **Meeting court mandates:** Some of the programs help women meet the court-ordered requirements for reuniting with their children or treatment for themselves. Most of the programs have components aimed at advocating for and promoting the woman's self-interest: legal advocacy, child visits, counseling about parenting the children, and foster care for children.
- **The individualized approach:** One director stated that the "best hook" for bringing women into treatment is the individual type treatment her program offers.
- **Fear and shame:** Women who are incarcerated and taken from their families are often ashamed and humiliated; they are facing the consequences of their substance use and are eager for help.
- **Self improvement:** Many women in correctional settings want to take part in programs aimed at self improvement and personal growth.

Issue 3: Voluntary vs. mandatory participation

Nearly all the women in the programs described in this *Guide* enter treatment voluntarily. The exception is WCI Village, where

about 90 percent of the women are court-ordered and 10 percent are voluntary. At the Choices community punishment facility in Arkansas, some women are mandated to treatment by the

courts, and these women may voluntarily choose the CHOICES TC program. If treatment is refused, the court may opt for the prison alternative. If not mandated to treatment, women may select the Choices program or a less intensive drug education program.

At the Recovery In Focus program, the first group of women was mandated to the program (all women since then have been voluntary participants). This first group of mandated women was very angry about the situation. In dealing with this angry group, the project director came up with a highly successful strategy that now undergirds the entire program. The women were asked to help develop the new program and to be involved in key decisions—to help set the rules, the sanctions, the procedures that would be followed. Their anger melted and they eagerly took on responsibilities. Ever since, the women participants have had a strong voice in running this program, including self-monitoring (see table 7 in chapter 4). This program director recommends that women's treatment models use this strategy—allowing the participants as great a voice as

possible in running the program and setting and in upholding the rules and policies.

At WCI Village, where women enter the program on both a mandatory and a voluntary basis,

Rules are the backbone of any type of women's treatment program.

the program director says that this distinction is basically irrelevant to the treatment process. The women who come in on a mandatory basis are angry initially, but this dissipates in about a week. Both the mandatory and the voluntary participants are involved in a similar denial process; the voluntary group is no more "ready" for treatment than those who are court-ordered. The experience at WCI Village is that it takes all women—whether court-ordered or voluntary—about 2½ to 3 months to become emotionally engaged with the program and committed to it. At this point, the women begin to identify the critical issues in their lives, to move past denial and toward being in touch with their feelings, and to start really listening to other women who are past this early stage.

Issue 4: Program rules and sanctions

Rules are the backbone of any type of women's treatment program. They need to be stated in an absolutely clear manner, and the consequences of violating the rules should also be clearly stated. Other recommendations from the grantees follow:

- Rules need to be specific and, with this population, they must be consistently enforced by everyone—staff, security officers, and participants.
 - Goals for each woman need to be specific and individualized, with a time limit. The woman helps to set her own personal goals, and she is expected to be responsible for working toward and meeting those goals. Then if the woman does not meet her personal goals, she is in essence choosing not to stay in the program. This means that failure to progress in the program—and the decision to leave the program—is a choice made by the woman and shown by her actions. In this framework, women understand that failure depends on their actions; it is not a decision being imposed externally.
 - Institutional rules should not override program rules. In other words, if a woman “screws up” in the program, the institution should not impose extra days of incarceration or add some other sanction to her sentence.
- Issue 5: Environment suitable for women**
- In developing a program for women, it’s important to set up an environment in which women will be comfortable and thrive. This kind of environment helps to explain why the CSAT programs have been so successful at drawing women in and retaining them in treatment. Some of the critical elements that resonate with women include:
- *Taking an individualized approach.* While a very concrete approach works with men, women want to deal with issues on an emotional basis. Women want an approach that is individualized to themselves.
 - *Building on women’s natural behaviors.* Men and women behave in very different ways while incarcerated. Men “do their own time.” Women tend to form their own “families” and informal networks while in jail or prison. Programs can successfully build on this need of many women to connect in a supportive way with others. The TCs actively promote a sense of the group as “family.” One of the programs also helps the women to identify who within the group they choose to relate to as parent and child figures, and to understand these factors in their relationships.
 - *Modifying the confrontation tone.* As discussed earlier, the authoritarian, harsh confrontation style of traditional male TCs is not appropriate for women. Many TCs for men, as well, have toned down their stark, “in your face” confrontation style. Research done by William Miller demonstrates that confrontation begets confrontation. That is, aggressive, “finger pointing” behavior by the staff leads to aggressive or avoidant behavior by the clients. Alternatively, empathic staff responses lead to more appropriate, participative behavior by clients.

The entire context of confrontation must be adapted for

women. To help gain a sense of empowerment, women do need to be assertive and they need to learn how to confront another person in an effective, assertive manner. The language used should never be degrading. From the standpoint of experiencing power, the women need to learn how to address issues with others in a frank, controlled, caring, assertive, and yet supportive way. Women can be very hard on each other, yet supportive at the same time.

Some women may need to have their natural confrontation style toned down. A California program reports that some women, especially young women from ethnic gangs, use aggressive body language and operate verbally on a very loud, hostile plane just short of violence. These women must learn that the way they relate at home and in their social group does not work in a treatment setting. And beyond that, the women need to learn alternate ways to behave while in treatment and at home.

- *Providing rewards and honoring achievement.* These women’s programs have found that honoring the women clients is very important for both the women participants and the staff. Both participants and staff need affirmation. Official ceremonies are affirming for the women, and they also help to encourage and bolster staff morale. Staff feel rewarded for each woman’s achievement. Among these programs, the

general practice is to have an awards ceremony when a woman or group completes each program cycle. There is also a graduation celebration when a woman completes the program. These ceremonies often include a cake, the awarding of a certificate, and official recognition from the podium by staff and other participants. Several, such as the OPTIONS program, also have anniversary celebrations for their graduates. These are gala events that renew ties with the graduates and offer inspiring role models for the current program participants.

These events bring the community together as a bonding experience. Some suggestions from the CSAT programs: have a play day for the annual celebration, with picnics, games, and festivities for fun. The Recovery In Focus program has found videotaping to be very popular with the women. They videotape the award ceremony and videotape the women as they're involved in the play day games and other activities. At the end of the day, the videotape is played for everyone to enjoy.

At the OPTIONS program, a project committee is used to involve all the women clients in planning some special project, such as a play, a graduation presentation, or a program newsletter.

Issue 6: Handling denial issues

Working through a woman's denial is a central hurdle for treatment programs. The pro-

grams described in this *Guide* view denial from two different perspectives, and therefore deal with it somewhat differently. Planners setting up new programs are also likely to use one or the other of these approaches.

The first approach represents the traditional 12-Step model, in which denial is seen as a symptom of the disease, with the person blocking out and refusing to accept the reality of his or her substance abuse problem and the negative effects this has on self and others. Confronting and breaking through that denial is perceived as central to recovery. For those using this 12-Step approach, the CSAT grantees made the following suggestions.

- **Self-esteem issues.** The Forever Free program has tested the self-esteem ratings of their women participants as they enter the program and then move past the denial stage. The scores show that self-esteem, already very low in these women, plummets virtually to zero as they face the overwhelming reality of their substance use problem and their own deficits. The program director emphasizes how vulnerable the women are at the stage when they break through their denial. The recommendation is to provide every possible means of support to the women during this period. At the Forever Free program, breaking through the denial is the low point in self-esteem and then the women's scores begin to rise.
- **Support strategies.** At WCI Village, the program is set up so that women do not feel iso-

lated or alone when they face through their denial. The program director says that, if a woman is to break through her denial, she must have support. Whether standing to address the group or sitting in a circle, the woman has a buddy who is beside her to offer support, either verbal or through touching. This support person is there to say, "you're OK," "we're here to help you get better." The particular support person rotates so that all the women in the group are taking part in what is designed to be a supportive and nurturing environment.

The second perspective, based on a therapeutic model, addresses denial in a different context. In this perspective, women are not seen as denying their addiction and its consequences. Instead, women are seen as ambivalent about giving up their substance use because they are deeply attached to it. The addiction is functional for these women. For many, it is numbing their depression and the pain they feel in their lives and from abusive relationships, present and past. As one woman client said, "Alcohol is the only thing in my life I have control over; when I drink, I know just how I will feel." It is a dynamic similar to that for domestic violence. It is not helpful to say to a woman who is being abused, "just leave the guy." The woman has too great an investment in the relationship—or is too dependent on it—to let the relationship go.

In this perspective, a woman is denying and ambivalent because she has a compelling attachment

to the drug. There will be grief and loss at giving it up. The way to help clients is to help them address the nature of their attachment to drugs. What is the woman getting out of it? Why is the need so compelling? How does this attachment affect her individually? With this perspective, the approach is to explore these issues of attachment, grief, and loss. Confrontation would be used only when working with highly antisocial women.

Issue 7: Addressing intense emotional issues

A very high percentage of addicted women offenders have experienced physical, emotional, and sexual abuse. Some have abused their children. These are intense and emotionally charged issues for the women. If women do not deal with these issues in their lives, they are at increased risk of both relapse and recidivism.

The issue for treatment programs is how best to address these topics. Several of the programs urge great caution. Counselors need training in how to work with women on these issues. Women often have great difficulty acknowledging the abuse that has been done to them and may be very disturbed when facing this. However, these issues are so central to a woman's recovery that they must be acknowledged and addressed.

The CSAT-supported programs suggest two principles. First, don't ever brush off this topic when it comes up. If it can't be handled within the program context at the particular time, then it should be acknowledged as a serious issue important for

recovery. The woman should be given next-step options for how and when she can be helped with this. The second principle is "guided self-disclosure." Women are not pushed to bring up this topic. They are instead given opportunities to bring it up as an issue, such as through the counselor's inviting of comments or open-ended questions.

Following are suggestions for handling these emotional issues at different stages in treatment.

- *During screening and assessment.* The screening process should not ask questions about traumatic emotional issues unless the program expects to help the woman deal with them. Such inquiries should not be made if the woman will be going on for treatment elsewhere. Some program directors questioned whether taking a history of physical or sexual abuse is appropriate during screening, since such abuse is so widespread for these women. Early in the program, some women don't even realize they have been abused. Others lie about it initially. As one director put it, "This topic comes out naturally during the group work; there's no need to ask about it during screening."

Some screening instruments are set up to elicit research-oriented yes/no counts; this approach is not desirable. Instead of simple "yes"/"no" responses, women should feel encouraged to discuss their issues. When emotional issues are asked about during screening, it is suggested that an invitational tone be used, so the woman can answer any way

she wants. For example, "Many of our women have experienced physical or sexual abuse. Is this an issue you wish to discuss right now?"

- *In short-term programs.* For short-term programs, which do not have the time to work through these intense emotional topics with a woman, it is recommended that the topic not be glossed over for any woman who brings up the issue. Rather, the issue should be briefly processed. It needs to be pointed out that (1) this is an important issue affecting many women who have addiction problems, and (2) it is critical for a woman's recovery that she talk about and have help in dealing with any physical, emotional, or sexual abuse in her past or current life. This should be used as an encouragement for the woman to enter community treatment—that she will receive help with this when she goes for more extended treatment. Referrals should also be available.
- *In mid- and long-term programs.* In mid- and long-term therapeutic communities, abuse and victimization issues need to be dealt with in depth. At WCI Village, the project director says that it would stigmatize the women to have separate process groups for sexual and physical abuse or for those with the human immunodeficiency virus (HIV). Abuse is such a pervasive problem for everyone that it is a theme in the ongoing flow of group discussions—"this is something that happened in your life, that happened in the lives of most

people here.” The effect of feelings, like depression, is another pervasive theme throughout.

Staff of the Forever Free Program in California point out that, in focusing on sexual issues, it is important not to de-emphasize other forms of abuse, such as physical, emotional, or psychological abuse. Although 90 percent of the women in the Forever Free program have experienced sexual abuse and this becomes the program norm, there is a subcategory of this abuse that is even more severe. It involves primary sexual abuse coupled with a secondary form, such as psychological abuse. An example would be a person who was sexually abused and locked and restrained in a closet for a long period of time ... suffering some sensory deprivation as well. This more severe, multi-level abuse may raise issues beyond the treatment capabilities of some drug treatment programs, depending on the counseling/therapy capabilities of staff. Such problems may require a referral to psychiatric counseling as well as work within the drug treatment program.

Most of the CSAT-supported programs have been able to refer women to psychiatric services when they may need additional help. Having a staff member with expertise in mental health issues is an advantage for identifying and caring for such women.

Issue 8: Retaining women in treatment

Research shows three important facts about treatment outcomes:

(1) successful outcomes are related to how long a person stays in treatment, (2) women generally are not retained in treatment at as high a rate as men, and (3) retention tends to be a problem in TC programs. A program’s ability to retain a high rate of its woman participants until they complete the program is therefore critical.

The in-custody programs described in this *Guide* are quite new programs. Although all but one of these programs are voluntary, none is reporting significant retention problems. Those reporting on actual data show very successful results in being able to retain the women in the programs. Examples include:

- **Baltimore Detention Center pre-trial program:** Graduation rates have been steadily rising. Currently, 90 percent of the women graduate from this 2-week program.
- **Forever Free prison program:** A review of 2 years of Forever Free program data shows that more than 92 percent of women admitted to this 4- to 6-month treatment program complete it.

The WCI Village program director has the following comment about retention, “Once we help the woman get past her first difficult issue—whatever that is, whether it’s being abused herself or abusing her child—then that woman stays.” However, TC programs such as WCI Village are intense and require a high level of personal commitment. Some women do drop out. WCI Village now offers drug education classes for women who drop out of the program so they have some

continued involvement on alcohol/drug issues.

More severe retention problems are likely to occur at the community level, after women offenders are released from prison or jail. This issue is discussed later in this chapter.

Issue 9: Sustaining motivation until discharge into the community

When a participant completes an in-custody treatment program, the person should not be returned to the general population of the prison or jail. This is a lesson learned from women in the Stay N’ Out program and in many programs for addicted male offenders. Experience shows that treated offenders need to move on to the next stage in the rehabilitation process right away. When they are returned to the general population and must wait for release, people lose their treatment gains.

In all the CSAT-supported women’s programs, every effort is made to admit women in conjunction with their anticipated release dates. However, women do not move through treatment at the same pace, so the date when they will complete treatment can’t be exactly predicted. There are also many uncertainties and changes in the dates when inmates are released.

The grantees have developed a number of strategies for the many cases in which women have completed treatment, but must wait in the institution for release. (The best option, of course, is for the sentence to be tied to completion of treatment, so the woman can proceed

directly from completing her in-custody treatment program into community-based treatment and supervision.) These strategies include:

- **Separate dormitories.** Several programs have been able to arrange for separate buildings or dormitories to house women who have completed treatment. This includes the 2-week Baltimore detention center program, the Choices community punishment facility, and WCI Village—where program graduates live in an independent living program for trusted, long-term women offenders.
- **Senior program positions.** At Recovery In Focus and WCI Village, graduates can stay on as senior residents and mentors, continuing to be involved in the treatment program. New job positions were created for these women at WCI Village, which also strengthened and enhanced the chain of command. These positions include resident counselor, house monitor, facility manager, coordinator, and senior coordinator. Seniors run groups and take part in the program. However, expanding top positions in TCs can only go so far. If too many veterans remain at the top of the seniority structure, this will shut down opportunities for other clients to progress into positions of increased responsibility.
- **Continued services.** In the Baltimore detention center program, women still in custody after the 2-week program participate in a weekly acupuncture aftercare group

and in twice-weekly psychosocial aftercare groups.

- **Transfer to other programs.** Recovery In Focus is able to transfer some graduates to another treatment program; some can also go to a work release program.
- **Specialized program positions.** The WCI Village program has had difficulty recruiting Hispanic staff. One of their Hispanic program graduates, while waiting to be released, has been able to help fill this gap. She has translated their program manual and procedures into Spanish and now teaches Spanish to women in the program. She may next offer Spanish classes to the entire prison population.
- **Institution jobs.** WCI Village has been able to place program graduates in prized institutional office jobs, like receptionist positions. This gives the women job experience and is a visible sign to inmates in general about advantages of being in the program. However, the project director cautions that the correctional staff may need training about how to interact with these program graduates. Initially, the correctional staff overreacted by giving the women gifts, treating them as “special,” and engaging in enabling behaviors.

Stage 3: Transition/Pre- Release Planning

Research and experience identify the first 90 days after an offender’s treatment and release from

custody as posing the greatest risk of relapse, “when clients are exposed to drug-related stimuli, without the support of a structured program to help resolve their conflicts” (Leukefeld and Tims 1988, pp. 1-7). Pre-release planning for this transition period is absolutely critical for women offenders. As one project director put it, “Many of our women clients cannot make it on their own [in the community]. We must identify these women and get them proper help and resources before they leave.”

Case Management in the Pre-Release Period

Throughout the correctional treatment process, two important themes are (1) to motivate the woman to enter community treatment and to involve herself in 12-Step or other mutual-help groups after her release, and (2) to identify the social, economic, and vocational problems that need to be resolved to help the woman remain drug- and crime-free. Case management and planning in the final weeks before the woman’s release need to focus on, and advocate for, actual links to services. Major links involve:

- **Connections and individualized planning with probation and parole officers,** so that correctional requirements can be met and, whenever possible, the parole process will reinforce treatment goals.
- **Connections and individualized planning with community treatment providers,** so that there is continuity between a woman’s in-custody treatment

and the treatment she receives in the community.

- **Connections with local service networks**, so that the woman has the ancillary services she needs. The most important of these are safe and drug-free housing, child care for her children during her treatment, vocational training and job-hunting assistance, and economic help until she is employed.

The director of the North Rehabilitation Facility suggests that the planning process with the woman should not be a checklist-type operation. It needs to be an in-depth exploration of what the woman feels she needs to remain drug- and crime-free. She recommends that this process involve a housing case manager, a mental health specialist, a person expert in financial and welfare aid, treatment beds available on contract, and a strong job/vocational component. Access to care is a universal problem for women, unless they're pregnant. (The message this may send to women is that they're only important in their maternal function, not as a person.)

Transition From Prison Programs

For the CSAT-supported prison programs described in this *Guide*, there is a strong transition planning component that operates through the State's corrections or community punishment departments. This transition phase is supervised through probation and parole functions and, in some States, continuing treatment is mandated for some or all of the women being released.

Many women offenders' pressing need for services comes after this transition phase, when they are in the continuing care phase. The transition phase is structured as follows for the CSAT prison grantee programs:

- **Oregon.** Women can leave the Recovery In Focus program only to go to community treatment programs—either residential or outpatient. The State corrections department puts women on probation/parole into treatment, with costs picked up by the Oregon health plan or by the counties, using CSAT block grant moneys. There are correctional treatment beds in the counties and also resident and outpatient work release facilities (until recently, there were nine work-release beds for women at the Multnomah County YWCA). For compliant women with long sentences, there is a structured program that combines work release, job search, and outpatient treatment. The In Focus program follows the women for 30 days, and a transitional specialist monitors the women for the 6 months of work release. Volunteer mentors then work with the women during the aftercare period (up to 1 year), reporting to the transition specialist.
- **California.** Women in the Forever Free program are encouraged to volunteer for post-release community treatment, with a program placement goal of 50 percent. Multi-funding sources are available, including a component from the California Department of Alcohol and Drug Programs, which tar-

gets four southern California counties and contracts with nine residential treatment facilities. A new referral component, recently funded by California's Department of Corrections (DOC), now provides treatment dollars for placement within any California county or licensed treatment program. The primary objective is placement in a full-time residential treatment facility for up to 6 months. Two full-time staff—1) a DOC employee who is a Parole Agent, and 2) a contract employee who is a Recovery Advocate—dedicate their time to transitioning participants into community treatment. Forever Free reports that it is essential for the client to be transported directly to the residential facility upon release. Transportation is always scheduled or provided directly by the Parole Agent.

- **Delaware.** Delaware, a small State, has been restructuring its correctional system to provide a continuum of services for substance-abusing offenders. This continuum will provide treatment and supervision at all stages, from detention through in-custody treatment to structured work-release and supervised aftercare. The WCI Village TC for women is one element in this evolving, integrated system. Treatment Alternatives for Safer Communities (TASC) provides a case management function for the WCI women, both before and after they are incarcerated. The Delaware transitional work-release component is described in the next section.

- **Arkansas.** Choices staff, part of a new community punishment facility, conducted an education effort with judges and parole administrators. The court now orders women into treatment for a minimum of 90 days, and the women may select the Choices program. There are post-prison transfer board orders and judicial transfers to the Department of Community Punishment (DCP) if a woman is eligible for treatment. Some orders extend into the community, with treatment recommendations passed on to parole officers. The DCP pays for substance abuse treatment, mental health services, and general equivalency diploma (GED) preparation. This is done through DCP contracts with statewide substance abuse and mental health providers across the State.

Only outpatient treatment is available for women in Arkansas. Since there is just one drug-free living center for women in the State, many women are returning to undesirable living situations. Choices staff work with the women's families whenever possible to gain their support for the women.

Transition From Jail Programs

For the CSAT women's jail programs, the transitional period after release tends to have less systemwide structure than for prison programs. The jail programs tend to be more involved in actually developing and running post-release services for the women. Since so few residential treatment facilities are available, housing for the women is a cen-

tral issue. In addition, the jail programs often maintain a continuing support function, setting up support groups and other ongoing activities for their graduates.

The Stepping Out program in San Diego has a particularly comprehensive strategy to prepare women for the post-release transition period. This program includes the following components:

- Staff from treatment programs in the area come to the jail on a monthly basis to talk about their programs.
- Staff from these community programs come into the jail to screen the women for entry into their programs.
- A staff person from the community treatment facility where the woman will be going meets with the woman and her in-custody case manager before the woman's release; the client and this staff person mutually agree on her community treatment and make a personal commitment to this treatment.
- For women going to outpatient treatment, Stepping Out arranges and pays for 30-45 days of living in a drug-free environment, either through their own houses or through a San Diego network. Housing is subsidized only if the woman is in treatment.
- For women going to residential treatment, there is often a waiting period of several weeks before a treatment slot becomes available. Stepping Out develops an interim plan for this waiting period that includes housing in a drug-free

living house and outpatient treatment.

- The aftercare program connects the women with a network of other services. This network includes community service agencies, employment, and acupuncture. A planning forum of service providers takes place during the 1 week before and 1 week after each woman's release. This forum identifies and prioritizes the woman's needs. Primary needs are delivered first. These include clothing, food, housing, and personal hygiene products.
- The women are picked up by car and taken to their new treatment settings.

Important Principles in Transition Planning/Supervision

The women's programs described in this *Guide* offer a number of strategies for dealing with key issues in the pre-release phase.

Issue 1: Voluntary vs. mandated participation in community residential/outpatient treatment

Although some women offenders are currently mandated to post-release treatment, many are not. The reality is that, on a voluntary basis, a great number of women offenders who need treatment do not get it. For example, at the OPTIONS county program in Philadelphia, all women who leave the treatment center are given referrals to community agencies. However, only 45 percent actually attend treatment. At

the Forever Free prison program, where all the women are encouraged to enter community residential treatment, one-half of the graduates choose to enter residential treatment; some also enter community outpatient treatment. At the Baltimore detention center, all women are encouraged to enter community treatment. About 25 percent of the women are sentenced to prison instead of being released at the time of trial. Of those released, roughly 47 percent go into community treatment.

Two of the CSAT programs report good results in raising the percentage of women entering community treatment. Stepping Out made a real effort to prepare women for the transition into other treatment programs, not in the abstract, but in the transition to the particular program that the woman will be entering (see the description above). These efforts have reduced the attrition rate. The Baltimore program is having excellent results in increasing the number of women in treatment by means of a new court-based project, a special project of the Alternative Sentencing Unit. This project offers sentencing inducements for entering treatment combined with intensive case management and outpatient treatment.

Clearly, a higher percentage of women offenders engage in community treatment after their release when treatment is mandatory rather than voluntary. They also stay longer in treatment. With this population, mandating treatment along with supervised sanctions, such as regular urinalysis, may be the most effective way to promote

recovery and a crime-free lifestyle. But the move toward more universal mandatory treatment for women needs to be done with full awareness of the ethical and possibly legal issues involved. For example, is it ethical to force women into mandatory treatment for longer periods of time than their crime would

otherwise exact? Another ethical issue relates to the scarcity of community residential treatment facilities for women. As a society, we certainly don't want to have to incarcerate women because that's the only place where they can receive adequate treatment. CSAT's TIP 17 on planning treatment for adults in the criminal justice system (CSAT 1995a) offers an overview of these ethical issues.

Issue 2: Critical importance of immediate placement

Upon release, the women need to go immediately to their treatment centers. As the In Focus director points out, "Even waiting a few hours, you can lose them." One of the CSAT-supported programs experienced a tragic example of this. A program graduate agreed to enter residential treatment in her community but she wanted first to spend the weekend with her boyfriend. That weekend she died of a drug overdose.

Several of the CSAT-supported programs physically transport

women to their new treatment facility. These programs include the SISTER project, Stepping Out, In Focus, and Forever Free. The Recovery In Focus program recently lost the use of the State cars used by staff to take women to their new treatment sites across the State. The program now makes arrangements for the

Once a woman is released, she should go directly to treatment.

women to travel by bus, and their new treatment provider will be there waiting at the bus stop to meet the woman when she reaches her destination.

Issue 3: Waiting lists

Once a woman is released, she should go directly to treatment. If there is a waiting list, then an interim plan needs to be devised. At Stepping Out, such a plan would include safe housing, ongoing supervision, acupuncture, and short-term treatment support.

Issue 4: Handling relapse

Addiction is a chronic condition. As anyone who has tried to give up smoking knows, it may take several or numerous attempts, with lapses between, to completely give up cigarettes. These women can be expected to have lapses and relapses. Relapse prevention therapies have become increasingly concrete and adept at training people to recognize their own personal cues of impending lapses and to cope with them. The SISTER project

devotes time 5 days a week to work on coping with relapse.

In some jurisdictions, probation and parole officers receive special training in how to case manage women with addiction problems. Probation/parole officers, if they are knowledgeable and skilled, can be instrumental in helping paroled offenders weather relapse episodes. What is needed when a woman relapses is to increase the level of services. However, many jurisdictions do not take this approach. Instead, they use relapse as a technical reason to return a woman to custody. The CSAT grantees suggest the following strategies:

- Work with both the woman's community treatment provider and the probation/parole officer. Both should get the same paperwork—the woman's assessment, relapse prevention plan, and the prognosis.
- Make sure each woman leaves with a specific relapse-prevention plan that lays out the behavioral specifics crucial to her in recovery. Both the woman and her parole officer can then recognize the signs that she is needing extra help.
- Have a personal conversation with the woman's probation/parole officer; the officer must make sure that the woman becomes connected to Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or other mutual-help group meetings. At Choices, each woman's probation/parole officer is sent her discharge summary and program recommendations, along with the information given her about local AA/NA contacts.

- Give the woman, before she leaves, a list of names and addresses for AA/NA support groups in her area and ask the woman to attend. At jail programs, a person from local AA or NA chapters can visit and make contact with the woman before her release. This is a natural contact if the jail already has mutual-help group meetings at the facility.

Issue 5: Integrating in-prison treatment with community-based care

It is very desirable to have a continuum of treatment planning between the in-custody program and the community program. The CSAT grantees have used a number of strategies to link their programs with community treatment and other services. These include the following strategies:

- Invite treatment providers to come into the facility to screen women clients for the program, and work with them to develop a coordinated ongoing treatment plan for each individual woman. In Focus, Stepping Out, and the Baltimore Detention Center all do this.
- After obtaining consent of the client, provide the new treatment provider with detailed paperwork and other communications about the woman.
- Share training and cross-training events with community providers.
- Look for opportunities to work as a team; an example would be the forums that Stepping Out holds before and after a woman's release to identify and prioritize her needs.

- Bring community service representatives into the facility to tell about their services. The OPTIONS program, for example, in 3 years has had 145 seminars given by 70 community representatives from many different agencies and disciplines.

Issue 6: Mobilizing women to enter treatment programs

Motivating women to want to go into community treatment is a theme of the short- and mid-term in-custody programs, as already explained. But when it comes to a woman's actual decision, in the critical pre-release period, CSAT grantees suggest several strategies. Most strategies reflect the fact that the women are frightened and in crisis; they need to feel that they will be safe. Women offenders want to know where they will be going, how they are going to be treated, who will be the people involved in their treatment, and what will be expected of them.

- **Bonding with the new caregiver.** Most critical is that the woman gets a chance to meet a person from the new treatment program. Stepping Out says that this needs to be a personal bond. The In Focus program has found that, since community treatment providers have come to the prison to do their screening and to meet with each woman client ahead of time, the length of time that women stay in community treatment is lengthening.
- **Making a one-to-one commitment.** The new caregiver needs to get a commitment from the woman client, a promise about the appointment. "We're

counting on you for next week.” The staff member from the new program also must make a commitment to the client. “Yes, I’m the one who will be there for you.”

- **Visiting the new program.** One project manages to arrange for a woman client to make a visit or to spend a weekend, so the woman can see the new program in advance and meet other participants. This is also helpful if the woman is going to a work-release center.
- **Meeting child care needs.** Whether the woman goes to residential or outpatient treatment, she will have to resolve child care issues first. One project has arrangements for child care through women in an Oxford House. (The Oxford Houses are a national network of self-run, self-supported recovery houses for individuals recovering from alcohol or drug addiction; see “Program Materials” in the Resource List for the address of Oxford House, Inc.) The SISTER project offers a legal liaison who advocates for the woman regarding custody issues. This legal advocate also prepares women for their court appearances and advocates to get the women into treatment instead of jail or prison.

Stage 4: Post-Release Treatment and Continuing Care

The prison and jail demonstration programs described in this *Guide* are designed to serve

women in custody. For women offenders with serious, long-term drug abuse problems, in-custody treatment offers a valuable window of opportunity for motivating the woman into substance abuse treatment. The period of incarceration provides a period of relative stability, giving

women the breathing space to look at themselves and their addictions and to begin the difficult process of changing their lives.

In-custody treatment can be critical for these women. However, this treatment and supervision is only the beginning. Practitioners agree that women offenders must have help during the transition to community life. Most women offenders with substance abuse problems successfully manage to be abstinent and drug free during the structured jail or prison period. Remaining abstinent in the community, without any structure and while facing myriad personal and economic problems, is much more difficult. Women’s program directors on the CSAT expert panel stressed that women offenders with drug problems are not receiving the structure, support, and time they need to rebuild their lives after leaving the institution.

The experience of the CSAT grantees supports the conclusion of a number of experts—that one of the most feeble links in the

criminal justice system is the connection between rehabilitation efforts in prison and the process of integration into society after release (Wexler and Williams 1986). A national 1992-93 mail survey of jail and prison programs that provide drug treatment and other services to

Women offenders must have help during the transition to community life.

women offenders found that more than 90 percent of these programs encouraged women to begin or continue attending 12-Step meetings, and more than 80 percent said they made arrangements for continued care in the community. But fewer than half of the prison and jail programs reported providing other transition services from custody to the community, such as housing, income, medical care, or follow-up contacts (Prendergast et al. 1995).

The Bureau of Justice Assistance has concluded that “women have a more difficult time integrating into the community after release than men do. This is because women are likely to be at a more advanced and severe stage in their substance abuse when they are incarcerated, and because women suffer from a broader range of problems, including more medical and mental health problems, educational deficits, a lack of vocational skills, and more complicated family and community relationships” (BJS 1994).

Components for Post-Release Transition to the Community

A broad range of concrete experience with addicted offenders suggests that, in the period after release from prison or jail, the person with a history of chronic drug use will need the following components:

- **Continuing treatment for drug abuse.** This may be primary treatment subsequent to an in-custody motivational program, or less intense continuing treatment for those who received primary residential treatment while incarcerated. The principle is that the offender continues in treatment, at ever decreasing levels of intensity, until the person's recovery and crime-free lifestyle are stabilized. Most programs plan a process lasting 6 months to a year.
- **Probation/parole supervision.** Regular urinalysis is an important part of this supervision, to ensure that the offender remains drug free and to trigger immediate help for a relapse. It is an enormous advantage to have ongoing treatment required as a sanction by the criminal justice system during this period.

One Federal research demonstration project designed to offer highly intense case management and outreach to offenders during post-release concluded, "Without an external force making sure they attend [treatment] when first released from prison, there is little that can be done to help clients internalize the motiva-

tion to stay in treatment and to stay clean" (Martin et al. 1995). For this research project, the inability to require participation in treatment—either as a means for early parole or as a *condition* of parole—severely impacted on retention (Martin and Scarpitti 1993).

- **Case management to ensure services.** Case management is critical for providing coordinated services at transitions between stages of the justice system. Case management needs to provide a way of linking the treatment and criminal justice systems, ensuring that offenders meet both their criminal justice and treatment requirements. Case management services have also been found to enhance retention in community treatment among drug-involved offenders, an outcome that is closely linked to reduction in recidivism (Hubbard et al. 1988). In addition, a case manager is needed to link the women with other needed services.

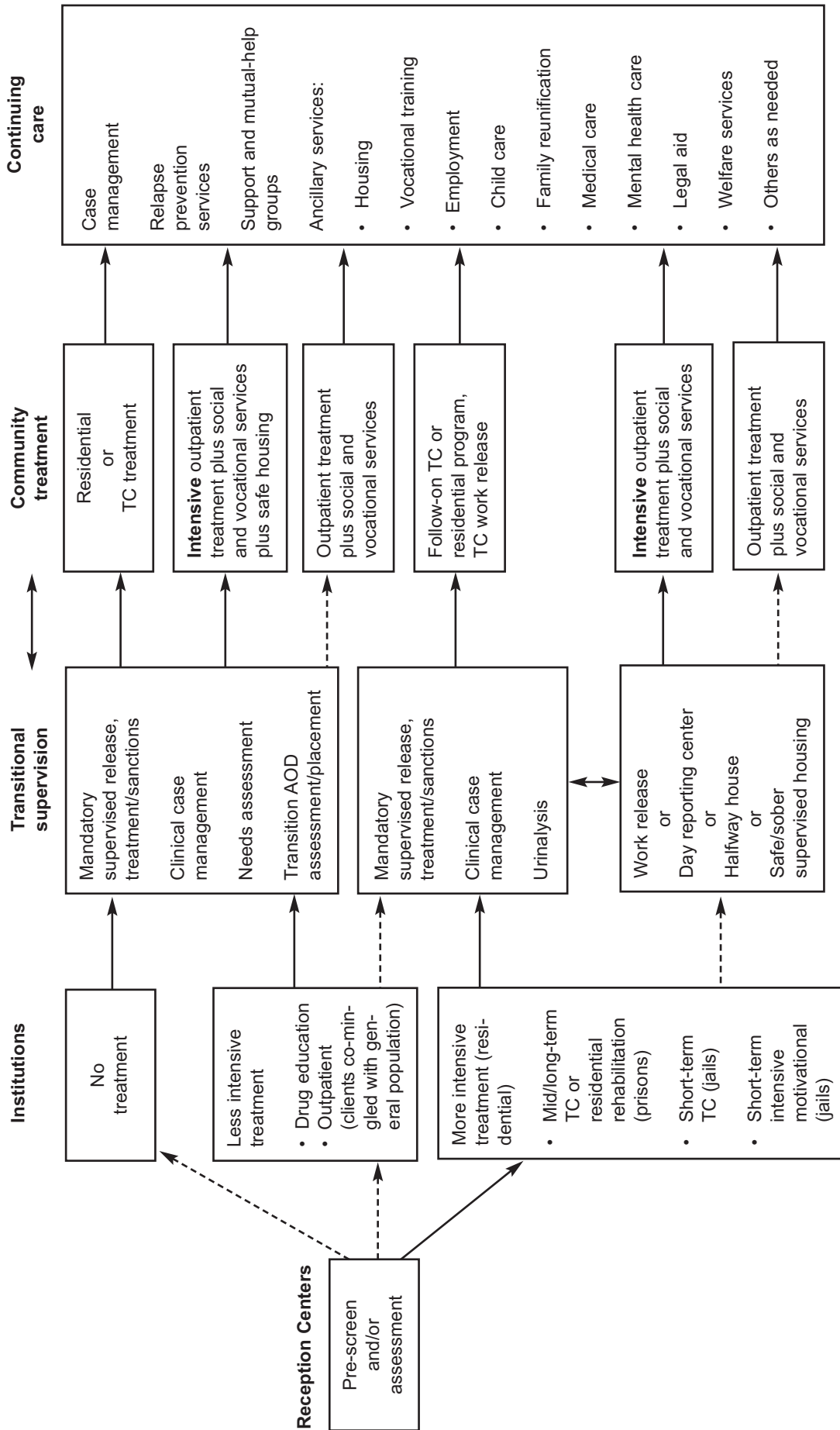
Those in residential treatment will have their housing and other needs met while they are in treatment. But after release, and for women who go from custody directly into outpatient treatment, there are immediate, pressing needs for such services as medical, dental, and mental health care; child care and assistance in maintaining custody; housing; educational and vocational training; legal aid; and assistance in obtaining any potential entitlements, such as Medicaid and public assistance.

- **Participation in mutual-help and support groups.** The follow-up studies show that the addicted offenders who remain longest in treatment—the group most successful on parole—also have the highest participation in AA, NA, and other mutual-help groups. These groups serve as therapeutic bridges from incarceration to the community. Relapse prevention is a major concern for recovering addicted clients, and a supportive group of non-using peers is clearly an important asset. Other appropriate mutual-help groups for women offenders could include Women for Sobriety, Survivors of Incest Anonymous (SIA), or Rational Recovery. However, these groups are not a form of treatment, and attendance at meetings should not be used as a sanction (CSAT TIP 17, 1995a).

Various Paths for Women Upon Release

Research suggests that community-based aftercare is necessary to reinforce the primary treatment initiated in prison. Women need a continuum of care upon release into the community. Table 12 shows the various paths that a woman may take, depending on the individual's need, the intensity of treatment received in custody, and the care available in the community. The type of treatment provided should, if at all possible, be consistent with the treatment philosophy used in the corrections treatment program. Major paths are described on the following pages.

Table 12. Paths into community treatment from institutional programs for women offenders with chronic, severe AOD problems



Code:
 Solid lines represent more desired paths of treatment/supervision.
 Dotted lines represent less desirable optional paths.

Residential Treatment, Including Residential Community TCs

Women with severe, chronic AOD problems will benefit most by transferring from correctional treatment into supervised treatment in a community residential setting. The program should serve women only. Outcome data support the value of a reentry TC for reducing both drug use and criminal recidivism. Some research suggests that TC treatment during the transition from prison to the community is the most influential component of the prison TC/community TC continuum (Martin et al. 1995, p. 115).

For some women offenders, a residential program for mothers and their children will be desirable. TC models for women only are often not available. TCs that serve mothers and their children are even more scarce (Brown et al. 1996). Three model programs are Par Village, St. Petersburg, Florida, a collaborative research and demonstration project between Operation PAR, Inc. and the University of South Florida Psychiatry Department; Amity, Inc., in Tucson, Arizona, and the Prototypes Women's Center in Pomona, California.

Intensive Outpatient Treatment

Intensive outpatient treatment can be as effective as residential treatment for some addicted women offenders, and it may be the most intense treatment option available in some communities. The women should be treated in women-only groups, rather than in coed settings. Also,

outpatient treatment needs to be combined with supervision, case management, and safe and drug-free housing arrangements. Women-centered, intensive outpatient treatment is even more desirable when the woman's children can be included.

Work Release Facilities

Work release is a correctional program in which incarcerated offenders are allowed to leave a correctional institution or facility during daytime hours to work, attend school, obtain treatment, or pursue other purposes identified by correctional officers. Drug testing is often required. Outpatient substance abuse treatment can be available as part of the program or may need to be arranged as an adjunct to it. Delaware is unique in having a TC work-release center; this center serves both men and women offenders.

Work release programs are quite common, but they can be less effective for women than for men, because women have significant treatment and habilitation needs that cannot be addressed in this setting (Illinois Criminal Justice State Plan Working Group 1995). Treatment experts point out that work release programs do not provide an appropriate continuity of care for offenders following in-custody substance abuse treatment. This uncontrolled environment "can do much to undo progress in the in-custody treatment program by throwing the recovering clients abruptly into an environment that is contaminated with the outside influences of the street—the drugs, the violence,

and the attitudes and values that militate against rehabilitation" (Scarpitti et al. 1993).

Work release programs should offer women the chance to continue their recovery efforts while learning job skills and gaining employment experience. Recovering women need to receive simultaneous AOD treatment and to be separated from the general population. Women-only programs are an advantage. A sample study of women in Delaware found that although the women appreciated the chance to work, about 60 percent indicated difficulties related to being a woman within a predominantly male work release program (Miller 1990).

TC Work Release

Delaware has developed an innovative program called CREST that combines a TC program and a work release program (see description below). CREST is located on the other side of a wall from Delaware's traditional work release program for the general prison population. The program serves both men and women offenders who have drug-abuse problems. This TC initially provided the primary drug treatment for women offenders, who had no TC available in prison. Since the startup of the WCI Village TC, CREST has become a transitional TC for Village graduates. The treatment providers now recommend a women-only work release TC, rather than a coed program, as being more suitable for their women Village graduates.

Day Reporting Centers

Treatment programs at day reporting centers allow women to participate in rehabilitation programming during the day and return home at night. Drug testing is often required. Programs that are designed to serve women will provide or arrange for extensive services, including substance abuse treatment, life skills training with ancillary counseling, child care, parenting education and observation, and employment. Each participant will have an individualized treatment plan. Women participate in activities for 4 to 10 hours daily. Women awaiting their trial dates, as well as sentenced offenders, can both utilize day treatment programs.

Though the CSAT programs did not have access to day reporting centers, this is a promising model. Day centers can provide daily supervision, urinalysis, parenting assistance, and the other services needed by recovering women in one location (the “one-stop” model).

Illinois has set up program models in the community for women—day reporting centers and a family unity demonstration project—in which women can receive the types of treatment in which they can be successful under Department of Corrections supervision. These programs are expected to be less expensive and more effective than in-prison treatment (Illinois Criminal Justice State Plan Working Group 1995).

Halfway Houses

A halfway house is a residential, transitional living arrangement

in which residents are supervised by paid staff. Residents may work and receive education, training, or outpatient treatment in the surrounding community, although some treatment may be provided in the house. The women share house responsibilities and must follow rules. The length of stay may be limited or unlimited, and depends on the woman’s attaining her specific progress goals.

Halfway houses are important because they give women a safe

from the halfway house. Only 32 percent of such offenders (that is, substance-abusing offenders who go to a halfway house but do not receive any residential treatment either in prison or afterwards in the community) are still drug-free at 6-month follow-up. This compares to 91 percent drug-free status among offenders who participated in a prison TC and a transitional work release TC (Peyton 1994, pp. 15-16). It is recommended that, for women drug offenders,

Halfway houses are important because they give women a safe and sober place to live so they do not have to return to the environment in which they lived before incarceration.

and sober place to live so they do not have to return to the environment in which they lived before incarceration. At halfway houses, residents are under constant supervision during initial placement and later transition into the community. Regular urine monitoring is conducted, and positive urines may result in violations and reincarceration.

Some people with drug abuse and criminal histories can control their drug use while they remain in a tightly structured halfway-house environment. However, unless they also receive drug treatment, many of these offenders cannot control their drug use once they leave this structured environment. A study in Delaware showed that, if these offenders do not receive residential treatment, they are unable to maintain abstinence after release

gender-specific treatment be included with halfway house supervision.

TC Work Release: A New Approach

Upon their release from prison, WCI Village graduates go to CREST, a 6-month work release program operated by Correctional Medical Services. This is the only program in the country that combines a TC with a work release program. It is an 80-bed program that serves 12 women and 68 men. This model is of interest, because it combines the advantages of TC treatment with a structured program of work release, regular urinalysis, and participants’ graduated levels of responsibility during release to the community. A research study reporting on this program shows

that men who go through the combined multistage prison/work release TC have very positive outcomes. Eighteen months after release from prison, 76 percent of these men were still drug free and 71 percent were arrest free. In comparison, only 19 percent of a control group receiving no treatment were drug free and 30 percent were arrest free. Outcomes are not yet available for women who go through the combined WCI Village and CREST programs.

The Delaware work release TC includes the following phases:

- **Phase 1:** 2-week orientation, involving induction into the TC, assessment, and evaluation.
- **Phase 2:** 8-week component, emphasizing involvement in the TC community, such as participation in morning meetings, community jobs, group therapy, individual counseling, confrontation, and nurturing. Phase 2 residents are encouraged to begin engaging family members in the treatment process through family and couples groups led by CREST counselors.
- **Phase 3:** 5-week component, stressing role modeling and supervision of other clients with assistance of staff.
- **Phase 4:** 2-week component, preparing the women for transition from the TC community to the outside community, with mock interviews, resume preparation, and seminars on job seeking.
- **Phase 5:** 7-week reentry component, including obtaining and maintaining employment outside the TC, finding appropriate

housing, and preparing for the final recovery stage of living independently. Residents open a bank account and begin to budget for housing, food, and utilities (Lockwood 1992).

Women who have been through the WCI Village TC proceed faster through the program than those without prior TC experience. The biggest difference is in the two early phases, when the WCI Village women already know about TC principles. In all phases of treatment at CREST, urine is monitored on a regular but unscheduled basis.

After the last work release phase, graduates are free to live and work in the community. Most have probation or parole stipulations to follow. CREST provides a 6-month “aftercare” component to ensure that graduates fulfill their probation and parole requirements. The aftercare component provides a reduced level of continued treatment services to combat the risk of relapse and recidivism. The aftercare component requires the woman to be totally abstinent from drug and alcohol use, to attend one 2-hour group session per week as well as individual counseling, and to continue with urine monitoring. Graduates must return to the work-release TC once a month to serve as role models for current CREST clients. The women are encouraged to participate in 12-Step programs. The women also have access to an aftercare support group through WCI Village.

The considerations and issues to resolve in setting up a TC for work release are discussed in several articles written by authors

from the University of Delaware Center for Drug and Alcohol Studies (Lockwood 1992; Inciardi et al. 1993b; Lockwood and Inciardi 1993).

Issues Concerning Treatment in the Community

The CSAT prison demonstration programs have encountered gaps in the services available for women on their return to the community. Programs report that their greatest challenge has been the difficulty of linking clients with community-based aftercare following their release. The network of services is fragmented for women, with varying gaps depending on the particular State or community. Communities, for example, may offer a number of outpatient treatment programs serving women but not have available residential care for mothers and children. Women receiving community outpatient treatment are often unable to find safe and sober housing.

Some of the most critical challenges emerging in the link-up to community treatment are the lack of access to treatment beds, the dropout rate among women who enter community treatment programs, and the great diversity among community programs. The most cost-effective treatment for offenders is a system that can match a woman to the type and length of service she needs. Incarceration treatment programs can only make this kind of match for their clients if they have in-depth information about the available community treatment programs—and if an appropriate

program is accessible and has beds or treatment slots available. Second, women coming out of fine in-custody treatment programs are in danger of losing their gains if they can't be linked to community treatment programs. This programming is critical to ensure continued benefits for the women and thereby to improve public safety.

Issue 1: Lack of access

The reality is that many of the CSAT-supported programs cannot find enough community treatment slots for their women graduates. They make full use of what is available. In some places, only outpatient treatment is available for women. Residential treatment for women with children is scarce. This very spotty availability of community treatment facilities for women offenders is a national problem. The number of available slots for women offenders is far short of demand, particularly for women who are pregnant, have children, are mentally ill, are homeless, or have a history of violence (Prendergast et al. 1995). The treatment that is available does not necessarily offer the types of services that returning women offenders need.

The shortage of transition services becomes glaringly apparent to State agencies when they assess their custody/community continuum for offenders. Delaware, for example, found that no one—no system—was fully responsible for drug-involved offenders until the Treatment Access Committee (TAC) was established in 1992 (Peyton 1994). This lack of system

responsibility was true even though well over half of Delaware's offenders were drug involved, and over half of all people in drug treatment were offenders. Delaware found that all the outpatient and residential treatment slots available statewide for all Delawareans were inadequate to meet the needs of just the criminal justice population (Peyton 1994, p. 21).

However, the state of treatment facilities specifically designed for women is steadily improving. Enormous gains have been made over the past decade. CSAT has sponsored a number of multi-agency criminal justice initiatives across the country, and these are creating better treatment opportunities for women. For example, the OPTIONS TC program in Philadelphia has recently gained access to community treatment slots through a multi-agency criminal justice effort for early parole called the Forensic Intensive Recovery (FIR) project. Many of these slots are designed to meet the specific needs of female substance-abusing offenders.

Another important boost to women's programming has come through the Federal substance abuse prevention and treatment block grants. In 1992, States were required to set aside a portion of these funds for specialized women's programs. The upshot has been the creation of many more women-specific programs across the country than were available even 5 years ago. Pennsylvania, for example, now has a statewide network of 16 licensed long-term residential treatment programs for pregnant

and parenting women and their children, plus 35 other licensed programs that specialize in treating this population.

The Center for Substance Abuse Treatment (CSAT) has recently conducted two extensive demonstration programs for substance-abusing women and their children—the Residential Treatment Services Grants for Pregnant and Postpartum Women and Their Infants and the Residential Treatment Grants for Women and Their Children. Women involved in the criminal justice system have been successfully treated in these comprehensive programs. CSAT found that, of women referred to these women's residential programs by the criminal justice system, 81 percent had no new charges following their treatment (CSAT 1995b).

Issue 2: High dropout rate

Poor retention of women clients in community treatment programs is a widely reported problem. The Forever Free program undertook a pilot study to investigate how their program graduates fared in the months after their release back to the community (Prendergast et al. 1996). At 1 to 1½ years after their release, the researchers interviewed a small pool of Forever Free graduates and a comparison group of women offenders who had been barred from participating in the Forever Free program for logistic or administrative reasons. Findings from this small study are tentative, but suggest some compelling conclusions about the post-release status of these women. The study looked at

their drug use and parole outcomes, treatment experiences while on parole, their various needs, and whether the women were able to meet those needs.

Longer times in community treatment translated to better outcomes, but most women dropped out early. Of 48 Forever Free graduates who (voluntarily) entered a 6-month community residential treatment program, 17 (35 percent) left the program within the first 30 days, with 12 of them leaving within the first 7 days. Among the 19 interviewed women, fewer than half (8) remained in treatment for more than 3 months, which research has found to be the minimum length of time in treatment necessary for significant program effects to be observed (Prendergast et al. 1996). As for being successful on parole, involvement in residential treatment made a difference:

- A quarter of the comparison group who did not participate in the Forever Free prison program were successful on parole (23 percent of this comparison group entered outpatient treatment after release to the community).
- Half of Forever Free graduates who did not enter community residential treatment were successful on parole (30 percent of these graduates entered outpatient treatment after release).
- Two-thirds of Forever Free graduates who entered community residential programs were successful on parole.
- 86 percent of Forever Free graduates who stayed in residential treatment for 5 months or more were successful on

parole, compared to 58 percent of those who remained in residential treatment for less than 5 months (Prendergast et al. 1996).

Issue 3: Diversity among treatment programs

Those who operate correctional programs need to know specifics about individual treatment programs in the communities where women clients will return. The Forever Free study found “vast differences in the programming and policies” of the eight community residential facilities entered by their graduates. Community treatment facilities are often small, stand-alone facilities; these programs are quite diverse and operate on a variety of models. Among the questions to ask are: what components and services does each program offer, what referral sources are used, and what has been the outcome success with different types of clients?

The Prendergast et al. study (1995) of corrections and community treatment programs nationwide found that programs vary considerably with regard to which services are offered and whether particular services are offered on-site or through referrals. He concluded that few if any programs—whether located in the community or in a jail or prison—are able, at the site, to provide all the services that women need.

TASC is a model in which expertise is present in AOD, criminal justice, and other service systems. Case management across systems requires competency in those systems.

Issue 4: Continuity in treatment approach

Each of the CSAT-supported women’s jail and prison programs operates under a coherent program philosophy about addiction and how to treat this problem in women. The program directors point out how important it is for women to move from their correctional treatment program to a community program that has a similar philosophy. A woman may be confused and lose ground if she has to shift from one treatment philosophy and environment to a program operating on different assumptions. Achieving continuity with the post-release treatment was a common problem among the programs. Some of the issues encountered by the CSAT grantees were:

- *The difficult adjustment for women who must go to traditional male-dominated community programs from women-focused prison programs.* When outnumbered by men in treatment, many women tend to focus on meeting the men’s needs instead of dealing with their own. To overcome long-time patterns of physical, social, and/or emotional abuse, women need a continued focus on these issues and on personal empowerment.
- *The disconnect for women who go from jail or prison TCs to traditional community treatment programs that are 12-Step oriented.* Because there are few community TCs available for women, women offenders may be moving from a correctional TC to a 12-Step oriented program in the community. Even

though many prison TCs may incorporate 12-Step principles, the overall models are very different. This makes for a discordant and confusing transition, instead of a continuum of care. In the CSAT program, several of the correctional TCs modified for women are beginning to develop their own aftercare components to provide continuity.

- *The problems of moving from a women-specific TC to a coeducational TC.* This happens in Delaware with women going from WCI Village to a coeducational work release TC, where the women constitute about 20 percent of the client population. Some of the work-release TC staff are women, but the majority of staff are men.

The approach is very confrontational. The TC environment is therefore very different from what the women experienced at WCI Village.

Village treatment staff say the women need their own TC. It is difficult to avoid male/female relationship issues in such close quarters, and women have been expelled for “flirting.” The women [participants] also tend to focus their attention on the men’s issues, rather than on their own concerns.

The program director at WCI Village states that women come out of this prison treatment program as much stronger people. But the women need additional time to work on their own independence and addiction issues. The women are not ready to enter a coeducational setting immediately on release from prison.

Case Management in the Community

When a woman offender returns to the community, a number of systems—at a minimum, corrections, Federal- and State-funded substance abuse treatment, and social services—need to coordinate and communicate with each other. Who makes the treatment decisions? Who makes the decisions about sanctions? Who is responsible for seeing that the woman’s many needs for shelter, employment, child care, and relapse prevention are being met?

In setting up a case management function for women offenders, it is important to identify who will have specific responsibility for the woman and who will make the treatment decisions. The points of accountability between the criminal justice and treatment systems need to be clearly defined, with some method set up for timely reporting to both systems. The roles for the involved agencies should be stated in written agreements. This will involve memorandums of agreement and cross-training for AOD treatment agencies and the criminal justice system.

The hub for this crucial case management function can be in a variety of places—with probation officers, with the treatment provider, with an independent organization like TASC. Table 13 provides a summary of different approaches for handling the case management function. The important factor is that some entity, and some individual caseworker, be responsible for supervising each offender after her release.

Need for Intensive Case Management

Case management with recovering women offenders does not mean making referrals. It entails coordinating the entire system of care for the woman, including her parenting and custody problems. Ex-offenders also require an intensive level of outreach beyond what treatment providers and parole officers are accustomed to providing. This can mean that the worker physically goes “to the park bench” to talk to the client. Some programs are beginning to use an intensive and promising case management model from the mental health field, called Assertive Community Treatment (ACT).

The ACT case management model is based on a holistic approach that involves all needed support systems and treatment modalities, determined on an individual basis for each mental health client. Multidisciplinary teams, with one team member acting as a coordinator for each client, provide services 24 hours per day, every day, on an unlimited basis. The ACT system is designed to encourage client independence and functioning in adult social and employment roles, to meet the basic needs of mental health clients, and to lessen the family’s burden in providing care.

This ACT case management model has been specifically applied to high-risk drug-involved parolees through a demonstration grant supported by the National Institute on Drug Abuse (NIDA). The reports on this model provide a number of ideas about the barriers—and the

Table 13. Selected approaches for case management

1. **Case management provided by the justice system.** In this model, justice system case managers are assigned caseloads at specific stages of the system, such as probation or parole. An advantage of this model is that the criminal justice system has “ownership” of the case management process. Justice system officials are invested in the process because their own staffs are implementing it and reporting back to them. A major disadvantage is that this process can be expensive.

Some jurisdictions have probation/parole officers especially trained to act as case managers for substance abusing offenders. This method can be extremely effective, but officers need small caseloads. Today’s average caseload for probation/parole officers is 120 offenders—far too many to permit effective case management of addicted women offenders.

2. **Case management provided by a treatment agency.** This model is community based. One advantage of the model is that the case manager has a thorough understanding of the AOD treatment process. The disadvantages include the expense and the possibilities that the case manager may not be familiar with the criminal justice system or that the AOD treatment agencies may not have the resources for effective case management.

3. **Case management provided by an agency separate from the treatment and justice systems.** To reduce costs, this model could employ a case management coordinator, with or without a caseload, to conduct intake interviews and supervise paraprofessional staff. The disadvantages of this approach include the addition of another agency to the collaboration and expense. TASC is a successful example of this model.

4. **Case management provided by a coordinator from the justice system who provides consulting services and technical assistance to support existing criminal justice case management.** One advantage of this model is system ownership. A coordinator, with or without a caseload, oversees the work of a paraprofessional staff. The coordinator can move the criminal justice system toward a greater awareness of treatment issues by providing technical assistance that demonstrates service coordination.

5. **Case management provided by multidisciplinary groups in the criminal justice system for offender management.** This type of group may meet regularly and during crises. This model is the most inexpensive. However, it is the most difficult to successfully operate because no one is assigned overall responsibility for the offender.

—**Excerpted and adapted** from Center for Substance Abuse Treatment, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System*. Treatment Improvement Protocol (TIP) Series, No. 17. DHHS Publication No. (SMA) 95-3039. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995a, p. 49.

incentives—of using a case management model for promoting continued community treatment among this population (see Inciardi et al. 1992; Martin et al. 1995). With this model, counselors had difficulty doing adequate outreach in the parolees’ neighborhoods, and the parolees showed low motivation to stay in substance abuse treatment. Counselors in this demonstration agreed that the backing of the criminal justice system was needed to compel clients into treatment, and that treatment personnel cannot function as both treatment counselors and intensive case managers.

Case Management for Prison Parolees During the Post-Release Period

It is clear that women offenders with long-term drug problems need a whole range of coordinated services during the period after release from prison. In most States, the women in State prisons will be drawn from a broad geographic area. It is essentially impossible for a prison treatment program to be the hub providing these continuing services. The case management function needs to be passed on to some other system operating at the community level. For the CSAT prison programs, these linkage mechanisms include:

- WCI Village: Coordination passes to the transition work release component; WCI Village graduates go to a work release TC with urinalysis where supervision is provided by treatment rather than security staff and TASC is involved in coordinating aftercare.

- **Recovery In Focus:** The coordination function passes to a Department of Corrections transition specialist, who coordinates treatment and services along different paths. For women going to work release, the transition specialist arranges for a hook-up to outpatient treatment close by. During the work release period, the woman is supervised, goes to two 12-Step meetings per week, and has a urinalysis every day.
- **Forever Free and Choices programs:** Through their Departments of Corrections and Community Punishment, community probation and parole officers become the organizing hub for coordinating treatment and parole.

Case Management of Jail Releasees in the Post-Release Period

Because the women clients are local, jail treatment programs can physically provide a focus for coordinating treatment, relapse prevention, and social services after a woman's release. However, this solution has some inherent limits. Program staff is of a finite and stable size. The number of women who successfully pass through a jail program and then need services over time will continue to grow. A 2-week program, such as the Baltimore Awareness and Acupuncture program, literally serves hundreds of women a year. There are obvious logistical limits to a program's ability to provide and manage the transition treatment and aftercare for such large numbers of women.

Case Management Strategies by CSAT Jail Programs

In Baltimore, a new case management program for women has been set up under the CSAT Target Cities program. This program occurs through the Alternative Sentencing Unit (ASU), which provides treatment

inducements in lieu of incarceration. Many of the 2-week program graduates now receive case management and supportive services through the ASU. The treatment path after a woman's release includes:

- Initial participation by clients in an intensive day treatment program at the Johns Hopkins Hospital's Comprehensive Women's Center.
- Graduation of the women to less intensive care based on attendance, evidence of drug abstinence, and progress on their treatment plan goals.

The Baltimore ASU provides intensive case management by specially trained ASU employees who coordinate substance abuse treatment, medical, psychosocial, and other service resources. This new program is having a positive impact on increasing the number of women who enter community treatment following the detention center program.

The longer jail programs serve a smaller total cohort of clients. When there is no community-based system to case manage the

women's housing, treatment, and aftercare, the CSAT-supported programs have set up their own services to meet the gap.

- In the OPTIONS county jail program, an outreach coordinator is assigned to develop linkages with community agencies. The aim is to encour-

It is clear that women offenders with long-term drug problems need a whole range of coordinated services during the period after release from prison.

age these agencies to deliver services within the jail, as well as to arrange for treatment slots as referral sources for clients after their release.

- In the Stepping Out jail program, a holistic continuum of care is provided through the Community Connection Resource Center's extensive service network for offenders in San Diego county. (Stepping Out is managed through this agency.) The services include sober living houses, intensive outpatient treatment, job development and placement assistance, referrals to supportive services, clean and sober recreation, and an agency mutual-help group.
- In the SISTER project, a limited number of women can receive follow-up residential treatment at Walden House or, if pregnant, at Jelani House. The program is developing new initiatives to help women unable to access these limited resources. The focus is on finding the women safe housing and some access to outpatient

treatment, and on setting up alumnae and support groups. The program tracks clients after they leave and loops them back to the program through continuing care, to ensure reintegration and continuing support.

Women's Need for Continuing Services

Although the number of women in the pilot research study of Forever Free graduates was small (Prendergast et al. 1996), this study gives real insight into the needs that addicted women offenders experience when they return to the community—and of the extent to which these needs may go unmet. The women were interviewed 12 to 18 months after being released to parole and were asked “During the past year, what help or services did you need for yourself and/or your children? Did you get assistance for this need?” All three groups studied—Forever Free graduates who entered residential treatment, graduates who did not enter residential treatment, and the comparison group of addicted women who had not experienced the Forever Free program—reported having the same needs, although their rankings were somewhat different.

Identified Needs of Women Ex-Offenders in the Community

After “help with preventing relapse to alcohol/drug use,” the most often mentioned needs by women offenders in the Forever Free study were:

- Getting employment (58 percent)

- Getting help with Supplemental Security Income (SSI) and Aid to Families with Dependent Children (AFDC) (56 percent)
- Getting treatment for alcohol and drug use (47 percent of those not in residential treatment listed this need)
- Self-esteem and living skills (42 percent)
- Medical or dental exams and treatment (38 percent)
- Housing (36 percent)
- Food, furniture, clothing, household supplies (28 percent)
- Education programs, GED (27 percent)
- Transportation assistance (25 percent)
- Spiritual or religious support (23 percent)
- Psychological counseling (23 percent)

Issue 1: Providing for help with relapse prevention.

The women's high perceived need for help in preventing relapse is one of the key findings from the pilot study of Forever Free graduates and untreated offenders done by UCLA and the California Department of Corrections (1995). Women who were not in residential treatment listed the need for help in preventing relapse to alcohol and drugs as their number one need over 25 other categories. While almost 2/3 (64 percent) of the no-treatment comparison group listed this need, so did 63 percent of the Forever Free graduates who entered residential treatment. Among women in residential treatment, 6 of 8 (75 percent) reported that they got assistance

for this need. Of Forever Free graduates who did not enter residential treatment, just 1/3 (2 of 6) received help with preventing relapse. Among the comparison women, only 1 of 9 women (11 percent) received any help.

Issue 2: Unmet needs of women after residential treatment.

The leading need reported by Forever Free graduates who had entered residential treatment was for employment help (79 percent). Only 57 percent of the women who had entered residential treatment reported that they got employment assistance. Only 2 of 6 women needing help with SSI, AFDC, and food stamps actually received such help. The reason for the lack of help is not clear, but it may reflect the fact that some of the residential programs do not have an aftercare component or that women who dropped out of residential treatment early did not receive after-care services.

Issue 3: Unmet needs of women receiving no community treatment.

Among the women not in a community residential program, it is noteworthy that half (47 percent) said they needed treatment for alcohol and drug use. Their two top reported needs were for relapse prevention and employment. Only 3 of 15 women listing relapse prevention as a top-rated need actually received help; only 2 of 14 women needing assistance with employment actually received it. One of the main reasons that women said they were unable to get specific needs met

was because they did not know how or where to get services for the need. The study team concluded that “little assistance was forthcoming in the community to those women who had not had the services of the community-based residential treatment” (UCLA Drug Abuse Research Center and California DOC 1995, p. 41).

The experience of Forever Free graduates is fairly typical. Being in community treatment—either residential or outpatient—is no guarantee that a woman offender will receive help with the services she needs. A recent survey of 336 programs nationwide that serve women offenders found that many do not arrange for ancillary services (Prendergast et al. 1995, p. 246). Concerning two of the most critical—safe housing and finding a source of income—programs reported:

- *Mixed-gender outpatient programs*—24 percent arrange for adequate housing before treatment is completed; 27 percent keep women in treatment until a source of income is obtained.
- *Women-specific outpatient programs*—53 percent arrange for housing and 37 percent make sure a source of income is obtained.
- *Women-specific residential programs*—83 percent arrange for housing and 56 percent ensure a source of income.

Although, on a percentage basis, fewer outpatient than residential programs help clients with housing, these percentages may be misleading in terms of the absolute numbers of women who are helped. Typically, residential programs serve much

smaller numbers of clients and for longer periods of time than outpatient programs. Thus, outpatient programs may actually help the larger number of women clients with housing.

Issue 4: Providing for safe, drug-free housing.

CSAT program grantees report an almost total absence of halfway house facilities for women after their release from custody. The Choices program—at a new facility in Arkansas—points out that the entire State has only one sheltered apartment for women with children. Choices program graduates can be released only if they have some place to live. The women may not want to return to living situations with drug-using relatives or friends, but often there is no other option.

The Jail Substance Abuse Program in Washington County, Maryland, a rural area, found that the lack of available structured housing for their female program graduates was a major factor in the higher rate of recidivism among women as compared to male offenders (C.R. Messner, personal communication 1996). Their informal statistics based on a small group of women clients showed that women who had access to halfway house facilities were more likely to succeed in staying out of jail. In their jail program, only 25 percent of women program graduates who were admitted to the supervised halfway house facilities returned to jail. Other women graduates could not be admitted to the halfway house for lack of space, and 90

percent of these women graduates returned to jail.

Strategies for Providing Services

Strategies for Providing Safe, Drug-Free Housing

As already discussed, finding safe and drug-free housing for women after their release is very difficult. Halfway houses are much less available for women than they are for men, and few of those that are available can accommodate children. As one program director pointed out, “Women can be classified as homeless when they leave mental institutions, so they get housing on a priority basis. Housing would be much easier if women could also be classified as homeless when they leave prison or jail.”

The SISTER project director recommends working with the local housing authority and identifying funding sources. It may be possible to arrange housing through section 8 or to get a housing priority status for the women in public housing. Another possibility is to assist women in setting up an Oxford House. There are currently 87 women’s Oxford Houses nationwide. These houses are run, paid for, and lived in by recovering clients, who may stay as long as they remain drug- and alcohol-free and abide by the group rules. The national Oxford House headquarters can provide information on how these houses are structured and managed (see the Resource List).

Some of the ways used in the CSAT programs to provide safe housing include these:

- The SISTER program arranges for residential treatment for women offenders, and for pregnant women, through Walden House, Inc. Walden House operates a number of satellite women's shelters, where SISTER graduates can stay. Support groups are available through the Walden House residential programs.
- For In Focus graduates, some housing was once available at the YWCA in conjunction with the Oregon Department of Corrections work release program. Although this resource is no longer available for the In Focus program, it represents an interesting, practical strategy that others may find worth exploring.

Modifying Oxford Houses for Mothers and Children

As the Choices and SISTER project directors both point out, there is a pressing need for halfway houses for women who, after being stabilized, can be with their children. However, women who set up in their own apartments or are in an Oxford House situation still need a case manager and a variety of supports. As one director stated, "The woman gets her own safe apartment and the next thing you know, her drug-addicted brother has moved in with her and she's right back in that drug-using environment." Women caught in such circumstances need to break from their earlier family relationships and attachments, which is extremely difficult.

Only five Oxford Houses nationwide admit women with their children. Experience suggests that the rules for these houses need to be modified and that the amount of caseworker support is considerably greater than for adult houses. The kinds of issues that need to be looked at include:

- *Size and cost of the house.* With children needing bedrooms and play space, the houses need to be larger than those housing only adults. Also, there will be fewer resident adults to pay the rent than in all-adult facilities.
- *Number and relationships among children.* The number of families needs to be assessed carefully, to avoid possible conflicts among the children and the mothers. A very preliminary suggestion, based on one Oxford House for mothers and children, is that no more than two families—combined with a few women without children—may be a workable configuration.
- *Parenting skills of the mothers.* The very limited Oxford House experience to date suggests that the mothers need ongoing help in developing their parenting skills.
- *Guidance on budgeting.* The mothers need help on budgeting their limited funds. Even though they have sufficient funds to pay the rent, the mothers tend to spend the money instead on high-quality clothes, video games, and other items for their children.
- *Development of new rules.* An Oxford House mother with children who relapses can't be

thrown out of the residence at 3:00 a.m., as would be usual in these houses. Who would be responsible for the children? These types of issues simply show why supervision and support need to continue during the months that a woman is stabilizing her recovery and becoming self-supporting.

CSAT Program Strategies for Preventing and Controlling Relapse

The Stepping Out program recommends building on the women's strengths—even if the women don't think they have them. For example, many of the women have great strengths in terms of nurturing and perseverance. They need to be encouraged to continue to attend women's Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), and other support groups. In addition, the women need to have particular individuals they can turn to for help and support when they need it. Several of the programs have set up support groups and other methods of providing one-on-one help. Some of these include:

- *Freedom 1st mutual-help group.* At Stepping Out, a mutual-help group is available that was created by and for ex-offenders. Stepping Out alumnae can attend this support group for ex-offenders sponsored by the program operator, Community Connection Resource Center.
- *Alumnae group.* The SISTER program is starting an outpatient alumnae group that will meet in the evenings. The

SISTER project plans outings with program alumnae and staff to bring the group together for fun and continued bonding.

- **Alumnae support group.** The SISTER program is also developing a SISTER support group for alumnae, with names to contact when a woman needs to talk.
- **Winners Circle.** This is a voluntary peer support group set up at WCI Village. The group offers each woman a person she can call if she fears relapse.

Winners Circle is a mutual-help support network for substance-abusing offenders. Started in Connecticut, the Winners Circle concept has been adopted in several States and is growing into a national movement. A Winners Circle chapter can be integrated into the program of TCs or other residential programs in correctional facilities. It is designed to offer addicted ex-offenders a chance to meet regularly to discuss common issues and engage in problem-solving strategies within a supportive environment.

* * * * *

Technical assistance, training, and videotapes, as well as written materials, are available for setting up a new chapter of Winners Circle. For information, contact the CSAT Systems Development and Integration Branch, Criminal Justice Project Office (telephone 301-443-6533).

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CSAT Strategies for Ongoing Support

In Oregon, the In Focus project uses a volunteer women's mentor program to provide a supportive role model for women in their communities during the aftercare phase. Although outcome statistics are not yet available, a similar women mentor model in New York State has demonstrated great success in reducing recidivism among women ex-offenders. This program, called WomenCare, has matched 218 volunteer mentors with women ex-offenders ("mentees") over a 6-year period. The mentees are home from prison, where they participated in drug rehabilitation programs; about 75 percent are single parents. The WomenCare program reports a recidivism rate of just 3 percent among women offenders in its program (D. Breslin, personal communication, 1997).

The Recovery In Focus program is involved in matching up the personality of each woman graduate to a mentor in her home community. The mentor stays in contact with a woman for 6 months to a year after the transitional work release/treatment phase. Mentors report back to the transition specialist.

The mentors make a minimum 6-month commitment and go through extensive training with a resource treatment specialist. The mentors need training to understand about setting boundaries and supporting women who have both a criminal and a sub-

stance-abusing background. It is a major commitment for the mentors. If the mentor comes from a 12-Step mutual-help group, she needs at least 5 years of sobriety to qualify. Mentor volunteers have been bank employees, retired workers from the Child Services Division, and members of community churches. The In Focus director believes that the structured transition and aftercare component is a major factor in success of the program graduates.

Both the prison and the jail programs have events that help their graduates maintain contact and give them recognition for successful recovery. Some of these activities include:

- **Annual celebrations for alumnae.** Recovery In Focus recently honored a graduate who had completed 4 years in successful recovery. As previously discussed, a number of the programs have these annual celebrations.
- **Return opportunities.** At the OPTIONS program, women in stable recovery come back to the unit, chair NA meetings, and offer recovery seminars to active clients.
- **Continuing activities.** All CREST graduates are urged to return to the facility periodically, to participate in the groups, the one-on-one interactions, family sessions, and retreats that represent the final stage of prison-based TC treatment in Delaware.

Chapter 7—Critical Issues in Implementing Programs

Every substance abuse treatment program—no matter in what setting—faces operational challenges. Such challenges range from the need to maintain community support and funding, to how to locate and recruit skilled staff, to setting up ways to attract appropriate clients. Programs in criminal justice settings share some particular and unique challenges. Critical issues include the need to:

- Engage in a systematic planning process that covers not only the program itself, but the relationship between the in-custody treatment program, the correctional system, and treatment in the community
- Select an appropriate treatment approach and good programming principles
- Gain and/or maintain the support and understanding of the prison or jail administration and the on-line security staff
- Select and train both the security and treatment staffs
- Set up good working relationships with the institution's medical/psychiatric staff
- Establish a plan for providing continuous quality improvement and evaluation.

This chapter highlights what the CSAT women's program grantees suggest about how to handle these issues. Other program planners may find it helpful to know what kinds of difficulties the grantees have encountered in implementing their women's programs, as well as the strategies and methods they are using to resolve these issues successfully.

Engaging in a Systematic Planning Process

Those interested in developing a drug treatment program for women in a correctional facility need to go through a systematic planning process. With the help of a number of practitioners and experts in the field, the Center for Substance Abuse Treatment (CSAT) has compiled a manual titled *Critical Elements in Developing Effective Jail-Based Drug Treatment Programming* (CSAT 1996a). This manual, available as publication number PHD 729 from the National Clearinghouse for Alcohol and Drug Information (NCADI), provides chronological guidelines on the following critical elements perti-

nent to both women's and men's treatment programs:

Stage I: Pre-Planning Assessment

1. Identify resources
2. Identify costs and benefits
3. Study legislation and regulations
4. Identify possible barriers

Stage II: Planning and Program Development

1. Determine jail or prison population profile
2. Write a mission statement
3. Develop a support base
4. Select a treatment approach
5. Develop a strategy for continuity of care
6. Develop a screening and referral system
7. Design an information tracking system
8. Develop policies and procedures
9. Plan and conduct training
10. Foster interagency partnerships
11. Establish an ongoing continuous quality improvement and evaluation program

Selecting an Effective Approach

Choosing an effective approach is the most critical basic task in designing treatment for addicted women. Good treatment is designed to address women-specific issues, and good programming addresses issues directly related to the women's substance abuse behavior. Chapters 2, 4, and 5 in this *Guide* provide a framework for making choices about program design.

What does experience suggest works best in programming for women offenders? The experience of the CSAT women's prison demonstration programs is consistent with earlier findings concerning what works in treating women offenders. In a nationwide study of innovative strategies and community programs for female offenders, Austin et al. (1992) concluded that the most promising strategies often used the "empowerment" model of skill building to enhance the women's coping and decision-making skills and enable them to achieve independence.

The study found that effective therapeutic approaches are multidimensional and deal specifically with women's issues, such as alcoholism/addiction, parenting, relationships, gender bias, domestic violence, and sexual abuse. The following characteristics appeared to influence successful program outcomes:

- A design that provides for a continuum of care
- Program expectations, rules, and sanctions that are clearly stated and uniformly enforced

- Consistent supervision
- Diverse and representative staffing
- Coordination of community resources
- Access to ongoing social and emotional support
- Multidimensional approaches that deal with women's issues specifically

This *Guide* focuses on issues that are specific to treating women offenders. However, there are many established principles for effective AOD treatment programs that apply regardless of whether men or women are being treated. Table 14 summarizes these generic principles, based on a broad review of the experience of a number of jail and prison treatment programs (Peters 1993, pp. 17-19).

Gaining Support From the Prison Administration

Introducing intensive substance abuse treatment into a corrections setting requires meshing two different systems that often have differing goals and philosophies. The overall environment in a prison or jail can be supportive for treatment or it can be non-responsive, setting up a series of structural, physical, and emotional barriers for a treatment program and its clients. Those setting up new programs for women will obviously need to work within the basic climate of the particular institution.

It is important to be aware that, in the past, some custodial officers have distrusted TC staff and

operations and have deliberately sabotaged treatment programs (Camp and Camp 1990; Inciardi and Scarpitti 1992). One potential source of resistance can come from correctional staff who have alcohol problems themselves. Because alcohol problems occur among people in all segments of U.S. society, such resistance is commonly encountered by alcohol prevention and intervention programs across all American institutions, be they school systems, workplaces, or prisons and jails.

The literature makes clear how important it is to gain administrative support for correctional treatment programs (Peters 1993, p. 17). For CSAT women program grantees, experience has been mixed but positive. Some grantees received enthusiastic support for their programs and an understanding of treatment needs from the beginning. Others have had to work hard to educate the administrators and to advocate for the needs of their women clients. These grantees report that it took about 2 years to overcome institutional barriers and to make fundamental changes needed by the programs. Two of the grantees had to struggle against sabotage efforts by various levels of correctional staff.

Support is important at two levels: from administrators at the top and from the overall institution, particularly on-line security staff. Situations are so varied it is hard to generalize, but it appears that women's treatment programs are likely to face the greatest obstacles when they are in traditional male-oriented correctional settings

Table 14. Principles of effective treatment with offenders

Reviews of the literature and of substance abuse treatment programs within the criminal justice system indicate key principles that are associated with successful treatment of offenders (Andrews and Kiesling, 1980; Bush et al. in press; Falkin et al. 1990; Gendreau and Ross 1984; Leukefeld and Tims 1992; and Wexler et al. 1988a). These principles, drawn from experiences in implementing both jail and prison treatment programs, are briefly summarized below.

1. **Develop commitment from jail administrators** to support the substance abuse treatment program and to provide adequate staff and technical resources.
2. **Use a coordinated approach in the design and implementation** of the in-custody substance abuse program, involving both substance abuse and custody staff.
3. **Conduct cross-training** for substance abuse treatment staff, custody staff, and key administrators to review the program philosophy, inmate management techniques, policies and procedures, and other common areas of interest.
4. **Provide a treatment unit that is isolated from general population inmates.** This strategy tends to remove participants from the corrosive influences of the jail/prison subculture and encourages development of prosocial behaviors and group cohesion.
5. **Provide incentives and sanctions** to encourage inmates to enter and complete in-custody treatment programs.
6. **Develop a sequence of in-custody treatment services** that is consistent with the expected length of incarceration.
7. **Provide comprehensive assessment** examining an inmate's treatment needs, risks presented to the institution (e.g. suicidal or aggressive behavior), and level of supervision required. Match inmates to treatment services according to the results of this assessment.
8. **Develop a structured treatment environment.** An intensive array of in-custody program services tends to encourage self-discipline and commitment to treatment, and is necessary to address the many skills deficits and areas of psychosocial dysfunction among this population.
9. **Provide clear consequences for inmate behavior within the institutional treatment program.** Positive and negative consequences for inmate behaviors should be clearly indicated. Program rules and guidelines are reinforced through a system of formal and informal sanctions.
10. **Encourage sustained participation in substance abuse treatment.** Institutional programs of less than 3 months duration should develop procedures to ensure that inmates are placed in supervised aftercare treatment within the community.
11. **Provide multimodal treatment services.** Treatment activities should address the range of psychosocial problems and areas of skills deficits that may inhibit successful recovery from drug and alcohol dependence.
12. **Encourage identification and modification of criminal thinking patterns, values, and behaviors.** Program counselors systematically model and reinforce prosocial behaviors within the treatment unit. Clearly defined sanctions are provided for antisocial behaviors.
13. **Employ cognitive-behavioral treatment techniques.** Self-management strategies such as cognitive restructuring and self-monitoring should be addressed in treatment programs. Opportunity should be provided for modeling, rehearsal, and overlearning of these techniques.
14. **Involve inmates in skills-based interventions.** Programs should encourage the acquisition and rehearsal of drug-free and prosocial skills to deal with interpersonal problems, stress, anger, and other personal, parental, and professional challenges faced during recovery.

(Table continued next page)

**Table 14. Principles of effective treatment with offenders
(continued)**

15. **Provide training in relapse prevention techniques.** Exercises should promote awareness of individual relapse patterns, including warning signs, high-risk situations, and covert setups. A range of coping skills should be provided to anticipate the high rate of relapse among drug-involved offenders. Opportunities should be provided to rehearse these skills in the institutional treatment program and during aftercare.
16. **Involve inmates in “core” group treatment experiences.** Involvement in a primary treatment or therapy group provides a catalyst for behavior change. This behavioral change is achieved through reinforcement of the client’s progress toward recovery and the confrontation of her denial and resistance. Group treatment also provides a cost-effective vehicle for educational and skills-based interventions.
17. **Provide pre-release planning and assist program participants in the transition to aftercare services.** Successful in-custody substance abuse treatment programs help to coordinate placement in follow-up treatment services. Most program participants are in need of at least 1 year of follow-up treatment and regular drug testing that is provided within the context of probation or parole supervision. TASC-like agencies have proven to be particularly useful in linking offenders to community treatment and in monitoring compliance with aftercare treatment.
18. **Develop measures to assure accountability to short- and long-term program objectives.** Evaluation strategies are implemented in the early stages of program development. Evaluation should include process, impact, and outcome measures.

—**Excerpted and adapted from** Treatment in jails and detention settings, by R.H. Peters. In: *Drug Treatment and Criminal Justice*. Thousand Oaks, CA: Sage Publications, 1993.

where the institution’s philosophy focuses on punishment and control. For jail programs, the Sheriff’s department philosophy and orientation in the hiring and training of deputies will affect how supportive and accepting the correctional staff is toward a treatment program.

In some correctional institutions, understanding and support for substance abuse treatment can be very strong. Two CSAT grantees, the Forever Free and Choices programs, report particularly positive support from their institutions. In both cases, the institution is headed by a female warden who is committed to rehabilitation goals for the women offenders. In addition, Choices—a new community pun-

ishment facility in Arkansas where residents can move about freely on the grounds—is designed to be a rehabilitation facility; the security guards are called “residential supervisors” and wear nontraditional uniforms (khaki pants and blue oxford shirts). The officers wear regular uniforms at times when they oversee residents who are performing community service.

Also, the way correctional treatment programs are structured can produce close and reinforcing ties across systems, with all entities perceiving success of the treatment program as a shared mission. The Forever Free program at the California Institute for Women in Frontera, California, is one example. The

women’s treatment program is coordinated by two agencies—the Office of Substance Abuse Programs in the California Department of Corrections (CDC) and the State Department of Alcohol and Drug Programs (the CSAT grantee).

In this coordinated structure, the CDC Office of Substance Abuse Programs provides: (1) the overall grant project director and evaluator; (2) a correctional counselor who provides project oversight, is responsible for screening and selection of program participants, and is the liaison with institutional management staff and parole services; (3) a correctional counselor who handles case management, classification, and disciplinary issues; and (4) a

parole agent who serves as the continuity of care coordinator. This parole agent is responsible for assuring that program participants make a smooth transition from custody into the community and that the women stay in treatment for as long as possible while they are on parole. The subcontractor—Mental Health Systems, Inc.—operates the in-custody treatment program and provides the project manager and counselor staff. The State Department of Alcohol and Drug Programs provides funding for the women’s post-release community treatment.

For treatment programs, it is important to build communication, understanding, and support not just with the top administrators but throughout the entire institutional setting. These efforts need to be ongoing. Two key areas that need continuing attention include:

- *Differences that arise from the differing responsibilities and roles of treatment and correctional staff.* At the North Rehabilitation Facility, for example, the correctional staff has been involved with treatment for 15 years in integrated treatment/security situations, yet staff says there are still differences to be worked out. Even the vocabularies may be different, with the women being “offenders” to one system and “clients” to the other.
- *Lack of understanding about principles of treatment, especially treatment in therapeutic communities (TCs).* Corrections staff may perceive treatment as “coddling” the inmates. Some corrections staff may have dif-

iculty adapting to the client autonomy and control inherent in the TC models. According to Pan et al. (1993), TCs implement techniques and strategies that challenge the routines of highly organized prisons.

Natural bureaucratic resistance can arise either from suspicious or willful individuals, from sheer organizational rigidity, or both. These authors

ices by contracting with an outside agency. In some cases, the correctional facility has designed the treatment program before the person who will run that program becomes involved. The expected project director needs to be included early in the program planning, so that person can work cooperatively with the decision-makers at the correctional facility and with any other agencies to be involved.

Creating a supportive relationship
between the institution and the treatment staff
needs to start at the very beginning—when
initial plans are made for a program.

suggest that this type of resistance is very difficult to overcome unless the TC modality is supported by high-level staff.

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For a clear discussion of the underpinnings and differences in perceptions between the corrections and treatment systems, see CSAT TIP 17: *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT 1995a).

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Program Planning Phase

Creating a supportive relationship between the institution and the treatment staff needs to start at the very beginning—when initial plans are made for a program. Usually a correctional facility provides treatment serv-

As was discussed earlier, there are a number of treatment models. Once a given model has been decided on, it can be very difficult if not impossible to make fundamental changes in how the program will operate. For this reason, correctional institutions need to be careful not to make all the key decisions about the model until after the project director comes on board. Institution policies and constraints may limit some desired treatment options, such as the ability to make 8 hours every day available for treatment. All parties need to be working together to find the best compromise.

In the planning stage, treatment staff need to look very carefully at the institution’s history, especially at the correctional staff who will gain or lose power and position when the new treatment program starts. One grantee

stressed that, to avoid possible undercutting and sabotage, it is important to know about and address any existing turf issues in a frank manner and at the beginning.

The Stepping Out project points out how important it is to get input about program plans from all affected personnel, particularly custody staff. Pivotal custody staff positions, such as sergeants and work assignment deputies, need to work closely with program designers and operators from startup through the life of the project. Without the cooperation and buy-in of key custody staff, a treatment program will not operate successfully.

Sufficient startup time for a new program is important. Several of the CSAT-funded programs were expected to be up and running within brief periods, such as 1 month after their contract was awarded. This does not allow enough time for the treatment staff to work with administrators in selecting and training security officers for the program. Neither is the time adequate to develop or update needed curriculum materials or to recruit and train the treatment staff.

Ongoing Relations With the Institution

Two of the CSAT grantees commented that it takes a lot of work to build and maintain their relationship with correctional staff, but that this relationship continues to improve over time. Some of the grantees' suggestions for building this acceptance for the program include the following:

- Consistently try to involve the administration in the program process at every opportunity. Promote the TC or other model as a highly attractive form of rehabilitation.
- Meet with the administration on a regular, ongoing basis and confront any issues immediately. Don't let problems or conflicts linger unresolved.
- Be persistent and determined about the needs of your program. As one project director said, "They know I won't be deterred and I'll keep calling."
- Look for opportunities to integrate treatment staff into the institution as a resource. As an example, the WCI Village program now has a senior counselor assigned to the institution's classification board. This assures that appropriate, eligible women are being sent to the program, but it is also providing a substance abuse specialist as a resource for the institution.
- Take advantage of any chance to orient and train the entire agency about the program. This is a new direction that offers promise. Such institution-wide orientation would help with the situation reported by one grantee, where the staff felt fortunate to have two positive, supportive security deputies assigned to their program. However, these two supportive deputies did not represent overall staff attitudes about the program; these deputies experienced trouble with their peers when the time came for them to assimilate back into the institution's overall deputy staff.

One of the grantees stressed how essential it is to establish clear lines of communication within the institution. For example, program changes that affect deputy duties must be communicated through the chain of command, not in a memo from the program director to deputies. It is important to hold regularly scheduled meetings between custody staff, program operators, and other concerned parties as often as is practical and necessary. The treatment program also needs to have a designated staff person on site at all times, or available by telephone, who can respond to any institutional concerns.

Selection and Role Of Corrections Security Staff

Security officers are significant players in a woman's treatment unit, particularly in TCs or other residential programs that operate in a therapeutic milieu. Security staff can be a positive force in helping women heal. If they are negative about the program or the women in it, they can also damage the treatment process. One grantee reports their program experienced "sabotage and undercutting." According to this grantee, "It was necessary to facilitate transfers of key custody people on the female unit in order to implement services and to penetrate the existing regime and their antifemale inmate attitudes and behavior." The CSAT women's programs, nearly all TCs or intensive residential programs, share a set of consistent

recommendations about selecting security staff. They suggest that:

- *Many officers or deputies will not be appropriate* for the treatment program. If at all possible, the treatment staff should be allowed to reject those persons who are not suitable.
- *Training for security officers will be necessary* and should be ongoing. Alternate or substitute staff must also receive training.
- *Security staff for the program should be a regular assignment.* Rotating security personnel is not desirable.

The CSAT grantees believe that either women or men deputies can be equally successful. A supportive male deputy can be a fine role model for the women clients, many of whom have primarily experienced abusive males in their personal lives. As a result of their very low self-esteem, these women are sensitive to feelings of being devalued. Deputies who are not highly supportive of the treatment process can sabotage it. One grantee pointed out that negative, nonsupportive attitudes from any deputy can undermine the women's vulnerable sense of self-esteem and their progress, but if that deputy is a woman, the effects are especially bad. Women clients really feed into the negativism coming from another woman. In addition, a negative deputy can have a divisive influence, splitting the treatment group.

Functions of the Security Officers on Treatment Units

Some officer functions will be determined by the particular institution. At some facilities, for example, the officers may accompany the women for security reasons to all their education, vocational, or other sessions outside the treatment unit. In the CSAT women's programs—both TCs and others—the officers are trained and available to support the women participants during evening and night hours, when treatment staff are not onsite.

The daytime functions assumed by security officers in the WCI Village program are fairly typical of TCs. The officers can perform their share of tasks, have a non-clinical role as part of the group, and support the process. They participate in the ongoing life of the group but do not take part in treatment sessions. In other words, for confidentiality and other reasons, the officers do not sit in on groups where the women are dealing with their issues.

Qualities of Corrections Staff

The North Rehabilitation Facility finds that security officers who are successful have an accepting attitude toward addicted women offenders as fellow human beings; they are able to perceive of the inmates as people, not objects. In a pragmatic sense, their officers want to help the women become better neighbors and citizens as a benefit to the

total community. Other desirable qualities for custody officers to possess include:

- Having a nurturing personality
- Being empathic and emotionally healthy as individuals
- Feeling comfortable with inmate/client decision-making
- Having participated in a TC themselves (an advantage in TC programs)

The assigned security officers will need to have cross-training, which is described later in this section. But in addition to that, the treatment staff needs to provide clear guidelines and expectations for officers in TC settings. The officers will need ongoing guidance and individual interventions. For example, a new officer in one of the short-term TC programs was not allowing the women to give each other friendly hugs after treatment hours.

The security officers' behavior needs to be consistent with treatment goals. Officers need to understand and appreciate the TC treatment process, so they can be "on board" with treatment staff in supporting and reinforcing the TC milieu. Officers need to understand all the rules thoroughly, to enforce them consistently, and be careful not to bend the rules. They need help in setting boundaries. Some officers may simply not be oriented to substance abuse treatment and may need help in understanding what a difficult process the women are experiencing.

The CSAT-supported treatment programs have had some limited experience with security officers who are themselves recovering from substance abuse.

Such officers understand what the women participants are going through, but they also need training and other guidance.

Program staffs say that officers who are recovering from substance abuse themselves can be highly supportive of treatment goals, contributing significantly to a positive environment for clients. On the other hand, such officers can be unduly biased in favor of their own recovery philosophy or may tend to monopolize the group's attention with their own personal recovery issues.

“The selection of both correctional and treatment staff is the crucial element for any program. It is the attitude and energy of staff that make the most notable difference in the outcome of treatment efforts.”

—CSAT grantee

The essential point here is that security officers can be an integral, positive part of the TC community and treatment process. However, all security officers—even those in personal recovery with a positive attitude toward treatment—will need guidance.

Selection and Training of Substance Abuse Treatment Staff

For corrections treatment programs, there can be debate about which staffing model will be

more appropriate: the “professional” model or the “recovering addict” model. The “professional” model calls for selecting staff who are educated, trained, and experienced in counseling, psychology, or social work. The “recovering addict” model promotes the use of ex-addicts and/or ex-offenders in key leadership and clinical positions (Inciardi 1995). Counselors who have professional academic degrees earn higher salaries and so cost more, but they generally have trained clinical skills and a detachment that may not be found in the recovering addict

counselor. However, recovering addict counselors are excellent role models. They have developed coping skills, in terms of living in the community while abstaining from drug use, that can be helpful for drug-dependent offenders. Recovering counselors provide offenders with a credible role model to which they can relate (Bureau of Justice Assistance 1991, p. 47).

The CSAT women's grantees are using two different staffing patterns, depending on the type and length of the program. For the short-term intensive programs that focus on motivating

and referring women to appropriate treatment, it can be an advantage to have staff with professional degrees who are clinically trained. All the other programs—whether intensive outpatient or TCs—use and recommend a staff/supervisor mix of trained professionals and certified substance abuse counselors who are either recovering or ex-offenders.

Staff for Short-Term Programs

The 2-week, intensive program in the Baltimore Detention Center uses a “professional” model, with all clinical staff having at least a master's degree. This program is a motivational model, designed to provide intense, targeted help to women and move them into appropriate community treatment programs and other services.

The short-term program at North Rehabilitation Facility combines addictions counselors with professional clinical staff. The project director points out that, when a program has only 13 or 14 days to assess and motivate the women, staff must be clinically astute. Among the skills they need will be:

- A sound understanding of the therapeutic models of developmental change for women
- The ability to assess where the individual woman is on the continuum of developmental change and motivation
- An awareness of the wide array of therapeutic tools available and a knowledge of how to match those tools with the

needs of a great diversity of individual clients

Staff for Mid- and Long-Term Residential Programs

The intensive, longer term women's programs depend on certified substance abuse counselors, both recovering individuals and recovering ex-offenders, as the backbone of their treatment staffs. Clinically trained professionals—both staff and supervisory personnel—help support the treatment process.

The clinical staff are selected for expertise in the areas most targeted by the particular program. Programs commonly have staff with special clinical expertise in screening and assessment, mental health (particularly co-occurring disorders), and family therapy. One program director mentioned that it had been of tremendous benefit for her to have a clinical background, as her program blended a medical model of substance abuse with a TC model.

In hiring certified counselors who are recovering, programs set certain criteria. The Forever Free program, for example, requires that counselors have been in "sober and clean" recovery for a minimum of 3 years, and they may not be on parole, probation, or under any other court-ordered supervision. Some correctional institutions have a policy that forbids ex-offenders to be employed on staff. This problem can often be overcome by having the treatment contractor hire the ex-offenders. However, the contract staff will still have to pass securi-

ty clearance checks. Corrections will always do background checks on anyone working in their prison. Consequently, obtaining the administration's buy-in with the program will be essential if they will be asked to waive restrictions on ex-offenders working in the institution.

Special TC Needs

TC models have special staffing needs. It is imperative that TC programs have some counselor staff who have themselves experienced a TC program. Finding and recruiting staff with this experience can be difficult, particularly in parts of the country where few TC programs exist. CSAT, through its technical assistance initiatives, may be able to provide some suggestions. Therapeutic Communities of America may be another resource. Time needs to be allotted for this recruitment process, because it may require a regional, if not national, search. Some strategies for expanding the available base of individuals with TC experience are mentioned below.

Attaining a Racial/Ethnic and Gender Staff Mix

It is very important that treatment staff be ethnically and culturally diverse, approximating the same mix as the women clients. Just having a representative staff mix will not be sufficient, however. Programs need to have a theme of cultural diversity within the program, and staff training will need to deal with understanding the women's cultural differences and sensitivities. Several of the women's correc-

tional programs offer separate group sessions by cultural grouping (such as Caucasian, African-American, Hispanic, Asian American, and Pacific Islander groups) and by sexual preference (such as groups for lesbian, bisexual, and transsexual women).

The issue of whether to include men as staff counselors in women's treatment programs is less clear-cut. The women's programs discussed in this report have predominantly all-female counseling staffs and point to this as an advantage of their programs. There are valid reasons for using male counselors, however. Among these are:

- The shortage of available women counselors who have experienced a TC and are recovering and/or have come out of the correctional system themselves
- The value for the women clients of working and interacting with a positive, supportive male role model, who can exemplify relationships in which men do not assume dominant, aggressive, and abusive roles

Male counselors, if used, need to be selected carefully. One program director said that she looked for a male counselor who would not be too aggressive and harshly confrontational. The male counselor selected had the desired low-key demeanor, but he was unable to confront the women with their issues. Instead, he felt sorry for the women, took on a role as their caretaker, and pushed to do such activities as taking the women to the gym. The women's response was to act out in relation to this man,

becoming very needy and dependent (for example, by urgently requesting immediate individual sessions).

Women are able to set responsible standards and to demand—in a positive, nurturing way—that other women meet these expectations. Male staff must also have this quality.

The grantees point out that, unquestionably, women clients need to experience a positive and supportive male role model at some point in their recovery. The real issue is: what is the best time for this—during in-custody treatment, in the post-release community treatment phase, or in the continuing care phase?

In Delaware, where women now receive a continuum of care at all these levels, the first tentative answer seems to be “after the community treatment phase.”

Their experience is that women in the coeducational TC work release program are still vulnerable to their pre-prison patterns of relationships with abusive men. Work on developing positive male-female relationships may need to come after the woman has set up a stable recovery process and has resolved her issues of employment and self-sufficiency.

Qualities of Treatment Staff

Staff at the North Rehabilitation Facility state the most important quality is “the counselor must be perceived as caring.” Other grantees point to the staff’s attitude and their energy, commitment, integrity, and compassion

as being paramount to the healing process.

Recruiting Staff

As one project director expressed it, what is emerging is a new type of professional—counselors who know both the custody environment and substance abuse treatment. This director suggests that it is highly desirable to find counselors who have come out of the correctional system. It is even better if this person comes with education or training about the developmental theories regarding women and treatment, how to handle paperwork, to do assessments, and to match clients with appropriate treatment strategies. At this point, few counselor candidates will have all these qualifications. The CSAT demonstration programs are using a variety of strategies to expand the number of qualified counselors available for their programs. These include:

- Agree in advance, at the time a counselor is hired, on a plan for further outside training, such as through seminars, bachelor’s degree programs, and workshops.
- Conduct intensive in-house training. At the In Focus program, staff receive 40 hours a year of trainings on such topics as women-specific issues, parenting, co-occurring disorders, relapse, and criminality.
- Offer internships and part-time placements for students. The OPTIONS TC program, for example, is a popular student placement choice, and both graduate and undergraduate students have participated in

the program. The students receive free training, and the project may possibly gain a staff member later.

- Provide part-time work for correctional officers who are starting a new career. Two projects have been able to employ corrections officers who were studying for a social work degree—an ideal combination.
- Employ returning program graduates within the program. The Forever Free program has graduates in stable recovery who are both on their staff and volunteer to come back to lead groups. WCI Village also uses graduates in a volunteer capacity; the graduates volunteer to lead groups and support the program. These volunteer activities help WCI graduates obtain the training and hours needed to become a certified substance abuse counselor.

Training and Staff Supervision

In-house training and ongoing supervision of staff are very important in a jail or prison environment. This is a difficult population, with multiple needs, and staff may need help to avoid becoming overinvolved emotionally and burned out. Staff who are recovering themselves have to be vigilant that the daily work is not their own treatment. TCs have been moving toward inclusion of more clinically trained staff members, not just supervisors, in combination with experienced certified counselors. This includes professionals who are oriented toward traditional mental health models of treatment

(Carroll and Sobel 1986). The balance in staff backgrounds is helpful in both TC and other models. Types of training may need to cover such issues as:

- ***Understanding the TC milieu for women.*** Clinical staff who have not experienced a TC themselves need to understand how to work in this environment, which is so dependent on mutual self-help and peer responsibility. Counselors who have experienced a male TC themselves can have great difficulty in adjusting to the less confrontational tone of a woman's program. In one of the CSAT demonstration programs, two counselors could not make this adjustment and had to be replaced.
- ***Adopting an open, clinical mind set.*** Counselors who are recovering themselves may have a tendency to overuse the techniques that helped them (the "comfortable and familiar" syndrome). The treatment models used by the CSAT grantees take advantage of a wide array of therapeutic tools, matched to the needs of the particular woman. Training can encourage counselors to understand the women as individuals, with different needs, and to broaden their repertoire of responses and techniques.
- ***Understanding the program's theory and process of change model and how to use it in assessing and planning each woman's treatment.*** Counselors need both the curiosity and the professional mind set to ask, "What is this woman ready for developmentally? For her,

what is the attraction of the addiction? How does it make her feel? What does she get out of it?" Women hold on to addiction and its lifestyle just as many abused women stay with the abuser. In both cases, the person must understand and come to terms with the pull—the attachment—before it can be given up.

Cross-Training for Treatment and Corrections Staff

Cross-training for program staff is considered to be critical for the success of a drug treatment program (Bureau of Justice Assistance 1991, p. 49). This training educates treatment staff about corrections issues, such as security, and educates corrections staff about treatment issues. The training serves a number of vital functions, such as promoting teamwork and helping the treatment and corrections staffs to understand their roles and any existing stereotypes.

Cross-training needs to be scheduled before the program gets underway, and then be followed up by regularly scheduled in-service training sessions. Such training may be complex in the beginning, and professional training assistance can sometimes be helpful.

Topics for Cross-Training

Table 15 lists general cross-training topics (not specific to women's programs) for treatment and corrections staff in prison and jail settings.

The CSAT women's program grantees suggest that, in addition to these generic topics, cross-training for the assigned program security staff and their substitutes needs to encompass the following:

- Training regarding AOD treatment, including such issues as confidentiality of program information
- Need for sensitivity to the emotions and potential distress that can be evoked during counseling
- Importance of maintaining a positive, nonpunitive environment within the treatment program
- The critical role of support and encouragement that correctional staff can play after treatment hours

Grantee Lessons on Cross-Training

The Stepping Out program staff recommends that cross-training begin early in the startup process. One lesson they learned was that custody staff need succinct and unambiguous information about the program. Giving the custody staff volumes of material is not useful to them; what they need are program summaries and focused information on how their duties interact with the program.

For the treatment staff during cross-training, women's program grantees suggest the following topics:

- Special issues regarding treatment within a corrections setting
- Security issues and potential breaches

Table 15. Cross-training topics

Basic addictions curriculum	Report writing
Program philosophy	Team building
Treatment methodology	Legal issues/inmate rights
Inmate management style	Policy and procedures
Life/safety procedures	Communication skills
Disciplinary procedures	Cultural diversity

From: Bureau of Justice Assistance, *Design and Implementation Issues for Drug Treatment in the Jail Setting: Monograph*, 1991.

- Importance of not “triangulating” patients, treatment staff, and correctional officers

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One available resource is the cross-training curriculum for probation/parole officers and drug treatment personnel developed jointly by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the American Parole and Probation Association (APPA). Call 202-293-0090 or e-mail: dcoffice@nasadad.org. CSAT also has a cross-discipline training course for corrections and drug treatment personnel (see *Criminal Justice-Substance Abuse Cross-Training* under Staff Training in the Resource List, this volume).

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Relationships With the Medical and Psychiatric Staffs

Much has been written about the inadequate medical services that jails provide to women (Gray et al. 1995). Lawsuits filed by or on

behalf of women in jails predominantly deal with medical services. Only about half of U.S. jails offer gynecological and obstetrical services, about 70 percent offer psychiatric services, and 90 percent do intake screening and health appraisals. Among State prisons, about 95 percent do intake screening and health appraisals and 80 percent provide obstetrical, gynecological, and psychiatric services (ACA 1990).

The CSAT demonstration grantees stressed how important it is to have a good relationship with the facility’s medical and psychiatric staffs. Based on their experience, the women’s treatment staffs in jails pointed out the following issues:

- **Screening for sexually transmitted diseases (STDs).** Women offenders with drug problems have a high rate of STDs, often untreated. Programs need to be aware that the medical screening available for women offenders may be so limited that STDs are neither diagnosed nor treated. One jail program supported by CSAT reported that none of their women clients were being diagnosed with STDs during

the standard medical exams. When an STD specialist joined the program and began screening the women, 70 percent were found to have one or more STDs.

- **Need for medication.** A number of women being admitted to jails and detention centers are in need of medication for major mental disorders. Women leaving mental institutions may find themselves alone and become homeless; they stop taking prescribed medications and self-medicate with street drugs that are easily accessible (Lord 1995). The problem is self-perpetuating. While actively using drugs, the woman becomes noncompliant with her psychiatric treatment and medications. Women with a dual diagnosis (a major mental disorder combined with substance abuse) need to be stabilized when they enter custody. With medication, a number of these women will be able to participate in a short-term, intensive pre-release program.

In prison settings, the staffs commented on the following issues:

- **Need for gynecological care.** One program director commented on the high level of gynecological problems among the women and their previous lack of medical care. Some women in this program have HIV and STDs. Other women are already starting menopause in their late 30s and early 40s. These are issues related to relapse in women.
- **Need for supportive prenatal and postpartum care.** At WCI

Village, the program provides a nurturing, supportive climate for a woman throughout her pregnancy and after birth of the baby. All the program participants provide this support. The woman delivers her baby at the hospital, and the infant is immediately removed either to foster care or to a relative. When the mother returns to the prison infirmary after the delivery, the whole Village group comes to visit and support her as she grapples with her feelings about the separation from her infant.

- **Overprescription of medications.** In the prison setting, program directors felt that, for some individuals, psychiatric medications are being overprescribed and prolonging their addictions.

Treatment staff needs to have good ongoing communication with the facility's psychiatrists and mental health care providers. As was discussed in chapter 4, most of the programs attempt to admit women who have serious mental health diagnoses, as long as they are stabilized on medication and can benefit from—and not disrupt—the program. These women will need a mental health consultation before entering the treatment program, and some may need to be transferred temporarily to the psychiatric unit while in treatment. Issues that have come up in this collaboration include:

- **A need for information.** One program finds it difficult to get adequate information about individuals from the mental health unit. For example, staff want to know more about the

expected effects of the drugs that each client is taking, particularly the potential side effects.

- **Need for orientation on the program.** The mental health staff needs to understand the criteria governing which women can be accommodated by the treatment program. One program found that, because programming is so scarce for women offenders with severe mental illness, the mental health unit kept trying to send women who were not appropriate for their program.

Evaluating the Program

Evaluation of programs has become increasingly important during the 1990s, as both the Federal and State governments have demanded more accountability for government funds. State AOD agencies generally require that programs have continuous quality improvement (CQI) or quality assurance (QA) programs. Because policymakers will want to know about results, it is important to design an evaluation while a treatment program is being developed. Even if there is no formal budget for evaluation, it is still possible to design simple but useful measures for evaluating process and outcomes. This information needs to be collected consistently from the time the program starts.

Research on outcomes of treatment, especially for women, is badly needed. The CSAT-supported demonstration programs described in this *Guide* have all developed process and/or out-

comes evaluation plans, so that findings will be available on these models. But every project should be doing some evaluation, and the plans need to be made in tandem with the initial implementation planning. Baseline data may need to be collected before the program starts. Some of the important reasons for carrying out some type of evaluation include:

- **Obtaining financial support.** This is a time of uncertain and changing funding streams. Gathering feedback that shows the success of the program, and the program's ability to demonstrate concrete results in reducing recidivism and saving public money, can be a significant asset in helping to generate continued funding and administrative support for the program.
- **Insight for staff about what works.** Specific feedback from participants is invaluable in showing what is working, or not working, in a program.
- **Knowledge for matching clients to community programs.** Feedback about follow-up outcomes can be particularly useful for in-custody treatment programs, since it will help determine which community continuing care facilities and resources are of most benefit to which types of clients. This information will improve treatment matching. Potential types of evaluation can demonstrate:
- **Advantageous effects on the institution.** Evaluation can show that a treatment program provides concrete advantages for the prison or jail. For example, data can show

the program's effects in reducing disorderly behavior and rules violations among the participant population.

- **Process information.** Data can show whether the program is being implemented according to plan, the number of clients being retained and for how long, the number of clients successfully completing the program, the range and type of community resources introduced to the clients, the level of client satisfaction with the program, and the clients' self-evaluation of change.
- **Treatment outcomes.** Post-release client outcome measures can show the percentage of program participants who enter post-release treatment, the types of treatment received, and the period of time they remain in treatment. At 3-month follow-up after release, outcome measures can be used to assess client drug use (self-report and urinalysis, combined with psychosocial

measures), and client attendance at mutual-help support groups.

- **Recidivism outcomes.** The recidivism of clients can be measured by: rate of recidivism for program graduates at 6 months and 12 months; rearrest status at 1 year follow-up; and the cause of the recidivism (for example, new arrests vs. technical probation/parole violations).
- **Other indicators of improvement.** Other measures can look at the clients' improved social and economic functioning, such as employment or schooling, gaining custody of children, and living in independent and drug-free situations. Cost data are particularly important in the current funding environment. How much government money is being saved when a substance-abusing offender, after treatment, is able to work and become economically self-sufficient, to resume care of her children, and to cease criminal

activities? Such cost-offset data are critical for convincing State policymakers about the cost benefits of treatment programs.

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For a brief discussion of process evaluation and its challenges in correctional settings, see "Process Evaluation Techniques for Corrections-based Drug Treatment Programs" (Scarpitti et al. 1993). Other brief resources on program evaluation will be found in *Establishing Substance Abuse Treatment Programs in Prisons: A Practitioner's Handbook* (CSAT 1993a, pp. 60-65) and in TIP 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT 1995a, pp. 91-95). For a full description of the evaluation process and the many variables that should be addressed in well-designed studies, see TIP 14, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment* (CSAT 1995c).

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Part IV

Summaries of Programs

Chapter 8—Summaries of CSAT Women’s Programs for Offenders

This chapter provides an overview of the key components of nine women’s prison and jail demonstration programs supported by the Center for Substance Abuse Treatment (CSAT). The materials that these programs are prepared to share with others are listed at the end of each description. Contacts are also listed, so that program administrators and others may request additional information about these demonstration projects. More extensive program summaries, histories of program implementation, and costs and evaluation results from most of these grant programs are also contained in an unpublished document (CSAT’s *Criminal Justice Program Briefs* 1998).

Prison-based Demonstration Projects

Choices TC Program, Pine Bluff, Arkansas

The Choices Program, operated by the Arkansas Department of Community Punishment (DCP), offers a modified therapeutic community treatment program with a minimum stay of 90 days

to 24 months. This institution is designed to serve only those offenders with nonviolent offenses. Many are first-time offenders—a population with a good opportunity to change their lives. The modified TC program, with a capacity of 50 clients, serves approximately 260 people per year and is available to both male and female residents in separate housing arrangements. To date, 149 residents have completed the program. Random drug testing occurs in this facility about once every 2 to 3 weeks. After completing the program, most participants proceed to probation and parole.

DCP and treatment staff have established linkages with mental health, substance abuse, and other health providers in the community to assist program participants with their transition back to the community. Many participants complete the treatment component before completing their sentence, and initially these women had to be released back into the general population in the facility before being released into their communities. In spring 1996, a separate dormitory was made available so those who have completed treatment can remain together while finishing their sentences without

returning to the general population.

The program offers a range of services from vocational counseling to parenting training. Choices is unique in part because it is the only residential treatment occurring in a secure community corrections setting, where the goal is rehabilitation and treatment. The institution is designed as an alternative to prison because of the lack of prison bed space.

Data from the CHOICES program show that as of July 30, 1997, 699 clients had been admitted to the program and 452 had successfully completed it, five had received participation certificates, 80 residents were currently participating, and 137 clients had been discharged. The discharged figure includes those who could not complete the program for reasons outside their control. Based on its initial success with the TC modality, all community punishment facilities in Arkansas are now being converted to modified therapeutic communities.

Materials available: A short guide on how to use and integrate a Rope Course into a treatment program.

Contact: Glenda L. Spratt, Arkansas Department of Community Punishment, 105

West Capitol Ave., 2 Union National Plaza, 2nd floor, Little Rock, Arkansas 72201, phone 501-682-9570, fax 501-682-9534

Delores J. Baylor Women's Correctional Institution (WCI) Village TC Program, Wilmington, Delaware

Roughly 42 women at a time live and work together in this State prison-based modified therapeutic community (TC), where the women share a positive family environment for 6 to 18 months. The program combines TC therapy strategies with culturally sensitive approaches designed to meet the needs of women. A "women oriented" focus is used to deal with issues of self-esteem, sexuality/intimacy, interpersonal skills, relationships with family and significant others, cultural/ethnic identity, parenting, health issues, empowerment, job skills, leisure time, and drug/alcohol use. Village staff is primarily female. Among the many techniques used are transactional analysis, psychodrama, branch groups, encounter and feelings groups, and seminars.

Recently, the Village added a new aftercare component. Prior to their release, an aftercare coordinator works with the women to arrange transitional care in community-based residential drug treatment programs. This includes preparing the women to go before the Parole Board, transferring them from WCI Village to the CREST Outreach Center, and providing them with educational, vocational, mental health, medical, and social services. Most residents enter a coeducational work-release TC. After this treat-

ment phase is completed, the Village coordinator continues to assure that ongoing support services and social supports are available.

Materials available: A program manual for participants in English and in Spanish and curriculum outlines.

Contact: Gwen Empson, Program Director, WCI Village, 660 Baylor Boulevard, New Castle, Delaware 19720, phone (302) 577-3004, ext. 1224, fax (302) 577-5861

Forever Free Program, California Institution for Women, Frontera, California

Forever Free provides an intensive in-prison treatment program lasting for a minimum of 6 months, with women participating in drug treatment programming for 20 hours per week. The women also participate in the prison work program for an additional 20 hours. Since 1991, the program has served 1,723 women. Approximately 250 women enter the program each year; the monthly caseload is 120 women.

However, this original program is now being expanded. In August 1997, the California legislature decided to double the in-prison program and to add \$500,000 annually to the community aftercare component. This expanded treatment program will now serve 240 women per month in prison and will place 50 percent of program graduates into contracted community treatment. The in-prison treatment staff will double and the program's annual capacity will expand from 250 to 500 women.

In prison, 60 women will start the intensive treatment program every 6 weeks, entering closed groups of 15 each. These groups will experience all six components of the program, which are: recovery education, relapse prevention, women's workshops, Reasoning and Rehabilitation, 12-Step groups, and case management. In California, prison inmates are required to work 8 hours per day. The Forever Free participants receive 4 hours of work credit for the time they spend in treatment and, in addition, work 4 hours a day. Twenty program participants receive random drug testing each week, with additional urine testing performed if drug use is suspected. Over the life of the program, the overall rate of positive urines has been less than 2 percent among program participants.

Under the planned expansion, 50 percent of Forever Free participants will have access to 6 months of community aftercare through contracted treatment slots. The expanded program offers community aftercare placement in any California county, whereas the original placement program offered community aftercare in just four targeted southern California counties. Based on the availability of local county funding, it will be possible to make additional community referrals.

Over the program's 6-year history, three separate outcome evaluations have looked at program effectiveness. Results have consistently indicated that length of time in treatment relates to success on parole, and that best outcomes occur when in-prison

treatment is combined with 5 months or more of community aftercare. More than 91 percent of entering participants have completed the in-prison program. The dropout rate has been less than 6 percent, with 3 percent of participants removed for logistical or judicial reasons. Results indicate that 38 percent of program dropouts were successful on parole compared to a success rate of 62 percent among program graduates, of 72 percent among program graduates who enter residential community treatment, and of 90 percent success on parole among program graduates who remain in residential aftercare for 5 months or more.

Contact: Angela Knox or Dick Jeske, Forever Free Program Coordinators, California Institution for Women, 16756 Chino Corona Road, Frontera, California 91720, phone 909-597-1771, ext. 6570, fax 909-597-7596.

Recovery In Focus Program, Salem, Oregon

This 6-month pre-release day treatment program is a modified TC serving incarcerated women who volunteer at Oregon Women's Correctional Center. The program provides substance abuse treatment services, as well as family and life skills to female inmates within 4 to 6 months of release. Goals are to promote treatment and recovery; prevent recidivism, relapse, and homelessness; and to reunite women with their children. Pregnant women and women with children receive priority. Clients receive group and some individual therapy aimed at enhancing

family, parenting, and life skills, as well as providing tools for job searches, self-esteem, and self-empowerment. Women receive family and child visitations supervised by a family therapist.

The transition component includes such elements as individual release/relapse prevention planning, transitional leaves, work release, and an individually matched mentor. The mentor is a volunteer from the woman's home community who is assigned before the client leaves the Recovery In Focus Program. Volunteers, who make a 6-month commitment and receive training, serve as guides and role models as well as positive support persons for the women.

An outcome evaluation of In Focus clients found that those who complete the program have fewer subsequent arrests, fewer acts of absconding, and are better adjusted to community life than clients who do not complete the program (primarily because of institutional transfers) or than women offenders who need AOD treatment in prison but do not receive it (Finigan 1997). The study compared 211 women: 93 who had completed the program, 62 non-completers, and a comparison group of 56 women. In Focus was effective in referring women into community treatment and motivating them to complete it. Of program completers, 84 percent entered community treatment after their release and nearly half (46 percent) completed it, compared with 48 percent and 28 percent respectively for the comparison group.

During the 1-year period after release from prison, women who completed the In Focus program had significantly fewer rearrests for new crimes and fewer acts of absconding during parole—an act that signals not only loss of supervision but often the return to a criminal lifestyle. Data showed:

- **Program completers:** Only 30 percent had a new subsequent arrest, with 31 total acts of absconding per 100 participants
- **Program noncompleters:** 44 percent had a new subsequent arrest, with 101 total acts of absconding per 100 non-completers
- **Comparison no-treatment women:** 65 percent had a new subsequent arrest, with 121 total acts of absconding per 100 women who needed but did not participate in the In Focus program.

In the year after release, In Focus program completers, compared to the noncompleters and comparison women, had entered or participated in more community-based self-improvement programs and had made more efforts to gain employment, to be involved in training, or to gain financial stability.

Materials available: An information packet and guidelines for mentors in the aftercare program. Client materials include a self-rating behavioral assessment tool (for personal accountability), a behavioral treatment contract, AA/NA meetings attendance report form, recovery worksheets, and a personal release/relapse prevention discharge plan form.

Contact: Linda Clays, Recovery In Focus Program, 2809 State St., Salem, Oregon 97310, phone 503-373-1928, fax 503-378-8370.

Jail-based Demonstration Projects

Sisters in Sober Treatment and Empowered Recovery (SISTER) TC Program, San Francisco, California

The SISTER Program is a jail-based modified therapeutic community for women operated by the San Francisco Sheriff's Department in County Jail Number 8. The program, set in a separate pod in the jail, has a capacity of 56 clients; the average length of stay is 53 days. Clients have a presentence or sentenced status, and the program is voluntary. About 225 clients were served during the 1994-95 fiscal year.

Within this modified therapeutic community, a wide range of clinical and ancillary services are provided, including group and individual counseling; acupuncture 5 days a week; parenting programs; GED, literacy, and writing training; HIV education and counseling; and specific counseling for prostitutes in a group called "EX-SEX Workers Group." The program has special groups for lesbian and bisexual women; culturally specific groups for African Americans, Hispanics, and Pacific Islanders; and AA/NA meetings in the facility in both English and Spanish.

Clients are tested for drugs if staff suspect use.

Aftercare is an important component of the program. Pre-release planning includes vocational and educational assessment, job training, and relapse prevention work 5 days a week. Residential treatment is provided in the community for some women at Walden House, and residential treatment for pregnant women is provided in the community by Jelani House. The program is beginning new initiatives for women unable to access these limited community services, including an outpatient alumnae group that will meet in the evenings and a SISTER support group.

A 3-year outcome evaluation of the SISTER Program concluded that this "in-custody jail-based substance abuse treatment is effective in decreasing substance use and decreasing the involvement of women in the criminal justice system due to substance abuse problems" (Santiago et al. 1996). This study analyzed the county arrest records of 146 out of 811 participants at 1 year after their successful discharge from the SISTER program. To analyze recidivism factors, the evaluation team studied 104 women who went through SISTER, looking at rearrest data 1 year after the women were discharged from the program. The program was most effective for African-American women between 30 and 40 years of age who had substance abuse problems but were not diagnosed with severe depression. Findings included:

- **Decrease in recidivism.** Women treated in the SISTER program were rearrested 50 percent less often than comparison group women. In addition, there was a longer period before rearrest for the SISTER women than for the comparison group.
- **Decrease in violent crimes.** The SISTER women were rearrested for less severe or violent crimes than the comparison group women. The program was also effective in reducing drug-related crimes.
- **Importance of post-release treatment.** The SISTER participants who were most successful were those who went to a community residential treatment program after discharge from the SISTER program.

The evaluators found that women who received acupuncture and participated intensively in treatment program activities were less likely to be rearrested.

Materials available: A program manual. Also an introductory booklet for women entering the SISTER Project titled "SISTER Project ABCs," which contains a warm and welcoming explanation about women's treatment and the caring family environment the program provides, as well as program/contract rules and worker assignments.

Contact: Ramona Massey, Program Director, SISTER Project, SISTER Project/Sheriff's Department, 425 Seventh Street, San Francisco, California 94103, phone 415-522-8000, fax 415-522-8056

Stepping Out TC Project, San Diego, California

This in-custody residential treatment program for women is operated at Las Colinas Detention Facility by the Community Connection Resource Center. Stepping Out is a 64-bed modified therapeutic community for sentenced inmates who have a minimum of 50 days remaining to serve. Women average 62 days in treatment, but have stayed as long as 179 days. The program is eclectic in design, incorporating elements of the TC and social model modalities in a cognitive behavioral framework.

The women participate in educational and process groups and receive individualized case management services. Elders in the program assist with orientation, housekeeping duties, and other assignments. The program's own registered nurse provides comprehensive medical screening, tests for STDs and other communicable diseases, and health education. Two deputies are assigned to the program, who assist with screening and movement of the inmates. Recommended levels of treatment following release are assessed by the Adult Substance Abuse Survey (ASUS) and the Level of Supervision Inventory (LSI), combining substance abuse severity and criminogenic factors. These instruments serve as a guide for treatment planning. Aftercare case managers facilitate transition into the community, driving participants from the jail at release to their appointed destinations. The Stepping Out Project uses bilingual program materials.

Stepping Out operates an aftercare component which provides intensive outpatient treatment services and sober living. Up to six Stepping Out participants can live in the program's own women's sober living house, or be placed in other sober living environments paid for by the program for the first 30 days. The program provides a holistic continuum of care facilitated by Community Connection's extensive service network for offenders in San Diego County. Additional services for Stepping Out clients include job development and placement assistance, referrals to supportive services, clean and sober recreation, and "Freedom 1st," the agency's mutual-help group created by and for ex-offenders.

An outcome evaluation was conducted for 174 women inmates who participated in the Stepping Out program between August 15, 1994 and August 15, 1995 (Paredes 1997). The study used criminal justice followup data for 1 year after participants' release. Outcomes were compared with those for a comparison group of 52 inmates who met the same basic criteria as Stepping Out participants, but who had not received AOD treatment in jail.

The evaluation showed a marked improvement in the arrest rates of women participants in months 4 through 12 of the followup period. The Stepping Out participants who had continued into community aftercare after their release were significantly less likely to be arrested and, if arrested, were less likely to be found guilty and

convicted of their alleged crimes. The provision of clean and sober housing for the first month and a half of aftercare significantly increased a woman's total time in treatment. Women who were provided only with aftercare treatment stayed in treatment for an average of 33 days. Women provided with both aftercare treatment and safe and sober housing stayed in treatment for 80 days, more than double the time for those in aftercare alone.

Contact: Anita Paredes, Deputy Director, Community Connection Resource Center, 4080 Centre Street, San Diego, California 92103, phone 619-291-4790; fax 619-291-4704

OPTIONS TC Program, Philadelphia, Pennsylvania (a family-oriented program affiliated with CSAT's Target Cities grant program)

More than 8 of every 10 women offenders in the Philadelphia county jail system are chemically dependent. Since October 1992, more than 1,500 offenders have received intensive treatment in this nontraditional, 70-bed TC specifically designed for women. This TC employs a communal, noncompetitive approach instead of a more traditional hierarchical TC structure. The Center encourages clients to share leadership and responsibility in nonauthoritarian and nonabusive ways. Program committees give participants a chance to exercise leadership and practice cooperation.

Clients are referred to the Center by the courts, by social workers or other staff, and through self-referral. Each potential client is assessed for chemical

use/misuse/abuse, psychiatric problems, and the woman's ability to handle the intense TC experience. Women enter the program at any time through a Newcomers group. This group allows staff to assess each new client's needs and adjustment problems and to determine suitable placement.

The program's treatment structure—a series of 8-week cycles—is designed to fit the rapid turnover in a county prison population. Cycles are built around recovery and other issues, although some concerns remain constant (e.g., abuse, self-image, parenting, and codependency). Clients can enter at any stage in any cycle. Group therapy is the principal mode of treatment, supported by individual counseling and 12-Step meetings. Clients eligible for an early release program may also receive family therapy. An innovative video therapy project is used to enhance self disclosure, family reunification, and relapse management skills.

During incarceration, clients receive a wide array of services from other components of the Philadelphia Prisons System. An outreach coordinator provides for community resources, including education and services. In addition, a multi-agency, early parole project called Forensic Intensive Recovery provides access to community treatment slots for female offenders with substance abuse problems.

Materials available: Program contract and rules, cycle materials, information related to the special video project, and smoke-cessation materials.

Contact: Deborah Raddock, Director, OPTIONS Program, Philadelphia Industrial Correctional Center, 8301 State Road, Philadelphia, Pennsylvania 19136, phone 215-685-7111; fax 215-685-7199

Incarcerated Women's Recovery Program, Seattle, Washington

This short-term, intensive program for women is housed in the North Rehabilitation Facility, a Seattle detention center. Average length of stay in the program is 14 to 17 days, although the model is designed for stays of 90 days or more. In 1995 approximately 1,000 women were admitted to the facility, and about 400 were involved in the Women's Recovery Program. Up to 39 women can be provided substance abuse services at one time.

The primary treatment modality within the institution is "out-patient care," with a focus on reducing recidivism. There is a special treatment group for chronic recidivists. Readiness for treatment is a major issue. Services include group counseling for substance abuse, chemical dependency education, relapse prevention, 12 step groups, anger management, an STD outreach project (including testing and on-site treatment), family counseling, adult basic education, GED testing and preparation for testing, general medical health services, acupuncture, mental health counseling, and housing placement assistance. Clients are tested for drugs if staff suspect use.

The program uses a 5-day "triage" process to assess clients. On day 1, clients fill out a two-page triage form. If necessary, a

multi-page assessment is conducted in one or more topic areas. A four-person triage team—made up of three chemical dependency counselors and an employment development specialist—meets every day, reviewing all new admissions. The team looks for chemical dependency and vocational, educational, and mental health issues, among others. On day 2, the client receives a case manager and recommendations for programs and on days 3 and 4, she receives a detailed program briefing. A client begins classes on the fifth or sixth day.

The program has designed transition services that minimize service interruption. The case management strategy is to link the client to a community-based substance abuse provider. Residential treatment is provided at one facility and outpatient treatment at three locations. The program pays for some of these placements. In addition, two mental health counselors and a housing counselor begin working with the clients while they are in the institution, and continue to work with them while they are in the community.

Materials available: Cognitive-based women's program curriculum based on stages of change and mastery of skills; participant materials for a group concerning "boosters" (chronic shoplifters).

Contact: Lucia Meijer, North Rehabilitation Facility, 2002 N.E. 150th St., Building No. 23, Seattle, Washington 98155, phone 206-296-6826, fax 206-296-7585

Women's Acupuncture and Awareness Center, Baltimore, Maryland

This short-term, 2-week intensive intervention program targets female substance abusers who are awaiting trial in the Baltimore City Detention Center (BCDC), primarily for drug-related offenses. Inmates selected for the program are those with less extensive histories of drug use and crime, who are likely to be released back to the streets at the time of trial.

Whenever possible, the women live in a single dormitory while they participate in the program, which combines structured individual and group rehabilitation services with acupuncture treatment 5 days per week. The program uses a short-term educational, skills-building, and motivational model, with special emphasis on enrolling women in commu-

nity substance abuse services after their release. Twelve women participate in each cycle, and currently, 90 percent of participants graduate. More than 600 women graduated from the program between August 1993 and August 1995.

The daily psychosocial sessions address not only drug dependency, but related issues that the women must resolve if they are to achieve long-term improvement. Educational groups focus on such relapse prevention skills as anger management, assertive communication, drug refusal skills, and daily planning. In addition, clients participate daily in a 1-hour group therapy session to process women's issues and concerns related to recovery. Finally, each client participates in a minimum of five individual counseling/case management sessions for treatment and after-care planning with her assigned master's-level therapist.

Women who remain incarcerated at the Detention Center after this intensive treatment receive aftercare. This aftercare includes a weekly acupuncture group and twice-weekly psychosocial groups that focus on motivating the women to enter post-release treatment in the community. When released, many graduates receive supportive services and sentencing inducements, with most aftercare provided by the Johns Hopkins Hospital Comprehensive Women's Center. Clients initially participate in an intensive day treatment program and graduate to less intensive care based on attendance, evidence of drug abstinence, and progress on critical goals of their individual treatment plans.

Contact: Mary E. McCaul, Ph.D., Comprehensive Women's Center, 911 N. Broadway, Baltimore, Maryland 21205, phone 410-955-5439, fax 410-955-4769.

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Resource List

The nine CSAT-supported women's treatment programs in prisons and jails were asked to suggest materials used in their programs that could be helpful to others. This Resource List presents a variety of materials recommended by the CSAT-supported programs for use both by treatment program staffs and by women participants in treatment programs.

Program Materials (Training Guides, etc.)

Clinical Issues/Training Manuals

Covington, S. S. *Helping Women Recover*. A PROGRAM FOR TREATING SUBSTANCE ABUSE, SPECIAL EDITION FOR USE IN THE CRIMINAL JUSTICE SYSTEM. Includes facilitator's guide and workbook. For ordering and cost information, contact Jossey-Bass Publishers, telephone 800-956-7739, fax 800-605-2665. Internet address: <http://www.josseybass.com>

A step-by-step guide that offers mental health professionals tools to implement an integrated treatment approach to substance abuse and issues of trauma recovery. The Helping Women Recover program is designed to be implemented in a closed group of six to eight participants.

Covington, Stephanie S. *Helping Women Recover*. A PROGRAM FOR TREATING SUBSTANCE ABUSE. SPECIAL EDITION FOR USE IN THE CRIMINAL JUSTICE SYSTEM, A WOMAN'S JOURNAL. For ordering and cost information, contact Jossey-Bass Publishers, telephone 800-956-7739, fax 800-605-2665. Internet address: <http://www.josseybass.com>

A coordinated workbook created to help participants through the healing process. It addresses the special concerns and issues of substance-abusing women in correctional settings.

DiClemente, C.C., and Hughes, S.O. Stages of change profiles in outpatient alcoholism treatment. *Journal of Substance Abuse* 2:217-235, 1990.

National Institute on Alcohol Abuse and Alcoholism. *Cognitive-Behavioral Coping Skills Therapy Manual*. Project MATCH Monograph Series, Vol. 3, series editor, Mattson, M.E. Rockville, MD: NIAAA, reprinted 1995.

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing People To Change Addictive Behaviors*. New York: Guilford Press, 1991.

National Institute on Alcohol Abuse and Alcoholism. *Motivational Enhancement Therapy Manual*, by Miller, W.R.; Zweben, A.; DiClemente, C.C.; and Rychtarik, R.G. Project MATCH Monograph Series, Vol 2. Rockville, Maryland: NIAAA, reprinted 1995.

National Institute of Corrections (NIC). *Critical Issues in Managing Female Offenders*, 1997. A limited number of training manuals are available on loan from NIC. For information, call 1-800-877-1461.

National Institute on Alcohol Abuse and Alcoholism. *Twelve Step Facilitation Therapy Manual*, by Nowinski, J.; Baker, S.; and Carol, K. Project MATCH Monograph Series. Vol. 1. Rockville, Maryland: NIAAA, reprinted 1995.

Prochaska, J.O.; Norcross, J.C.; and DiClemente, C.C. *Changing for Good*. New York: William Morrow, 1994.

Time Out for Me. CSAT-sponsored curriculum for women on health and recovery issues. For ordering information, contact J. Randall Webber, Director of Training and Publications via e-mail at rwebber@chestnut.org or call toll free 1-888-547-8271 or 309-827-6026. Fax inquiries to 309-829-4661, or write to Lighthouse Institute, Chestnut Health Systems, 720 W. Chestnut Street, Bloomington, Illinois 61701. Internet Web site: <http://www.chestnut.org>

Legal Rights of Incarcerated Women

National Women's Law Center. *A Vision Beyond Survival: A Resource Guide for Incarcerated Women*, edited by B.V. Smith and C. Dailard. Washington, DC: the Law Center, 1995. For ordering and cost information, contact the National Women's Law Center, 11 Dupont Circle, NW, Suite 800, Washington, D.C. 20036, 202-588-5180.

Criminal Thinking

David Koerner, *Mind Over Matters Corrective Thinking*, 2-day, 3-day, and 5-day training courses. For ordering and cost information, contact Rogie Spon at 815-389-0127, or e-mail truthot@aol.com. Web site address on the Internet: <http://www.truthought.com>. Address: Truthought, P.O. Box 222, Roscoe, Illinois 61073.

National Institute of Corrections (NIC). *The Think Curriculum: Cognitive Interventions Program Manual and The Options Manual*. NIC can be contacted at 1860 Industrial Circle, Suite A, Longmont, Colorado 80501, or by telephone at 1-800-877-1461 or 303-682-0213. Internet address: <http://www.nicic.org>

Terence T. Gorski (CENAPS model of relapse prevention therapy for use in the criminal justice system): Catalog of materials and information on training. For course information, contact the CENAPS Corporation, 18650 Dixie Highway, Homewood, Illinois 60430, telephone 708-799-5000, fax 708-799-5032. For ordering and cost information, contact Herald House/Independence Press, P.O. Box 1770, Independence, Missouri 64055-0770, telephone 816-252-5010, fax 816-252-3976. Internet Web site address: www.heraldhouse.org

Participant Workbooks and Manuals

Cocaine Recovery Workbooks are a series of three workbooks by A.M. Washton that are designed to help recovering cocaine addicts handle the first 90 days of recovery, identify relapse prevention techniques, avoid "trigger" situations, and check on progress. The workbooks, *Quitting Cocaine*, *Staying off Cocaine*, and *Maintaining Recovery*, can be ordered on-line (Internet address: <http://www.hazelden.com>) or from Hazelden Educational Materials, P.O. Box 11, Center City, Minnesota, telephone 1-800-328-9000.

Quitting Heroin, by C.C. Nuckols, is a workbook that contains a collection of exercises that aid in identifying the people, places, and situations related to previous heroin use. The workbook helps to develop the insights and skills used in abstaining from heroin. Available on-line (Internet address: <http://www.hazelden.com>) or from Hazelden Educational Materials, P.O. Box 11, Center City, Minnesota, telephone 1-800-328-9000.

Walker, Jan. *Parenting from a Distance* (Danville, Illinois: Interstate, 1987), a text used for inmate students who are concerned with the impact of incarceration on their children, available in both English and Spanish, and *Parenting from a Distance: Your Right and Responsibilities/Answer Key* (Danville, Illinois: Interstate, 1987). These titles are available from on-line book sellers.

Case Management

Treatment Accountability for Safer Communities (TASC)
1911 N. Fort Myer Drive, Suite 900
Arlington, Virginia 22209
Telephone: 703-522-7214
Fax: 703-741-7698
E-mail : nattasc@aol.com

Staff Training

Criminal Justice-Substance Abuse Cross-Training: Working Together for Change. A curriculum developed by the Virginia Addiction Technology Transfer Center (VATTC) at Virginia Commonwealth University, with support provided by the Center for Substance Abuse Treatment. Order from VATTC, P.O. Box 980205, Richmond, Virginia 23298-0205, telephone 804-371-0775, fax 804-828-7862, e-mail: vattc@vcu.edu. Internet address: <http://views.vcu.edu/vattc>

Student Handbook: Therapeutic Community Counselor Training. Corrections Research Institute (CRI), October 1996. This 5-day counselor training package includes cross-discipline team building. Order from CRI, 7617 Park, Lenexa, Kansas, telephone 913-962-1075.

Trainer's Handbook: Therapeutic Community Counselor Training. Corrections Research Institute (CRI). Order from CRI, 7617 Park, Lenexa, Kansas, telephone 913-962-1075.

Audio/Video Series; Pamphlets

Beat the Streets: Clean and Sober in the City, a five-part video series on relapse prevention for urban recovery and chemical dependence. Ordering information: FMS Productions, Inc., 5320 Carpinteria Avenue, No. D, Carpinteria, CA 93013-2107, telephone 1-800-421-4609, 805-684-7891; fax 805-684-0889.

Beyond the Looking Glass, VHS, 28 minutes, 1994. Available from Hazelden. Internet address: <http://www.hazelden.org>, telephone: 1-800-257-7800. Note that other potentially relevant videotapes are also available from Hazelden.

Commitment to Change: Overcoming Errors in Thinking, a three-part video series with accompanying workbooks by S.E. Samenow. To order, contact FMS Productions, Inc., 5320 Carpinteria Avenue, No. D, Carpinteria, CA 93013-2107, telephone 805-684-7891, toll free telephone 1-800-421-4609, fax 805-684-0889.

Family Trap, VHS. Order from Hazelden, Internet address: <http://www.hazelden.org> or call 1-800-257-7800.

A Framework for Breaking Barriers: A Cognitive Reality, 9-part video series with accompanying workbooks, produced and distributed by Gordon Graham and Company, Inc. To order on-line from the Gordon Graham Company, visit the Web site: <http://www.ggco.com/recovery.htm>. Mailing address: Gordon Graham Company, P.O. Box 3927, Bellevue, Washington 98004, e-mail: automag@pop.nwlink.com, telephone 1-800-875-3530.

A Framework for Recovery, 6- and 12-part video series with accompanying workbooks; produced and distributed by Gordon Graham and Company, Inc. To order on-line from the Gordon Graham Company, visit the Web site: <http://www.ggco.com/recovery.htm>. Mailing address: Gordon Graham Company, P.O. Box 3927, Bellevue, Washington 98004, e-mail: automag@pop.nwlink.com, telephone 1-800-875-3530.

Healing From Childhood Sexual Abuse: A Recovering Woman's Guide, by K.A. Kunzman. A pamphlet that deals with the flashbacks, grief, and shame that women face as they heal from incidents of childhood sexual abuse. Available from Hazelden, Internet address: <http://www.hazelden.org> or call 1-800-257-7800.

Healing the Wounds of Incest, VHS, 54 minutes—four women and one man, all victims of incest, speak of their experiences as children and discuss the problems they have faced; *Domestic Violence, The Conspiracy of Silence*, VHS, 28 minutes—narrated by Kathleen Turner and featuring Denise Brown, this video outlines the problem of domestic violence and provides a model for workable solutions; and *Season of Hope*, VHS, 28 minutes—about recovering addicts who want to be responsible, nurturing mothers. Available from Pyramid Media, P.O. Box 1048/WEB, Santa Monica, California 90406, 1-800-421-2304 or 310-828-7577. Internet address: <http://www.pyramidmedia.com>; e-mail, info@pyramidmedia.com.

Living Skills Series: *Hygiene and Self-Care*, VHS, 20 minutes, 1993. *Looking for Work*, VHS, 20 minutes, 1989; *Making Decisions* VHS, 20 minutes, 1993; *Managing Money*, VHS, 20 minutes, 1993; *Refusal Skills*, VHS, 20 minutes, 1993; *Values and Personal Responsibility*, VHS, 20 minutes, 1993. Order from Hazelden, Internet address: <http://www.hazelden.org> or call 1-800-257-7800.

Shame, with Claudia Black, VHS, 30 minutes, 1989. Claudia Black defines shame as a chronic feeling of being defective. Recovery begins with identifying the shaming events and messages from childhood, walking through the pain, and allowing others to help in the process of reclaiming a healthy self-identity. Available from MAC Publishing, 321 High School Road NE, No. 346, Bainbridge Island, Washington 98110. Telephone: 1-800-698-0148, 206-842-6303, fax 206-842-6235. Also available from Hazelden, Internet address: <http://www.hazelden.org> or call 1-800-257-7800.

Oxford Houses

Oxford House, Inc.
9312 Colesville Road
Silver Spring, Maryland 20910
Telephone: 301-587-2916
Fax: 301-589-0302
Internet address: www.icagroup.org

Oxford House is a concept in recovery from drug and alcohol addiction. In its simplest form, an Oxford House describes a democratically run, self-supporting, and drug free group home. Parallel to this concept lies the organizational structure of Oxford House, Inc. This publicly supported, nonprofit 501(c)3 corporation is the umbrella organization that provides the network connecting all Oxford Houses and allocates resources to duplicate the Oxford House concept where need arises. Oxford Houses include men's houses, women's houses, and houses for women with children.

Screening and Assessment Instruments

For general information on assessment and evaluation instruments:

The ERIC Clearinghouse on Assessment and Evaluation
Educational Resources Information Center

Web site: <http://ericae.net>

The Catholic University of America

210 O'Boyle Hall

Washington, DC 20064-4035

Telephone: 800-848-4815; 614-292-4353

DSM-IV

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, DC: American Psychiatric Association, 1994. See also "Appendix G—DSM-IV Criteria for Substance-Related Disorders," in the Center for Substance Abuse Treatment's *Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients*. Treatment Improvement Protocol (TIP) Series, No. 10. DHHS Pub. No. (SMA) 94-3004, Rockville, MD: CSAT, 1994. TIPs can be ordered from the National Clearinghouse for Alcohol and Drug Information (NCADI), 800-729-6686 or 301-468-2600.

Addiction Severity Index (ASI)

The Addiction Severity Index (ASI) is a multidimensional, 161-item structured interview that takes approximately 45 minutes to complete and score.

To obtain electronic, disk, or paper copies of the various editions of the ASI instrument, as well as supplementary materials, contact the Treatment Research Institute at the University of Pennsylvania via the ASI help line: 800-238-2433. These materials will be provided for the cost of shipping and handling.

The developer of the ASI form and administration manual is:

A. Thomas McLellan, Ph.D.

Department of Psychiatry

University of Pennsylvania

Philadelphia, PA 19104

215-823-6095

ASAM Patient Placement Criteria

American Society of Addiction Medicine

4601 N. Park Avenue

Chevy Chase, MD 20815-4519

Telephone: 301-656-3920

The following books are available through ASAM:

American Society of Addiction Medicine (ASAM). *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders*, by Hoffmann, N.G.; Halikas, J.A.; Mee-Lee, D.; and Weedman, R..D.

American Society of Addiction Medicine (ASAM). *The ASAM Patient Placement Criteria*, 2nd ed. *Updating, Understanding and Using the Criteria*, by David Mee-Lee.

For more information about the ASAM criteria, the reader is also referred to CSAT's Treatment Improvement Protocol: *Guide to Substance Abuse Services for Primary Care Clinicians*, Lee Gartner and David Mee-Lee, Consensus Panel Co-chairs. Treatment Improvement Protocol (TIP) Series, No. 24. Rockville, MD: CSAT, 1998. See especially chapter 3, "Critique of Existing Criteria." To order, contact the National Clearinghouse for Alcohol and Drug Information (NCADI) 1-800-729-6686 or 301-468-2600. Also note that the Recovery Attitude and Treatment Evaluator (RAATE-CE for clinical evaluation) and RAATE-QI (questionnaire I) are assessment of severity tools designed for compatibility with the ASAM Patient Placement Criteria. See the listing later in this section.

Beck Depression Inventory (BDI)

The Beck Depression Inventory is a 21-item, paper and pencil self-report depression rating scale that requires about 15 minutes to complete.

The manual and 25 record forms cost \$41 and may be ordered from:

The Psychological Corporation
555 Academic Court
San Antonio, TX 78204
Telephone: 800-228-0752

Minnesota Multiphasic Personality Inventory (MMPI)

Order from:

National Computer Systems
P.O. Box 1416
Minneapolis, MN 55440
Telephone: 1-800-627-7271, ext. 5151
Web site: <http://www.ncs.com>

Multidimensional Addictions and Personality Profile (formerly Compass), by John Craig. An assessment tool for addictions and a screening tool for life skills and psychological issues.

Order from:

Diagnostic Counseling Services
P.O. Box 6178
Kokomo, Indiana 46904-6178
Telephone: 1-800-292-4968

Recovery Attitude and Treatment Evaluator

Clinical Evaluation (RAATE-CE) and Questionnaire I (RAATE-QI)

The RAATE-CE and RAATE-QI are assessment of severity tools designed for compatibility with the ASAM Patient Placement Criteria. The RAATE-CE is a 35-item structured interview that requires approximately 20 to 30 minutes. The RAATE-QI is a 94-item self-report that takes patients about 30 to 45 minutes to complete.

The tools may be ordered from:

New Standards, Inc.
1080 Montreal Avenue, Suite 300
St. Paul, MN 55116
Telephone: 800-755-6299
Fax: 612-690-1303

The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). Used to assess readiness and commitment to change.

Author: William R. Miller

Distributor:

William R. Miller

Department of Psychology

University of New Mexico

Albuquerque, New MM 87131

Symptom Checklist-90-Revised (SCL-90-R)

Author: Leonard R. Derogatis

Contact:

National Computer Systems

Telephone: 1-800-627-7271, ext. 5151

Fax: 612-939-5199

Web site: www.ncs.com/assessments

Resource Centers on Women's Materials

National GAINS Center for People With Co-Occurring Disorders in the Justice System (GAINS)

262 Delaware Avenue

Delmar, New York 12054

Telephone: 1-800-311-GAIN and 518-439-7415; fax 518-439-7612

Internet address: <http://www.prainc.com>

The GAINS Center is supported by the Center for Substance Abuse Treatment, the Center for Mental Health Services, and the National Institute of Corrections. The GAINS Center can provide resources, information, and technical assistance documents on women with co-occurring disorders in the criminal justice system. A new resource is the *Women's Program Compendium*, a comprehensive guide to the 54 programs that offer services to women in the criminal justice system who have co-occurring mental health and substance abuse disorders. The *Compendium* is organized by State.

National Women's Health Information Center (NWHIC)

Operated by the U.S. Department of Health and Human Services

Monday through Friday: 9 a.m.–6 p.m. EST

Telephone: 1-800-994-WOMAN

Internet address: <http://www.4woman.org>

The National Women's Health Information Center (NWHIC) is sponsored by the U.S. Public Health Service's Office on Women's Health, with support from a number of different Federal agencies. NWHIC is a one-stop gateway for women's health resources and materials for consumers and professionals; it has an extensive Web site. The Web site delineates the Federal approach to women's health and includes a section on women of color.

The Stone Center

Wellesley College

106 Central Street

Wellesley, Massachusetts 02481

Telephone: 781-283-2500

Internet address: <http://www.wellesley.edu/WCW/scsub.html>

The Stone Center can provide a wide variety of inexpensive materials that concern the treatment of women, including working papers, audiotapes, books, videotapes, and project reports. Materials are available on such topics as the relational development of women, anger/depression/shame, diversity, family relationships/adolescents/children, gender relations, lesbian relationships, and power/effectiveness.

Drug-Related Federal Clearinghouses

***National Clearinghouse for Alcohol
and Drug Information (NCADI)***

1-800-729-6686

301-468-2600

Operated by the Center for Substance Abuse Prevention (DHHS)

Monday through Friday: 9 a.m.–6 p.m.

Internet address: <http://www.health.org>

NCADI disseminates a wide range of materials on drug education, prevention, and treatment, including Federal Government publications, fact sheets, posters, audiovisual materials, prevention curricula and program descriptions, comprehensive prevention resource guides, and articles. The clearinghouse maintains an extensive full-service library and coordinates the Regional Alcohol and Drug Awareness Network (RADAR), which facilitates access to State and local sources of information about alcohol and other drugs.

CDC National Prevention Information Network

1-800-458-5231

Monday through Friday: 9 a.m.–6 p.m. EST

Internet address: <http://www.cdcnpin.org>

The CDC National Prevention Information Network (NPIN) is a national reference, referral and distribution service for information on HIV/AIDS, sexually transmitted diseases (STDs), and TB, sponsored by the Centers for Disease Control and Prevention (CDC). All of NPIN's services are designed to facilitate the sharing of information and resources among people working in HIV, STD, and TB prevention, treatment, and support services. NPIN staff serve a diverse network of people who work in international, national, State, and local settings.

Drug Abuse Information and Treatment Referral Line

1-800-662-HELP

Operated by NIDA and the Center for Substance

Abuse Treatment (DHHS)

Spanish: 1-800-66-AYUDA

Monday through Sunday: 24 hours a day

Internet address: <http://www.health.org>

Provides information about drug use, treatment support groups, and services. Information counselors can discuss problems and provide referrals to State and local drug treatment facilities and programs.

National Criminal Justice Reference Service (NCJRS)

Operated by the National Institute of Justice (DOJ)

Monday through Friday: 8:30 a.m.–7 p.m.

Nonoperational on Thursdays 8-9 a.m. EST

Internet address: www.ncjrs.org**1-800-851-3420, ext. 8****301-519-5000**

Provides information and data on drug testing; drug control enforcement; sentencing and corrections policies for drug offenders; drug abuse prevention and treatment in criminal justice settings; drug-related crime; research evaluation strategies; and specialized bibliographic searches. NCJRS maintains a library, a large computerized database and microfilm collection, and a special resource package and compact disc (CD-ROM) library on drugs and crime. Clearinghouse resources and activities can also be accessed through the NCJRS electronic bulletin board at 301-738-8895.

ONDCP Drug Policy Information Clearinghouse

Operated by the Office of National Drug Control Policy (ONDCP)

Fax: 301-519-5212

Monday through Friday: 8:30 a.m.–5:15 p.m.

Internet address: <http://www.whitehousedrugpolicy.gov>**1-800-666-3332, press 2**

Collects, analyzes, and distributes data on drugs and crime, with a special emphasis on serving the data needs of State and local government agencies. The Clearinghouse offers access to a library and specialized bibliographic data bases, including Federal drug data sources and special reports on drugs and crime. The Center provides free an updated directory of contacts at State agencies concerned with drug abuse. Order *State Drug Resources: 1994 National Directory* (NCJ-147709). An updated version, *State Drug Resources: 1997 National Directory*, is available on-line only at the Internet address listed above. The Clearinghouse offers documents on women and housing.

Other Sources of Drug Abuse and Criminal Justice-Related Information

Anti-Drug Information Center

Operated by the Department of Transportation (DOT)

Computer modem: 1-800-225-3804

Monday through Sunday: 24 hours a day

Internet address: <http://www.dot.gov/ost/dapc>**1-800-225-3784****202-366-3784****Fax: 202-366-3897**

Provides immediate access to all regulatory information related to DOT's antidrug programs. Phone menus offer summaries of antidrug regulations, answers to commonly asked questions, a current list of certified drug-testing labs, a free catalog listing documents available via fax, and mail or fax delivery of specific documents.

BJS Clearinghouse

Bureau of Justice Statistics Clearinghouse

P.O. Box 179, Dept. BJS

Annapolis Junction, Maryland 20701-0179

Internet address: <http://www.ojp.usdoj.gov/bjs/>**1-800-732-3277****Fax: 1-410-792-4358**

Operated by the Bureau of Justice Statistics (BJS). This Clearinghouse is a component of the National Criminal Justice Reference Service. It provides criminal justice statistical information.

Juvenile Justice Clearinghouse

1-800-638-8736

P.O. Box 6000

Rockville, Maryland 20849-6000

Internet address: <http://www.ncjrs.org>

Operated by the Office of Juvenile Justice and Delinquency Programs, Office of Justice Programs, Department of Justice.

National Evaluation Data and Technical Assistance (NEDTAC)

1-800-7-NEDTAC

1-703-385-3200

10530 Rosehaven Street, Suite 400

Fairfax, Virginia 22030

Fax: 1-703-385-3206

Internet address: <http://www.calib.com>

The mission of the National Evaluation Data and Technical Assistance Center (NEDTAC) is to develop and implement a program evaluation system and evaluation resource center that will enhance substance abuse treatment service delivery and effectiveness. NEDTAC serves CSAT staff, CSAT grantees, and substance abuse treatment evaluators. NEDTAC products include bibliographies and reference papers that can be downloaded through its Web site.

Appendix—List of Reviewers

Consultant Reviewers

Mary E. McCaul, Ph.D.
Consultant
Comprehensive Women's Center
Baltimore, Maryland

Cassandra F. Newkirk, M.D.
Consultant
Caldwell, New Jersey

Field Reviewers

Virgil Barrett
Program Analyst
Department of Public Health
Coordinating Office for Drug
and Alcohol Abuse Programs
Philadelphia, Pennsylvania

Margaret L. Beaudry
Director of Research
Drug Strategies
Washington, D.C.

Barbara Bloom, Ph.D.
Consultant
Barbara Bloom & Associates
Petaluma, California

Sandra Buell
Treatment Administrator
Arkansas Department of
Community Punishment
Little Rock, Arkansas

Linda Clays, CADC II
Program Coordinator
Tualatin Valley Centers
Salem, Oregon

Stephanie Covington, Ph.D.,
L.C.S.W.
Co-Director
Institute for Relational
Development
La Jolla, California

Bonnie Cypull, M.S.W.
Manager of Treatment
Enhancement Projects
Baltimore Substance
Abuse Systems
Baltimore, Maryland

Marilee L. Dal Pra
Project Director
Maricopa County Adult
Probation Department
Phoenix, Arizona

Laura DeRiggi, L.S.W.
Clinical Coordinator
Coordinating Office for Drug
and Alcohol Abuse Programs
Philadelphia, Pennsylvania

Gwen Empson, B.A., CAC,
CADC
Program Director
Delores J. Baylor Women's
Correctional Institution
WCI Village TC Program
Correctional Medical Services
New Castle, Delaware

Ernest Jarman
Project Director
Office of Substance
Abuse Programs
California Department
of Corrections
Sacramento, California

Ramona Massey
Program Director
Sisters in Sober Treatment
Empowered in Recovery
(SISTER) Program
San Francisco, California

Kathleen L. Mayer
Program Manager
York Correctional Institution
Niantic, Connecticut

Lucia Meijer
Project Director
Incarcerated Women's
Recovery Program
North Rehabilitation Facility
Seattle, Washington

Anita Paredes, M. Ed.
Deputy Director
Community Connection
Resource Center
San Diego, California

Elizabeth Peyton
Consultant
Newark, Delaware

Deborah Raddock, M.A.
Director, Treatment
Philadelphia Industrial
Correctional Center
Philadelphia Prisons System
Philadelphia, Pennsylvania

Pamela F. Rodriguez, M.A.
Director of Program Services
Treatment Alternatives for
Safer Communities (TASC)
Chicago, Illinois

Michal Rubin, Ph.D., MAC
Consultant
Columbia, South Carolina

Glenda Spratt
Grants Coordinator
Arkansas Department
of Community Punishment
Little Rock, Arkansas

Barbara Hanson Treen
Executive Director
WomenCare, Inc.
New York, New York

Beth A. Weinman
National Drug Abuse
Programs Coordinator
Federal Bureau of Prisons
Washington, D.C.