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Drug-Abusing Women Offenders: Results of a National Survey

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In recent years, women, particularly women arrested on drug charges, have constituted the fastest growing population within the criminal justice system. From 1982 to 1991, the number of women arrested for drug offenses, including possession, manufacturing, and sale, increased by 89 percent.[1] The increasing arrest rate for women has been accompanied by a corresponding rise in the number of women offenders under community supervision or incarcerated in jail or prison.

Although drug offenses constitute only 7 percent of the charges for which women are arrested and about 12 percent of the crimes for which they are incarcerated in prisons, these numbers are deceptively low as indicators of drug involvement by women offenders.[2] Results of the National Institute of Justice's (NIJ's) Drug Use Forecasting (DUF) program, which interviews arrestees in more than 20 cities around the Nation, show that the majority of women interviewed, regardless of charge, test positive for at least one illicit drug.[3] These findings are expected, since a high proportion of the income-producing, nondrug crimes for which women are arrested—fraud, larceny, burglary, and prostitution—are committed, in part, to support drug habits.[4]

Although significant percentages of drug-abusing women offenders are in jail, prison, or under community supervision, little is known concerning their specific service needs. In 1987, 87 percent of State

Issues and Findings

Discussed in this Brief: A national survey in 1992–1993 of drug abuse treatment programs for women offenders funded by NIJ. The survey focused on issues of assessing drug-abusing women offenders' needs and services in community and custodial treatment programs.

Key issues: Drug-abusing women offenders constitute one of the fastest growing segments within the criminal justice system. Little is known regarding their specific needs since very few drug-abusing women offenders receive treatment in custody or in the community, and little is known about how treatment programs assess needs and conduct treatment services.

Key findings: Highlights of survey results include:

- More treatment programs are available than in the past, but they have not reduced the difference between those women who need and those who receive drug treatment services.
- Many programs do not assess the multiple problems of the drug-abusing women offender population and fail to address them with suitable services.
- Treatment provided by the programs surveyed is usually limited in intensity and duration.
- Services offered for women drug abusers are mostly found in women-only programs rather than both-sex programs.

Implications of these findings for changes in policy and practice include:

- More coordinated efforts among Federal, State, and local agencies are needed to research and implement improved treatment and related services for drug-abusing women offenders.
- More programs that provide continuing support for women are needed to enable a transition from treatment to independent living in the community; such support includes training in personal empowerment, as well as vocational training.
- More family services are needed, especially since few programs provide accommodations for infants and children; this deters drug-abusing women offenders from entering and continuing treatment.

Target audience: Local, State, and Federal legislators and agencies; policymakers; drug treatment program staff; law enforcement officials; community leaders; health care organizations; child protective services.

Characteristics of Drug-Abusing Women Offenders

To gain a picture of the special needs of drug-abusing women offenders, information was taken from several sources covering women arrestees, women incarcerated in jails and prisons, women offenders diverted into community-based treatment instead of incarceration or as a condition of probation or parole, and women in publicly supported drug treatment programs.[5] Provided below are characteristics of these women:

- Health problems. Many drug-abusing women are physically or mentally ill. All drug users, and cocaine users in particular, are at increased risk for extreme weight loss, dehydration, digestive disorders, skin problems, dental problems, gynecological and venereal infections, tuberculosis, hepatitis B, hypertension, seizures, respiratory arrest, and cardiac failure.[6]

- Educational/vocational background. Most of the women are unemployed or work at low-paying jobs. Most have not completed high school, have inadequate vocational skills, and lack many of the skills and knowledge needed to function productively in society.[7]

- Psychosocial problems. Drug-addicted women tend to come from families with a high incidence of mental illness, suicide, alcohol or drug dependence, violence, or are victims of incest, rape, or physical or sexual abuse.[8]

- Responsibility for parenting. Most drug-abusing women offenders are of child-bearing age, already have children, and are single mothers. Many of them receive little or no help from the children's father(s), lack supportive family and social networks, and have limited or no financial resources. Often their children become drug abusers themselves, thereby perpetuating both drug abuse and dysfunctional parenting across generations.[9]

- Drug use and treatment. Most drug-abusing women offenders started abusing drugs and alcohol at an early age, and many used drugs, especially cocaine, on a daily basis prior to incarceration. In one survey of women in prison, 46 percent of respondents reported they had used drugs and/or alcohol at the time of their offense.[10] Approximately 25 percent of adult women offenders have spent some time in a drug/alcohol treatment program, which, however, has most likely been of limited duration and intensity.[11]

- Criminal justice and child protective services involvement. A large percentage of drug-abusing women who seek treatment have had some involvement with the criminal justice system or with child protective services. One study reported that an estimated 60 to 80 percent of child abuse and neglect cases were from substance-abusing families.[12]

Although these characteristics have been found to typify the population of drug-abusing women offenders, they have different implications for programs. Individual women will differ in the manifestations and severity of these characteristics and attendant problems. Such diversity calls for an assessment of specific clients' needs and the provision of services designed to meet those needs. If a program lacks a well-developed assessment procedure, clients are less likely to receive appropriate services, such as treatment in a style matched to cultural identity and cognitive level and of adequate intensity and duration.

correctional institutions for women reported that 40 percent or more of their inmates needed treatment for drug problems at time of intake.[13] By all indications, few drug-abusing women offenders actually receive treatment, either in custody or in the community, and little information is available on how programs for women offenders determine needs, plan treatment, and perform services. This NIJ study conducted a nationwide survey of drug treatment programs for women offenders in the care or custody of the criminal justice system. The results, findings, and policy implications for improving treatment of drug-abusing women offenders are reported in this Research in Brief.

Survey approach

The survey, conducted in late 1992 and early 1993, was part of a larger study of criminal justice drug treatment programs for women offenders conducted by the University of California at Los Angeles (UCLA) Drug Abuse Research Center and the National Development and Research Institute, with funding from NIJ. Programs to be included in the survey were identified from a review of the literature, recommendations of colleagues, and a mailing to the directors of Treatment Alternatives to Street Crime projects and to the directors of State departments of corrections and State departments of alcohol and drug programs, asking them to identify drug treatment programs in their area that treated women offenders.[14] In all, 336 programs were identified through these sources.[15] Two questionnaire forms were mailed to these programs, one for community-based programs and the other for corrections-based programs. From the returned questionnaires, data were available for analysis on 165 community-based programs, 16 jail programs, and 53 prison programs. Information was received on programs in 40 States (including the District of Columbia).[16]

The survey aimed to increase the knowledge about needs assessment methods and services offered in community and custodial treatment programs serving drug-abusing women offenders, emphasizing the programs' methods for assessing women's needs and the services provided to meet the assessed needs. In addition, the survey identified programs for more indepth examination of needs assessment and services through site visits and personal interviews.[17] Results are reported separately for community-based programs and for custodial programs.

Results for community-based programs

Most responding community-based programs were either residential (55) or outpatient drug-free (77), followed by day treatment programs (24). The distinction between the outpatient drug-free (OP) and the day treatment (DT) modalities was not uniformly interpreted by respondents; some regarded OP as more intensive (providing more services and hours of treatment), while others viewed DT as more intensive. Consequently, they were

combined into a single modality (OP/DT). Thus, the two largest community-based treatment modalities, OP/DT and residential, accounted for 61 percent and 33 percent of the programs, respectively.

The remaining 6 percent of respondents were halfway houses (6) and methadone maintenance programs (3). The low number of methadone maintenance programs probably reflects the criminal justice agencies' reluctance to refer clients to methadone treatment.

Program characteristics

OP/DT programs had the largest clienteles (see table 1): the number of men and women in these programs averaged 141; the number of women averaged 48; and the number referred by the criminal justice system averaged 28. The average number of men and women in residential programs was 51; for women, 21; and for women referred by the criminal justice system, 14. The methadone maintenance programs averaged 79 clients, with an average of 29 women and 13 referred by the criminal justice system. Halfway houses had the fewest clients, and most were for women only; they had an overall average of 22 clients and an average of 19 women; approximately 50 percent had been referred by the criminal justice system. As indicated in table 1, there was a wide range in the number of people in the various types of treatment programs. Most of these programs (81 percent) provided treatment for both drug and alcohol abusers.

Program duration on average tended to be similar for residential and outpatient programs (both averaged 30 weeks), but the range in treatment duration was substantial: 1 to 105 weeks for the residential programs and 3 to 104 weeks for the outpatient programs. Day treatment programs averaged 25 weeks, ranging from 3 to 52 weeks. Halfway houses tended toward greater uniformity, with an average duration of 25 weeks and a range from 13 to 39 weeks. The methadone maintenance programs averaged 65 weeks and ranged from 26 to 104 weeks.

Interaction with the criminal justice system

Women referred into treatment by criminal justice agencies (see table 1) were usually referred by probation departments (31 percent) or by the courts (29 percent). The rest were referred by parole, prison, or jail. (Some clients were referred by child protective services, which some programs included in the criminal justice system referrals.) Most programs had formal arrangements with the criminal justice system (81 percent), which tended to encompass the criminal justice system inspection of the treatment programs' facilities, regular or as-needed meetings between the criminal justice system and program staff to resolve problems, and meetings on client progress. More than 70 percent of the programs reported that they had no major problems in dealing with the criminal justice system.

Client assessment

Since the purpose of this survey was to determine how treatment programs were assessing the needs of their clients and what services were available, it was assumed that all programs surveyed[18] were assessing drug use and obtaining drug treatment histories. However, the survey found less use of standardized instruments to assess drug use history than expected. As shown in table 2, most programs relied on the intake interview (about 90 percent) to assess drug abuse, supplemented by observation and client records; less than a third of the programs used locally developed or standardized instruments. For psychological assessment, standardized instrumentation was used in all of the methadone programs, but in just under 30 percent of the residential and outpatient programs. In general, most programs relied on the clinical intake interview for assessing most areas.

A small percentage of programs used examination by professional, medical/dental personnel to assess disease, infection, and other physical conditions requiring medical or dental treatment. However, as seen in table 3, women-only programs were more likely than both-sex programs to provide examination by professional personnel (60 percent versus 45 percent, respectively). The difference between women-only programs and both-sex programs in terms of professional examinations was more pronounced for OP/DT than for residential programs.

Treatment services

The survey requested respondents to indicate services that were regularly available to women offenders, both those provided by the treatment program and those arranged for by other agencies. Table 4 shows several similarities in service availability among the treatment modalities, including the near universal availability of case management, relapse prevention, HIV/AIDS education, counseling, and 12-step meetings. Most residential programs reported the availability of almost all services listed in the questionnaire.

Services related to women's special needs were of particular interest in this study. These services were not uniformly available across programs, but appeared to be available more often in women-only programs (see table 5). The following list highlights differences in the availability of services by program modality and gender mix:

- Nursery/child care facilities and live-in care for women and their children were found in less than 50 percent of the residential programs, but live-in care was much more available in residential than in outpatient programs. Nursery/child care facilities were more available in women-only OP/DT programs than in both-sex OP/DT programs.

- Approximately two-thirds of the residential programs and half of the outpatient programs made available prenatal, postpartum, obstetrical, and gynecological care.

- Family planning was offered in 78 percent of the women-only residential programs and in 70 percent of the outpatient programs. In the OP/DT programs, family planning was more available in women-only programs (68 percent) than in both-sex programs (47 percent).

- Training in parenting was available in 73 percent of the residential and 72 percent of the outpatient programs, with

women-only programs showing somewhat greater availability.

- More women-only OP/DT programs than both-sex OP/DT programs made other family life supportive services available; these services included training in hygiene and nutrition and group meetings for parents and children.

- Training in personal empowerment was available in 76 percent of the residential and 70 percent of all outpatient programs; 90 percent of the women-only OP/DT programs offered such training.

- All of the halfway houses provided services related to economic survival (education leading to the General Equivalency Diploma and vocational training); 78 percent of residential and 62 percent of outpatient programs offered education leading to the GED; and 69 percent of residential and 56 percent of outpatient programs offered vocational training.

- Transportation to hospitals, schools, and other places was available in 93 percent of the residential programs and in 83 percent of the halfway houses, but in only 44 percent of the OP/DT programs.

- Legal advice was offered by 51 percent of the residential and 42 percent of the outpatient programs.

- Assistance with post-discharge housing arrangements was offered in 80 percent of the residential and 46 percent of the OP/DT programs.

Transition and followup services

When women completed their formal treatment, most programs encouraged them to continue treatment on a less intensive basis, and the majority of programs encouraged them to begin or continue attendance at Anonymous Fellowship meetings (Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous) (see tables 4 and 5). However, where a greater outlay of resources was required to provide services, such as to arrange adequate housing, secure sources of income, maintain contacts, and provide support, more disparity in the services offered across modalities was observed. For instance, nearly three times as many residential as outpatient programs offered help in procuring housing and twice as many residential programs helped to secure income.

Residential programs and halfway houses were less likely than outpatient programs to offer immediate reentry to the treatment program after a client relapsed because they had limited housing space. Although some programs indicated that reentry was determined by space availability, others required a mandatory waiting period, presumably as a tenet of their treatment philosophy.

Results for custodial programs

Results from the custodial drug treatment programs are shown in tables 6 through 8. The survey methodology was the same as that for the community-based programs, although some of the questions differed to address special institutional characteristics of custodial programs.

Program characteristics

Information from 16 jail programs and 53 prison programs was available for analysis. The jail programs included five that were identified as therapeutic communities (TC's), three that were typical residential programs (non-TC), six that provided only a few hours of treatment per week, and two that were basically transition programs—clients were identified while they were in jail, but all or most treatment services were provided after their release into the community. Among the prison programs, 14 were identified to be TC's, 7 were residential (non-TC type) programs, 29 provided only a few hours of treatment per week, and 3 were transition programs.

Jail programs for women averaged 46 clients; prison programs averaged 58. Seventy percent of the jails and 45 percent of the prisons claimed they were able to treat all of the women who volunteered and who were eligible for treatment.

Jail programs averaged 19 weeks and ranged from 4 to 42 weeks, while prison programs averaged 24 weeks and ranged from 5 to 156 weeks. Jail programs averaged 20 hours of treatment per week (range 2 to 100 hours; mode 4 hours); prison programs averaged 21 hours (range 1 to 70 hours; mode 20 hours).

Most jail (75 percent) and prison (66 percent) programs had separate space within the institution to provide treatment services. Just under 50 percent of the custodial programs had separate housing for their clients. In 63 percent of the jails and 53 percent of the prisons, an external contractor provided the treatment program. Approximately 50 percent of the jails and 28 percent of the prisons indicated that there were major philosophical differences between correctional staff and drug treatment personnel. In most jails and prisons, survey respondents (mainly treatment staff) reported that the correctional administrators thought the treatment programs helped to maintain order and were effective in reducing recidivism and drug use.

Client assessment

Drug use history and drug treatment history were assessed in nearly all the drug treatment programs, primarily on the basis of the clinical intake interview. More prisons than jails used standardized instruments to obtain drug use history (34 percent of prisons compared to 19 percent of jails) and to assess drug treatment history (21 percent of prisons and 13 percent of jails).

Professional staff performed Medical and dental examinations in 56 percent of the jails and 60 percent of the prisons. One jail and six prisons surveyed indicated that medical conditions were not assessed at all.[19] Physical fitness was not assessed in 39 percent of the jails and 32 percent of the prisons; vocational skills were not assessed in 31 percent of the jails and 21 percent of the prisons. When assessment did occur in these two areas, it was provided mostly by clinical interviews or staff observation.

Treatment services

Similarities of treatment services in custodial programs were greater than their differences:

- Most jail and prison programs offered case management, relapse prevention,

HIV/AIDS education, counseling, and 12-step meetings.

- Training in personal empowerment was offered in all of the jail programs and in 75 percent of the prisons.

- More than 80 percent of the programs had groups dealing with specific issues such as sexual abuse, battering, and HIV-positive status. Psychotherapy was available in 50 percent of the jails and 77 percent of the prisons.

- Training in parenting was available in 69 percent of the jails and 74 percent of the prisons. Thirty-eight percent of the jails and 57 percent of the prisons provided family planning services.

- Accommodations for visiting children and infants were available in 63 percent of the jails and 85 percent of the prisons, but support groups for parents and children were available in only 25 percent of the jails and 36 percent of the prisons.

- Approximately 90 percent of the jails and prisons provided prenatal, postpartum, obstetrical, and gynecological care.

- Medical and dental exams and treatment were available in approximately 80 percent of the jails and in more than 90 percent of the prisons. HIV testing was available in 75 percent of the jails and 85 percent of the prisons.

- Vocational counseling was more available than vocational training (81 percent and 85 percent for counseling in jail and prison; 69 and 76 percent, respectively, for vocational training). Education leading to the GED and literacy classes/tutoring were generally available.

- Legal advice was available in 63 percent of the jails and 68 percent of the prisons.

Transition and followup services

As in the community-based programs, more than 90 percent of the programs provided transition by encouraging women to begin or continue attendance at Alcoholics Anonymous, Narcotics Anonymous, or Cocaine Anonymous meetings. More than 80 percent of the programs made arrangements for women to continue treatment in the community. More jail than prison programs said that women were contacted regularly after release, and that before release, arrangements were made for continuing social, medical, and welfare support, as needed. However, in both types of institutions, less than 50 percent offered these transition and followup services: 44 percent of the jails contacted clients after release and 50 percent made prior arrangements with community agencies for continued support; in prisons, the comparable percentages were 25 and 45 percent.

Transition services were coordinated with probation/parole officers before release in 25 percent of the jails and in 64 percent of the prisons; in 63 percent of the jails and 19 percent of the prisons, transition services were arranged by treatment staff only.

Discussion of findings

Results of surveys conducted over the past 14 years indicate that treatment programs for women offenders have been increasing:

- The National Institute on Drug Abuse (NIDA) 1979 survey identified 44 programs that met the selection criteria of publicly supported women-oriented drug treatment programs.[20]

- The National Council on Crime and Delinquency (NCCD) 1990 survey identified 111 community-based programs that provided services (but not specifically drug treatment) to women offenders exclusively (the selection criteria were more rigorous than the present survey since they specified that all clients had to be currently or previously involved with the criminal justice system).[21]

- The 1992–1993 survey reported in this study identified 165 community-based programs for women offenders.

Although more programs may be available for women offenders today than in the 1970's, evidence from other research[22] indicates that the increased number of programs have not significantly reduced the difference between those who need services and those who receive treatment. The percentage of those being served, relative to those in need, is probably not greater than it was in the late 1970's.

Treatment provided by the programs surveyed was usually found to be limited in intensity and duration. Although sufficient data on the effectiveness of highly intensive, well-designed programs of short duration are not available, evidence is available that shows that among programs in general, particularly residential programs, the effects of treatment are positively related to time in treatment.[23] The effectiveness of many of the surveyed programs that provide treatment of relatively short duration to a population with multiple needs, particularly programs that provide only a few hours of service a week, is questionable.

The survey found that although services for individual clients are supposed to provide for the special needs of women, many programs do not assess those areas known to be problematic for this population and fail to provide some of the services that these women require. It is notable that services needed by women are more likely to be found in women-only programs than in programs that serve both men and women. This finding suggests that the specific needs of women are an afterthought in many programs. Although the situation is changing, too many programs designed for men by men continue to exist.

In addition, relatively few programs accommodate infants and children since the facilities are costly and must meet special requirements in terms of space, neighborhood acceptance, insurance coverage, legal provisions, and staffing. Despite these hindrances, provisions for infants and children are important. Since many women cannot arrange adequate care for their children while they are in treatment, the absence of infant and child care in treatment programs becomes a major deterrent for them to enter and continue treatment. In cases where outpatient programs allow women to bring their children for limited periods but do not provide staff and facilities for the care of the children, mothers are prevented from receiving the full benefits of treatment activities because they need to attend to their children. Finally, the lack of provision for mothers and their children deprives these women of the valuable hands-on training experience of caring for their infants and children within the treatment program under expert supervision.

Implications for practice and policy

Since most drug-abusing women offenders are indigent, have multiple problems, and possess few personal and social resources, drug treatment alone, without an attendant, comprehensive range of rehabilitation services, can rarely effect stable, long-term behavioral change. Moreover, given the nature of drug dependence, which in the case of severe, long-term use—a characteristic of many women offenders—tends to be a chronic, relapsing condition, a single treatment episode is rarely sufficient to produce more than limited short-term benefits. Therefore, not only are more programs needed specifically geared toward rehabilitating women, but programs are also needed that provide continuing support for women to enable them to move from custodial to community care, or from intensive residential treatment to halfway houses or to cooperative living arrangements.

The study revealed the necessity to improve assessment of needs and then develop better programs to deliver a range of appropriate services. Assessment should enable program planners to determine what new services are needed, which services should be modified, and which are no longer relevant. The assessment process should also provide the basis for developing individual treatment plans, establishing a baseline from which progress in treatment can be monitored, and generating data for program evaluation.

Several Federal agencies and some State agencies have recently been active in promoting more and better services for women, but further direction and guidance are required to meet the needs of drug-abusing women, particularly drug-abusing women offenders. To achieve such improvements, many approaches should be taken:

Research

- Foster a collaborative effort among Federal, State, and local agencies and other organizations, including education agencies, the health policy research community, and health care services, to establish a research agenda.
- Focus research on such issues as:

— Identifying and describing basic aspects of drug treatment for women offenders, such as the number of women in treatment relative to those who need treatment; centralized needs assessment and referral; individualized services; empowerment; vocational training and jobs; duration of treatment; privatization; cultural/ethnic sensitivity and relevance; and family planning and contraception.

— Developing descriptions of examples of coordination of successful programs for women offenders and instances of systemization of treatment within the community.

— Developing analytical methods for evaluating programs and performing systemic evaluations of multiservice treatment programs.

— Performing cost-benefit analyses including nontraditional treatments.

- Set up developmental/experimental studies for the design, development, implementation, and evaluation of short-term, high-intensity drug treatment programs (perhaps combined with vocational rehabilitation programs) for those drug-abusing women offenders who are employable. Such short-term programs, if successful, would enable more women to receive treatment and rehabilitation services.

Federal and State action

- Define requirements as part of funding allocations or provide guidance for necessary procedures to assess client needs, such as general medical/dental examinations, psychological/psychiatric examinations, and gynecological examinations, all to be conducted by qualified professional staff.
- Require programs with Federal funding to provide education, counseling, and training in family planning by qualified consultants (this would include the availability of long-term contraception).
- Promote interagency linkages and treatment systemization in community-based treatment to provide multiple services and a range of treatment alternatives.
- Develop statewide systems of drug treatment for women offenders that include custodial programs and transition to continuity of care in the community.[24]

Local assistance

- Assist local communities in forming a longer term view of the relative costs of drug treatment for women offenders compared with the costs associated with crime, disease, and drug-exposed infants by assisting communities in developing long-term plans and budgets, lending them front-end money, and making more funding available for their population of drug-abusing women offenders.
- Assist communities with the planning required to establish treatment and rehabilitation systems that link drug treatment, public health, and criminal justice. Such systems would include workable procedures; sufficient, appropriate, and specialized programs where women (and their children) can be referred; and realistic, graduated sanctions. In addition, such systems would include transition programs, several levels of continuing care and support, and followup services. Recognizing that some clients need multiple episodes of treatment, they would also include expedited procedures for readmission to treatment.

In conclusion, great strides in treatment for offenders in general, and for women in particular, are likely to occur over the next few years. Overcrowding in jails and prisons, the anticipated increase in incarceration rates resulting from new statutory requirements, public reluctance to pay for the construction of more jails and prisons, and the expense of keeping people incarcerated—all these factors may have a salutary effect upon funding for drug treatment within the criminal justice system. Within this climate, to improve drug abuse treatment for women offenders, research should be directed toward identifying cost-effective methods for systemizing drug treatment, for linking drug treatment to the multiple medical and social services needed by this population, and for ensuring continuity of care as women pass from one treatment setting to another.

Table 1. **Characteristics of Community-Based Treatment Programs for Women Offenders by Type (In %)**

	All Programs N = 159	Residential N = 55	Outpatient/ Day Treatment N = 101	Methadone Maintenance N = 3	Halfway House N = 6
Program Information					
Types of treatment (%)		32.7	63.5	1.8	3.6
Type of substance abuse treated (%):					
Mainly alcohol users	12.5				
Mainly drug users	6.3				
Both alcohol/drug users	81.3				
Time in operation (in months)		128.4 (±97.05)	124.9 (±102.71)	169.7 (±121.82)	100.8 (±121.26)
Range		3 – 384	3 – 480	29 – 240	5 – 312
Client Population					
Number of people in treatment		51.1(±67.20)	140.9 (±213.58)	79.3 (±43.14)	22.4 (±6.50)
Range		6 – 353	2 – 1230	30 – 110	13 – 29
Number of adult women in treatment		21.3 (±20.52)	48.2 (±68.33)	29.3 (±19.14)	19.0 (±7.25)
Range		2 – 94	1 – 515	9 – 47	11 – 29
Number of CJS-referred women in treatment		13.7 (±18.46)	27.8 (±37.08)	13.0 (±12.12)	9.0 (±9.08)
Range		0 – 100	0 – 236	0 – 24	1 – 22
Of CJS-referred women, percentage referred by (%):					
Court	28.7				
Probation	31.4				
Parole	10.8				
Prison or jail	10.4				
Other CJS agency	17.2				
CJS-referred women in program until discharge		65.5	56.1	29.0	59.6
Treatment program length for CJS-referred women (weeks)		29.6 (±27.92)	30.3 (±21.70)	65.0 (±55.15)	24.6 (±4.71)
Range		1 – 105	3 – 104	26 – 104	13 – 39
Average length of stay in treatment program (weeks)		23.7 (±21.75)	23.7 (±18.57)	55.3 (±26.63)	17.8 (±3.63)
Range		1 – 91	3 – 104	26 – 78	13 – 21
CJS-referred women dropped for re-offending		5.6 (±11.07)	12.8 (±19.33)	13.3 (±5.77)	2.6 (±2.51)
Range		0 – 50	0 – 100	10 – 20	0 – 5
Coordination with CJS agencies					
Type of arrangements program has with CJS (%)					
None (informal)	18.8				
Contracted beds/slots	25.0				
Negotiated beds/slots	29.5				
Inspection of facilities and procedures	46.4				
Staff meet regularly to resolve problems	43.8				
Staff meet as needed to resolve problems	58.9				
Help in training, recordkeeping, etc.	20.5				
Payment for treatment programs	22.3				
Parole/probations agents meet to discuss client's progress	67.9				
Major problems with CJS (%)					
Yes	27.7				
No	70.5				
No answer	1.8				

Source: DARC/NIJ National Survey

Table 2. **Client Assessment Methods Regularly Used in Community-Based Programs (In %)**

	Residential (N = 55)	Outpatient/ Day Treatment (N = 101)	Methadone Maintenance (N = 3)	Halfway House (N = 6)
Disease				
Clinical interview	49.1	58.4	0.0	50.0
Standardized questionnaire	3.6	6.9	0.0	0.0
Staff-developed instrument	14.5	16.8	0.0	16.7
Medical/dental exam	67.3	37.6	100.0	33.3
Client's records	32.7	27.7	0.0	50.0
Staff observation	25.5	25.7	0.0	50.0
Not assessed	9.1	8.9	0.0	0.0
Information on Health Care				
Clinical interview	67.3	76.2	33.3	66.7
Standardized questionnaire	5.5	8.9	0.0	0.0
Staff-developed instrument	20.0	25.7	0.0	16.7
Medical/dental exam	34.5	13.9	33.3	0.0
Client's records	30.9	21.8	33.3	33.3
Staff observation	36.4	28.7	0.0	16.7
Not assessed	1.8	5.0	0.0	0.0
Psychological Status				
Clinical interview	74.5	86.1	33.3	0.0
Standardized questionnaire	28.7	28.7	100.0	0.0
Staff-developed instrument	12.7	23.8	0.0	0.0
Medical/dental exam	20.0	9.9	0.0	16.7
Client's records	30.9	28.7	0.0	33.3
Staff observation	52.7	45.5	0.0	66.7
Not assessed	1.8	3.0	0.0	16.7
Life Coping Skills				
Clinical interview	70.9	75.2	33.3	83.3
Standardized questionnaire	7.3	11.9	33.3	16.7
Staff-developed instrument	20.0	24.8	33.3	0.0
Medical/dental exam	3.6	2.0	0.0	0.0
Client's records	38.2	31.7	0.0	33.3
Staff observation	58.2	58.4	66.7	33.3
Not assessed	5.5	5.9	0.0	16.7
Interactional Problems				
Clinical interview	65.5	71.3	66.7	50.0
Standardized questionnaire	14.5	13.9	33.3	16.7
Staff-developed instrument	12.7	21.8	0.0	0.0
Medical/dental exam	3.6	2.0	0.0	0.0
Client's records	36.4	29.7	0.0	33.3
Staff observation	67.3	61.4	33.3	83.3
Not assessed	3.6	5.9	0.0	0.0

Table 2. **Client Assessment Methods Regularly Used in Community-Based Programs (In %) (continued)**

	Residential (N = 55)	Outpatient/ Day Treatment (N = 101)	Methadone Maintenance (N = 3)	Halfway House (N = 6)
Vocational Skills				
Clinical interview	67.3	77.2	33.3	83.3
Standardized questionnaire	12.7	9.9	33.3	16.7
Staff-developed instrument	18.2	22.8	0.0	33.3
Medical/dental exam	3.6	2.0	0.0	16.7
Client's records	27.3	29.7	33.3	33.3
Staff observation	34.5	46.5	33.3	33.3
Not assessed	9.1	5.0	0.0	0.0
Physical Fitness				
Clinical interview	36.4	40.6	0.0	50.0
Standardized questionnaire	3.6	4.0	33.3	16.7
Staff-developed instrument	9.1	13.9	0.0	16.7
Medical/dental exam	27.3	13.9	66.7	16.7
Client's records	14.5	9.9	0.0	16.7
Staff observation	41.8	35.6	0.0	66.7
Not assessed	18.2	32.7	33.3	16.7
Drug Abuse History				
Clinical interview	89.1	90.1	100.0	100.0
Standardized questionnaire	23.6	29.7	33.3	33.3
Staff-developed instrument	27.3	29.7	0.0	0.0
Medical/dental exam	16.4	8.9	33.3	16.7
Client's records	40.0	35.6	0.0	33.3
Staff observation	27.3	39.6	0.0	33.3
Not assessed	0.0	1.0	0.0	0.0
Drug Treatment History				
Clinical interview	89.1	90.1	100.0	100.0
Standardized questionnaire	10.9	18.8	33.3	33.3
Staff-developed instrument	30.9	30.7	0.0	0.0
Medical/dental exam	12.7	8.9	33.3	16.7
Client's records	41.8	36.6	0.0	33.3
Staff observation	23.6	35.6	0.0	33.3
Not assessed	0.0	1.0	0.0	0.0

Source: DARC/NIJ National Survey

Table 3. **Client Assessment Methods Regularly Used in Community-Based Programs by Program Type and by Gender (In %)**

	Residential		Outpatient/Day Treatment		Combined	
	Women Only (N = 18)	Both Sexes (N = 36)	Women Only (N = 19)	Both Sexes (N = 68)	Women Only (N = 37)	Both Sexes (N = 104)
Disease						
Clinical interview	50.0	47.2	42.1	57.5	45.9	54.1
Standardized questionnaire	0.0	5.6	5.3	6.8	2.7	6.4
Staff-developed instrument	5.6	19.4	21.1	16.4	13.5	17.4
Medical/dental exam	61.1	69.4	57.9	32.9	59.5	45.0
Client's records	44.4	27.8	31.6	27.4	37.8	27.5
Staff observation	27.8	22.2	10.5	30.1	18.9	27.5
Not assessed	11.1	8.3	15.8	8.2	13.5	8.3
Information on Health						
Clinical interview	83.3	58.3	68.4	76.7	75.7	70.6
Standardized questionnaire	5.6	5.6	15.8	6.8	10.8	6.4
Staff-developed instrument	16.7	22.2	31.6	27.4	24.3	25.7
Medical/dental exam	16.7	41.7	21.1	13.7	18.9	22.9
Client's records	38.9	27.8	21.1	24.7	29.7	25.7
Staff observation	44.4	30.6	15.8	30.1	29.7	30.3
Not assessed	0.0	2.8	10.5	2.7	5.4	2.8
Psychological Status						
Clinical interview	83.3	69.4	84.2	86.3	83.8	80.7
Standardized questionnaire	27.8	27.8	26.3	27.4	27.0	27.5
Staff-developed instrument	0.0	19.4	26.3	24.7	13.5	22.9
Medical/dental exam	11.1	22.2	15.8	8.2	13.5	12.8
Client's records	61.1	16.7	36.8	28.8	48.6	24.8
Staff observation	66.7	44.4	47.4	43.8	56.8	44.0
Not assessed	0.0	2.8	5.3	1.4	2.7	1.8
Life Coping Skills						
Clinical interview	72.2	69.4	68.4	75.3	70.3	73.4
Standardized questionnaire	11.1	5.6	10.5	12.3	10.8	10.1
Staff-developed instrument	11.1	25.0	36.8	24.7	24.3	24.8
Medical/dental exam	0.0	5.6	5.3	1.4	2.7	2.8
Client's records	38.9	38.9	47.4	30.1	43.2	33.0
Staff observation	66.7	52.8	63.2	57.5	64.9	56.0
Not assessed	5.6	5.6	5.3	5.5	5.4	5.5
Interactional Problems						
Clinical interview	66.7	63.9	68.4	71.2	67.6	68.8
Standardized questionnaire	16.7	13.9	15.8	12.3	16.2	12.8
Staff-developed instrument	5.6	16.7	31.6	20.5	18.9	19.3
Medical/dental exam	0.0	5.6	5.3	1.4	2.7	2.8
Client's records	44.4	33.3	36.8	30.1	40.5	31.2
Staff observation	66.7	66.7	57.9	61.6	62.2	63.3
Not assessed	5.6	2.8	10.5	4.1	8.1	3.7

Table 3. **Client Assessment Methods Regularly Used in Community-Based Programs by Program Type and by Gender (In %) (continued)**

	Residential		Outpatient/Day Treatment		Combined	
	Women Only (N = 18)	Both Sexes (N = 36)	Women Only (N = 19)	Both Sexes (N = 68)	Women Only (N = 37)	Both Sexes (N = 104)
Vocational Skills						
Clinical interview	55.6	72.2	73.7	75.3	64.9	74.3
Standardized questionnaire	16.7	11.1	15.8	9.6	16.2	10.1
Staff-developed instrument	11.1	22.2	42.1	20.5	27.0	21.1
Medical/dental exam	5.6	2.8	5.3	1.4	5.4	1.8
Client's records	38.9	19.4	36.8	30.1	37.8	26.6
Staff observation	27.8	36.1	42.1	46.6	35.1	43.1
Not assessed	16.7	5.6	5.3	5.5	10.8	5.5
Physical Fitness						
Clinical interview	38.9	33.3	36.8	38.4	37.8	36.7
Standardized questionnaire	0.0	5.6	5.3	4.1	2.7	4.6
Staff-developed instrument	5.6	11.1	31.6	11.0	18.9	11.0
Medical/dental exam	27.8	25.0	15.8	12.3	21.6	16.5
Client's records	22.2	11.1	5.3	12.3	13.5	11.9
Staff observation	44.4	41.7	36.8	34.2	40.5	36.7
Not assessed	11.1	22.2	31.6	34.2	21.6	30.3
Drug Abuse History						
Clinical interview	94.4	86.1	89.5	89.0	91.9	88.1
Standardized questionnaire	16.7	25.0	10.5	30.1	13.5	28.4
Staff-developed instrument	16.7	33.3	36.8	28.8	27.0	30.3
Medical/dental exam	11.1	16.7	10.5	9.6	10.8	11.9
Client's records	55.6	33.3	36.8	38.4	45.9	36.7
Staff observation	38.9	19.4	31.6	39.7	35.1	33.0
Not assessed	0.0	0.0	5.3	0.0	2.7	0.0
Drug Treatment History						
Clinical interview	94.4	86.1	89.5	89.0	91.9	88.1
Standardized questionnaire	5.6	13.9	5.3	19.2	5.4	17.4
Staff-developed instrument	22.2	36.1	36.8	31.5	29.7	33.0
Medical/dental exam	0.0	16.7	5.3	9.6	2.7	11.9
Client's records	61.1	33.3	42.1	38.4	51.4	36.7
Staff observation	27.8	19.4	31.6	35.6	29.7	30.3
Not assessed	0.0	0.0	5.3	0.0	2.7	0.0

Source: DARC/NIJ National Survey

Table 4. **Services Provided to Women Offenders in Community-Based Programs by Program Type (In %)**

	Residential (N = 55)	Outpatient/ Day Treatment (N = 101)	Methadone Maintenance (N = 3)	Halfway House (N = 6)
Services Available				
Case management	92.7	93.1	100.0	100.0
Relapse prevention	94.5	97.0	100.0	100.0
Urine testing	94.5	91.1	100.0	83.3
HIV testing	89.1	68.3	100.0	83.3
HIV/AIDS education	98.2	95.0	100.0	100.0
Groups for parents and children	69.1	62.4	66.7	66.7
12-step meetings	94.5	90.1	66.7	100.0
Special groups	81.8	83.2	100.0	100.0
Psychotherapy	61.8	66.3	100.0	66.7
Counseling	100.0	95.0	100.0	100.0
Training in parenting	72.7	72.3	100.0	66.7
Training in hygiene	89.1	61.4	66.7	83.3
Literacy	76.4	60.4	66.7	100.0
Training in nutrition	81.8	55.4	33.3	66.7
Training in empowerment	76.4	70.3	66.7	66.7
Family planning	70.9	52.5	33.3	50.0
Education leading to GED	78.2	62.4	66.7	100.0
Vocational counseling	80.0	69.3	33.3	83.3
Vocational training	69.1	56.4	33.3	100.0
Medical exam	87.3	65.3	0.0	66.7
Dental exam	61.8	31.7	0.0	33.3
Prenatal, postpartum, OB-GYN care	67.3	49.5	0.0	50.0
Legal advice	50.9	41.6	0.0	66.7
Help with job placement	76.4	61.4	66.7	66.7
Nursery	45.5	40.6	0.0	16.7
Transportation	92.7	43.6	33.3	83.3
Live-in care	40.0	10.9	0.0	16.7
Housing arrangements	80.0	45.5	33.3	50.0
Transition and Followup				
Adequate housing is arranged upon completion of treatment	76.4	27.7	0.0	50.0
Offenders remain in treatment until sources of income are procured	52.7	26.7	66.7	33.3
Encouraged to continue treatment on a less intensive basis	96.4	79.2	66.7	100.0
Encouraged to begin or continue attendance at NA/AA/CA meetings	100.0	96.0	66.7	100.0
Contacted regularly after release and provided support as needed	54.5	42.6	33.3	16.7
Arrangements for care and support are made before release	89.1	69.3	66.7	66.7
No delayed entry to program if offender relapses	50.9	80.2	100.0	33.3

Source: DARC/NIJ National Survey

Table 5. **Services Provided to Women Offenders in Community-Based Programs by Program Type and by Gender (In %)**

	Residential		Outpatient/Day Treatment		Combined	
	Women Only (N = 18)	Both Sexes (N = 36)	Women Only (N = 19)	Both Sexes (N = 68)	Women Only (N = 37)	Both Sexes (N = 104)
Services Available						
Case management	100.0	94.1	100.0	95.7	100.0	95.2
Relapse prevention	88.2	100.0	100.0	97.2	94.4	98.1
Urine testing	100.0	94.3	100.0	90.3	100.0	91.6
HIV testing	83.3	91.7	73.7	66.7	78.4	75.0
HIV/AIDS education	94.4	100.0	100.0	95.8	97.3	97.2
Groups for parents and children	72.2	69.4	84.2	56.9	78.4	61.1
12-step meetings	100.0	91.7	100.0	87.5	100.0	88.9
Special groups	83.3	80.6	89.5	81.9	86.5	81.5
Psychotherapy	55.6	63.9	63.2	68.1	59.5	66.7
Counseling	100.0	100.0	100.0	94.4	100.0	96.3
Training in parenting	77.8	72.2	89.5	68.1	83.8	69.4
Training in hygiene	83.3	91.7	84.2	57.7	83.8	69.2
Literacy	77.8	75.0	73.7	59.7	75.7	64.8
Training in nutrition	83.3	80.6	89.5	47.2	86.5	58.3
Training in empowerment	76.5	77.8	89.5	68.1	83.3	71.3
Family planning	77.8	69.4	68.4	47.2	73.0	54.6
Education leading to GED	72.2	83.3	63.2	65.3	67.6	71.3
Vocational counseling	83.3	77.8	89.5	66.7	86.5	70.4
Vocational training	66.7	69.4	68.4	56.3	67.6	60.7
Medical exam	72.2	94.4	68.4	68.1	70.3	76.9
Dental exam	72.2	58.3	52.6	27.8	62.2	38.0
Prenatal, postpartum, OB-GYN care	61.1	69.4	57.9	50.0	59.5	56.5
Legal advice	70.6	44.4	47.4	44.4	58.3	44.4
Help with job placement	83.3	72.2	57.9	63.9	70.3	66.7
Nursery/child sitting care	44.4	48.6	68.4	32.9	56.8	38.0
Transportation to hospitals, schools, etc.	100.0	88.9	63.2	38.9	81.1	55.6
Live-in care for women and their children	44.4	38.9	16.7	8.3	30.6	18.5
Help with post-discharge housing arrangements	88.9	80.0	63.2	45.1	75.7	56.6
Transition and Followup						
Adequate housing is arranged upon completion of treatment	83.3	72.2	52.6	24.3	67.6	40.6
Offenders remain in treatment until sources of income are procured	55.6	52.8	36.8	26.8	45.9	35.5
Encouraged to continue treatment on a less intensive basis	94.4	97.2	94.7	77.5	94.6	84.1
Encouraged to begin or continue attendance at NA/AA/CA meetings	100.0	100.0	100.0	97.3	100.0	98.2
Contacted regularly after release and provided support as needed	61.1	52.8	68.4	37.5	64.9	42.6
Arrangements for care and support are made before release	83.3	91.7	89.5	66.7	86.5	75.0
No delayed entry to program if offender relapses	33.3	58.3	73.7	83.3	54.1	75.0

Source: DARC/NIJ National Survey

Table 6. **Characteristics of Custodial-Based Treatment Programs for Women Offenders by Program Type (In %)**

	Jail N = 16		Prison N = 53	
Type of Treatment Program (%)				
Which of the following treatment models best describe your treatment model?				
Therapeutic Community (TC)	31.3		26.4	
Drug-free residential but not a traditional TC	18.8		13.2	
Treatment for a few hours, rest of day spent in jail/prison activities	37.5		54.7	
Other	12.5		5.7	
What type of substance abuse do you treat?				
Directed mainly toward ALCOHOL users	0.0		0.0	
Directed mainly toward DRUG users	12.5		0.0	
Combined ALCOHOL/DRUG users	87.5		100.0	
Client Population				
Number of adult women in program	46.0	(+45.1)	57.5	(+99.0)
Range	6 – 143		1 – 662	
Percent mandated to treatment by CJS	30.7		44.8	
Percent volunteered for treatment program	69.3		55.3	
Able to treat all women who volunteer and meet admittance criteria?				
Yes	69.7		44.8	
No	30.3		55.3	
If No, how many not admitted?	2.8	(+2.1)	53.3	(+75.7)
Range	0 – 5		0 – 250	
Time in Treatment				
Planned length of program for women in custody (in weeks)	18.9	(+12.7)	23.6	(+23.7)
Range	4 – 42		5 – 156	
Average length of time women remain in program (in weeks)	15.7	(+11.2)	22.7	(+29.2)
Range	3 – 40		5 – 208	
Hours per week in treatment activities	20.4	(+29.9)	21.4	(+17.0)
Range	2 – 100		1 – 70	
Average percentage of program completion	76.9		83.2	
Setting (%)				
Treatment program has space separate from rest of institution?				
Yes	75.0		66.0	
No	18.8		34.0	
Were women in the program housed separately from the rest of the inmates?				
Yes	37.5		49.1	
No	56.3		45.3	
Institutional Relationship (% responding Yes)				
Treatment provided by an external contractor	62.5		52.8	
Strong philosophical differences between treatment personnel and correctional personnel	50.0		28.3	
Relations between treatment and correctional personnel are mainly good	87.3		96.2	
Issues relating to security and/or inmate infractions have been amicably resolved	100.0		90.6	
Prison administrators meet with treatment personnel regularly to plan and resolve problems	75.0		81.1	
Jail/prison administrators feel that the program helps keep order	75.0		84.9	
Jail/prison administrators feel that the program is doing some good in reducing drug use and recidivism in the women who receive treatment	75.0		88.7	

Source: DARC/NIJ National Survey

Table 7. **Client Assessment Methods Regularly Used in Custodial-Based Programs by Program Type (In %)**

	Jail N = 16	Prison N = 53
Disease		
Clinical interview	53.8	22.6
Standardized questionnaire	7.7	1.9
Staff-developed instrument	7.7	13.2
Medical/dental exam	61.5	60.4
Client's records	15.4	20.8
Staff observation	7.7	18.9
Not assessed	7.7	11.3
Health Care		
Clinical interview	76.9	32.1
Standardized questionnaire	23.1	3.8
Staff-developed instrument	23.1	11.3
Medical/dental exam	7.7	32.1
Client's records	7.7	13.2
Staff observation	15.4	30.2
Not assessed	15.4	15.1
Psychological Status		
Clinical interview	46.2	66.0
Standardized questionnaire	23.1	35.8
Staff-developed instrument	38.5	24.5
Medical/dental exam	15.4	13.2
Client's records	7.7	28.3
Staff observation	46.2	49.1
Not assessed	0.0	5.7
Coping		
Clinical interview	61.5	54.7
Standardized questionnaire	7.7	11.3
Staff-developed instrument	15.4	15.1
Medical/dental exam	0.0	0.0
Client's records	0.0	26.4
Staff observation	30.8	34.0
Not assessed	15.4	13.2
Interactional Problems		
Clinical interview	53.8	60.4
Standardized questionnaire	23.1	22.6
Staff-developed instrument	7.7	11.3
Medical/dental exam	15.4	1.9
Client's records	15.4	37.7
Staff observation	53.8	67.9
Not assessed	0.0	3.8

Table 7. **Client Assessment Methods Regularly Used in Custodial-Based Programs by Program Type (In %) (continued)**

	Jail N = 16	Prison N = 53
Vocational Skills		
Clinical interview	46.2	52.8
Standardized questionnaire	15.4	15.1
Staff-developed instrument	7.7	17.0
Medical/dental exam	7.7	0.0
Client's records	7.7	26.4
Staff observation	23.1	26.4
Not assessed	30.8	20.8
Physical Fitness		
Clinical interview	30.8	28.3
Standardized questionnaire	0.0	3.8
Staff-developed instrument	0.0	11.3
Medical/dental exam	23.1	20.8
Client's records	0.0	15.1
Staff observation	7.7	34.0
Not assessed	38.5	32.1
Drug History		
Clinical interview	76.9	83.0
Standardized questionnaire	15.4	34.0
Staff-developed instrument	38.5	37.7
Medical/dental exam	7.7	7.5
Client's records	15.4	37.7
Staff observation	15.4	20.8
Not assessed	0.0	1.9
Drug Treatment History		
Clinical interview	76.9	88.7
Standardized questionnaire	7.7	20.8
Staff-developed instrument	38.5	32.1
Medical/dental exam	0.0	3.8
Client's records	23.1	35.8
Staff observation	23.1	13.2
Not assessed	0.0	1.9

Source: DARC/NIJ National Survey

Table 8. **Services Provided to Women Offenders in Custodial-Based Programs by Program Type (In %)**

	Jail N = 16	Prison N = 53
Services Available		
Case management	81.3	96.2
Relapse prevention	93.8	96.2
Urine testing	43.8	88.7
HIV testing	75.0	84.9
HIV/AIDS education	93.8	94.3
Accommodation for visiting children and infants	62.5	84.9
Groups for parents and children	25.0	35.8
12-step meetings	93.8	100.0
Special groups (e.g., sexual abuse, battering, HIV)	81.3	88.7
Psychotherapy	50.0	77.4
Counseling	100.0	100.0
Training in parenting	68.8	73.6
Training in hygiene	62.5	67.9
Literacy classes/tutoring	81.3	86.8
Training in nutrition	56.3	58.5
Training in empowerment	100.0	75.5
Family planning	37.5	56.7
Education leading to GED	87.5	94.3
Vocational counseling	81.3	84.9
Vocational training	68.8	75.5
Medical exam	81.3	98.1
Dental exam	81.3	90.6
Prenatal, postpartum, OB-GYN care	87.5	92.5
Legal advice	62.5	67.9
Transition and Followup		
Adequate housing is arranged upon completion of treatment	37.5	43.4
Offenders remain in treatment until sources of income are procured	81.3	86.8
Encouraged to continue treatment on a less intensive basis	31.3	22.6
Encouraged to begin or continue attendance at NA/AA/CA meetings	93.8	96.2
Contacted regularly after release and provided support as needed	43.8	24.5
Arrangements for care and support are made before release	50.0	45.3
No delayed entry to program if offender relapses	25.0	64.2
Transition services are arranged for by treatment staff alone	62.5	18.9
Transition services are arranged for by parole after women leave custody and return to the community	0.0	18.9

Source: DARC/NIJ National Survey

Notes

1. Federal Bureau of Investigation, *Crime in the United States 1991*. (Washington, D.C.:U.S. Government Printing Office, 1992.)

2. Flanagan, T.J., and K. Maguire, *Sourcebook of Criminal Justice Statistics 1991*. (Washington, D.C.:U.S. Department of Justice, Bureau of Justice Statistics, 1992.)

3. National Institute of Justice, *Drug Use Forecasting: 1993 Annual Report*. (Washington, D.C.:U.S. Department of Justice, 1993.)

4. Hser, Y.I., C. Chou, and M.D. Anglin, "The Criminality of Female Narcotics Addicts: A Causal Modeling Approach," *Journal of Quantitative Criminology*, 6 (2)(1990):201–228.

5. Wellisch, J., M.D. Anglin, and M.L. Prendergast, "Numbers and Characteristics of Drug-Using Women in the Criminal Justice System: Implications for Treatment," *Journal of Drug Issues*, 23(1)(1993):7–30.

6. Daley, B., and C. Przybycin, "Cocaine-Dependent Women Have Unique Treatment Needs." *Addiction Letter*, 5(10)(1989).

7. See Note 5.

8. Bureau of Justice Statistics, *Women in Prison: A Special Report*. (Washington, D.C.:U.S. Department of Justice, 1990.) Cusky, W. "Female Addiction: A Review of Literature." Journal of Addictions and Health, 3(1982). Teets, J. "What Women Talk About: Sexuality Issues Among Chemically Dependent Women." *Journal of Psychosocial Nursing*, 28(2)(1990):4–7.

9. Bekir, P., T. McLellan, A.R. Childress, and P. Gariti, "Role Reversals in Families of Substance Misusers: A Transgenerational Phenomenon," *International Journal of the Addictions* 28(7)(1993):613–630. And Burns, W.J., and K.A. Burns, "Parenting Dysfunction in Chemically Dependent Women," in *Drugs, Alcohol, Pregnancy, and Parenting*. I. Chasnoff, ed. (London:Kluwer Academic Publishers, 1988.)

10. See note 5.

11. See note 21.

12. Ramirez, H., and C. Sosa, *Substance Abuse Forum Abstract*. (Los Angeles County Department of Children's Services, 1991.)

13. American Correctional Association, *The Female Offender: What Does the Future Hold?* (Laurel, MD:American Correctional Association, 1990.)

14. To facilitate receipt of worthwhile nominations, researchers asked TASC directors to identify the programs that would provide comprehensive services. The cover letter to State respondents emphasized that programs that provided treatment should be identified, rather than only educational or self-help activities (e.g., Anonymous Fellowship, 12-step meetings).

15. This procedure identified four programs in Los Angeles County. Since another project at DARC was already conducting a detailed questionnaire survey of drug treatment programs in the county, researchers did not send our questionnaire to Los Angeles programs so as not to overburden them with having to answer two questionnaires at the same time.

16. Since the researchers did not identify programs in the following States, programs in these States were not mailed questionnaire packets: Louisiana, Mississippi, Montana, Nevada, New Hampshire, New Mexico, Utah, Vermont, and West Virginia. Questionnaire packets were sent to programs in Nebraska and Rhode Island, but none were returned.

17. Falkin, G.P., et al., *Drug Treatment for Women Offenders: A Systems Perspective*. Final Report, NIJ grant 92–IJ–CX–K018. (New York:National Development and Research Institutes, Inc.; Los Angeles:UCLA Drug Abuse Research Center, 1994.)

18. Although six halfway houses responded to the survey, halfway houses in general do not consider drug treatment to be their main function; however, all of the outpatient and residential programs were oriented mainly to drug treatment.

19. Although the treatment program itself may not regularly assess certain needs (e.g., medical conditions, vocational skills), these needs may be assessed in other sections of the jail or prison.

20. Beschner, G.M., and P. Thompson, eds., *Women and Drug Abuse Treatment: Needs and Services* (Services Research Monograph Series; DHHS Pub. No. (ADM) 81–1057). (Rockville, MD:National Institute on Drug Abuse, 1981.)

21. Austin, J., B. Bloom, and T. Donahue, *Female Offenders in the Community: An Analysis of Innovative Strategies and Programs*. (Report prepared for the National Institute of Corrections, U.S. Department of Justice; San Francisco:National Council on Crime and Delinquency, 1992.)

22. See note 5, and Chaiken, M.R., *In-Prison Programs for Drug-Involved Offenders*. (Washington, D.C.:U.S. Department of Justice, National Institute of Justice.)

23. Hubbard, R.L., M.E. Marsden, J.V. Rachal, H.J. Harwood, E.R. Cavanaugh, and H.M. Ginzburg, *Drug Abuse Treatment: A National Study of Effectiveness*. (Chapel Hill:University of North Carolina Press, 1989.)

24. For example, Oregon has a statewide system in which offenders are moved to different custodial institutions because of the requirement for different treatment services and in preparation for transition into the community; Colorado's Cooperative Plan promises to develop into a statewide system providing treatment alternatives within custody and is tied to a system of community-based treatment; and Texas is experimenting with State prisons that focus on treatment and can offer various treatment options within a single facility. See *Drug Treatment For Women Offenders: Research Agenda*, Criminal Justice Programs for Women Offenders, 92–IJ–CX–K018. March 30, 1994. p. 8.

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