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Drug Treatment for Women Offenders: A Systems Perspective

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Drug Treatment for Women Offenders: A Systems Perspective

During the past decade, the rate at which substance-abusing women entered the criminal justice system was substantially higher than the rate for men. The proportion of women arrestees who test positive for drugs, and the proportion arrested for drug offenses, are also higher than for men (Federal Bureau of Investigation, 1992; National Institute of Justice, 1993). Although criminal justice authorities have expanded the use of alternative sanctions for women, there has been a dramatic increase in the number of women incarcerated. Since 1980, the incarceration rate for women increased by about 160 percent, nearly twice the rate of increase for men (Austin et al., 1992). Criminal justice and drug treatment agencies have expanded treatment capacity for women under community supervision and in jails and prisons; yet, the majority of those who need treatment still do not receive it. Despite some recent developments in providing women with services tailored to their needs, the system continues to fall short in this regard because appropriate services are often not available.

Substance-abusing women pose a serious problem for criminal justice officials. Because most of these women are mothers, many judges and prosecutors have misgivings about imposing jail and prison sanctions, except in the most serious cases. The availability of alternatives, primarily drug treatment programs, is limited, and many programs either exclude women or certain types of women (e.g., mothers who cannot be separated from their children, women who are mentally ill or have AIDS). Whether in the community or in institutions, treatment generally consists of group counseling or attendance at Alcoholics Anonymous and other 12-Step meetings. Where more intensive treatment exists, the programs have often been established by men or modeled after programs intended for men. These programs do not meet the particular needs of women, which, in addition to treatment for substance abuse, include services related to physical and sexual abuse, mental health problems, lack of education and vocational skills, and children. Thus, there are considerable limitations or gaps in the system's success in responding to the needs of women.

This paper identifies some of these gaps and describes some of the efforts that have been made to improve the treatment system for women offenders. The primary focus is on how the system has responded to their needs. By "system" we mean all the organizations--criminal justice agencies and drug treatment programs--involved in providing treatment services to women. Treatment capacity, the kinds of programs and services available to women, and the nature of the linkages among organizations define the system's structure, which limits or constrains the ability of organizations and officials to meet women's needs. Changes in the system's capacity and services are made on the basis of information or assumptions about the unmet need for treatment in the aggregate and the specific kinds of service needs that individuals have. With better information, government officials and treatment providers may be able to improve the system's structure so that it better meets the needs of women. Thus, the basic questions addressed in the following sections are: what service needs do women offenders have, to what extent are they being met, and how are they being met?

The research findings summarized below are the results of a study of "Criminal Justice Drug Treatment Programs for Female Offenders," funded by the National Institute of Justice. The

research consisted of four main components: (1) a review of literature on the treatment needs of women offenders, (2) a quantitative assessment of the aggregate need for drug treatment among women in the criminal justice system, (3) a national survey of drug treatment programs that serve this population, and (4) case studies of about 30 treatment programs that serve women in various legal statuses and treatment settings (e.g., inmates in jails and prisons, probationers and parolees in community-based treatment programs). Although considerably more is being done to provide treatment services to women in the criminal justice system, a common theme is that the system's ability to meet their needs must still be expanded and enhanced.[1]

THE SERVICE NEEDS OF CHEMICALLY-DEPENDENT WOMEN

Drug abuse among women in the criminal justice system is a serious public health problem. In addition to the social and personal consequences of their criminality and drug use, substance-abusing women are at high risk for contracting and spreading HIV and for exposing neonates to the virus as well as to the deleterious affects of drugs. Because of the increasing prevalence of drug use among women offenders and the strong connection between drug use and crime, most criminal justice authorities perceive a need to provide these women with drug treatment (*CJN Drug Letter*, 1994). Yet, the expansion of treatment programs since the early 1980s--when the problem took a sharp upswing--has not been in proportion to the collective need for treatment. Furthermore, most programs are limited in the scope of services they provide.

The relationship between drug abuse and crime has been well documented in the literature. Substance-abusing women are predominately involved in three types of crime: drug dealing, income-producing crimes (e.g., shoplifting, forgery, and larceny), and prostitution (Hser et al., 1990). For a large proportion of women addicted to crack, prostitution is one of the only viable career choices (Fagan, 1992). While a sizable number of studies (e.g., Ball et al., 1983; Inciardi 1979, 1986; Johnson et al., 1985) have shown that severe substance abusers are responsible for a disproportionate amount of crime, Sanchez and Johnson (1987) have demonstrated this specifically for women. Recent research has also linked severe cocaine and crack abuse with involvement in relatively high levels of criminal and violent behavior (e.g., Brownstein and Goldstein, 1990; McBride and Swartz, 1990). In an American Correctional Association survey (1990) of incarcerated women, nearly half the women reported having used drugs and/or alcohol at the time they committed the crime for which they were incarcerated.

While drug treatment services, such as group counseling, psychotherapy, drug education, and 12-Step support groups, are necessary, they are not sufficient to meet the various needs that women have (Wellisch, Anglin, & Prendergast, 1993; Wellisch, Prendergast, & Anglin, 1994). Many drug-abusing women are physically and/or mentally ill. Typically, those who enter publicly funded drug treatment programs--particularly those mandated to treatment--do not enter treatment until their condition is desperate. For example, cocaine users are at risk for extreme weight loss, dehydration, digestive disorders, skin problems, dental problems, gynecological and venereal infections, hypertension, seizures, respiratory arrest, and cardiac failure (Daley and Przybycin, 1989). Women who share drug injection equipment or engage in sex with HIV-

[1] It was beyond the scope of the research to evaluate treatment programs in terms of their effectiveness or quality or their appropriateness for their clients.

positive partners are at risk of becoming infected with HIV, and the rate of HIV-positive women has been increasing (Wells and Jackson, 1992).

Drug-addicted women tend to come from families with a high incidence of mental illness, suicide, substance abuse, and violence. As children, they were often exposed to physical and sexual abuse and to foster care placement (Cuskey, 1982; Pearlman et al., 1982; Ryan, 1980). As reported by Mondanaro and colleagues (1989), on the basis of previous studies, a high proportion of substance-abusing women have been victims of incest (28 to 44 percent, depending on the study) and rape (46 percent).

Women are more likely to report having been victims of sexual abuse, and they indicate more emotional distress than men (Wallen, 1992). In general, chemically-dependent women are reported to have low self-esteem (Lord-Zankowski, 1988; Sutker et al., 1985). An investigation by DeLeon and Jainchill (1982), across seven therapeutic communities, showed that women clients had higher levels of emotional disturbance, more psychosomatic symptoms, and lower self-esteem than men clients.

Most drug-abusing women offenders are of child-bearing age. Many have children, and they are single mothers. Many of the mothers receive little or no help from the father(s) of their children. Prior to arrest, many mothers lose custody of their children. Most of the mothers who maintain custody expect to live with their children after release from prison (Bureau of Justice Statistics, 1990, 1993). Many drug-dependent women are without supportive family and social networks and have limited or no financial resources (Dunlap, 1992). Most of the women in publicly funded treatment programs have been unemployed or, if employed, have worked at low-paying jobs. Most have not completed high school, have inadequate vocational skills, and lack skills and knowledge to function productively in society. By providing only limited drug treatment services, without basic human services to meet these various needs, the chances for recovery and rehabilitation are diminished (Kleber, 1989; McLellan et al., 1983).

A NATIONAL ASSESSMENT OF TREATMENT NEEDS AND PROGRAMS

Because of the severity of problems associated drug abuse among women in the criminal justice system, it is essential to estimate the magnitude of the problem and the demand for treatment. In 1992, in 24 Drug Use Forecasting (DUF) cities, the percentage of women arrestees who tested positive at the time of arrest for at least one illicit drug ranged from 47 percent in San Antonio to 85 percent in Manhattan (National Institute of Justice, 1993). About 20 percent of women arrestees in most cities engaged in multiple drug use. Cocaine was the most prevalent drug for the majority of them. The American Correctional Association survey (1990) of adult and young women incarcerated in the nation's jails and prisons showed that close to one-third of the women reported that they used heroin at least once or twice a month, half reported using cocaine at least once or twice a month, and 14 percent reported using crack at least once or twice a month. About one-quarter of the adult women offenders in the ACA survey reported having been in drug treatment. The proportion of drug users on probation and parole and in prisons and jails is comparable (Belenko, 1990). While drug use has recently been declining among adults in general, there are indications that the rate of substance abuse among women arrestees has been stable in some cities and increasing in others (National Institute of Justice, 1993).

The Demand for Drug Treatment among Women Offenders

Drug prevalence estimates provide insight into the extent of the aggregate need or demand for treatment, but they do not provide a full indication of the magnitude and scope of the problem. The high percentage of offenders who use drugs does not indicate the aggregate need for treatment relative to the availability of treatment slots or the availability of programs that provide services appropriate to women's needs. Furthermore, not everyone who uses drugs is ready to give them up and enter treatment. To understand better the extent of the aggregate demand for treatment, we conducted an analysis of DUF data and census data. We also compared the aggregate demand for treatment to the availability of treatment resources. The basic finding is that there currently exists a substantial demand for treatment among women offenders, but most jurisdictions fail to meet it. The majority of women offenders who need treatment do not receive it because most jurisdictions do not have adequate treatment resources for women.

In brief, the methodology entailed secondary analysis of three data sets for 1990: the Drug Use Forecasting (DUF) program, the Uniform Crime Reports (UCR), and the U.S. Census. The development of the prevalence model involved several steps. First, we examined the relationships between several social indicators from census data and drug use rates among arrestees in 23 DUF cities. Predictors that accounted for sufficient variation in prevalence rates were retained in the model. Second, separate regression coefficients were estimated for gender and offense categories. These coefficients were used in the final models to derive drug use prevalence rates for non-DUF cities. The projected drug use prevalence rates for the 200 largest cities in the United States were then mapped to the arrestee population in each city (using UCR data) to obtain the estimated number of drug-using arrestees, broken down into categories by gender, drug type, and offense type (see Hser et al., 1994, for a more detailed description of the methodology).

For women arrestees, this procedure resulted in an estimated 242,311 drug users for the 200 largest U.S. cities in 1990. For example, it was estimated that 194,854 women arrestees used cocaine, 58,334 used heroin, and 33,508 used amphetamines. Based on self-report data for injection drug use, it was also estimated that 115,957 women arrestees injected cocaine, heroin, or amphetamines. Although these 200 cities account for about one-third of arrests reported to UCR, limitations in the data and in the prevalence models make it difficult to project prevalence estimates from these 200 cities to the total population of women arrestees or to the total criminally involved population. As the model is tested and refined, it will be possible to develop more precise and more comprehensive estimates of drug use prevalence.

Prevalence of drug use cannot be equated with need for drug abuse treatment. Not all people who used drugs need treatment (although they may need some type of less intense intervention), nor do all who need treatment want it. In a previous analysis of the DUF data for 1990 (Prendergast, Hser, Chen, & Hsieh, ,1992), the percentage of drug-using arrestees in probable need of treatment for various drugs was determined. (A person was identified as probably in need of treatment if he or she tested positive for a particular drug and met any one of the following conditions: reported using the drug at least 10 times a month, reported dependent use of the drug, was currently in treatment, or expressed a need for treatment.) The percentage of arrestees who were probably in need of treatment was 45% for those who tested positive for cocaine, 59% for opiates, 10% for amphetamines, and 77% for injection drug use (cocaine, heroin, or amphetamines). Applying these percentages to the estimated number of women drug-

using arrestees in DUF cities gives the following estimates for the number of women arrestees in probable need of treatment in DUF cities (rounded to nearest hundred): 87,700 for cocaine, 34,400 for opiates, 3,300 for amphetamines, and 89,300 for injection drug use.

Despite the need for drug treatment, only a small proportion of women arrestees in DUF cities reported being enrolled in a treatment program (although the percentages are higher for women than for men). For instance, in Los Angeles in 1990, 19.7% of women arrestees said that they had ever been in drug treatment and 2.8% said they were currently in treatment--this despite the fact that 31.9% reported that they needed drug treatment (DUF data, unpublished). Similarly, at the same time in Manhattan, although 42.7% of the women arrestees claimed that they needed treatment, only 6.2% said they were currently in treatment (24.5% of them reported that they had ever been in treatment) (DUF data, unpublished). Although several other studies have also documented the large gap between the number of individuals in the criminal justice who need treatment and the number of available treatment slots (e.g., Gerstein & Harwood, 1990; Harlow, 1991; Hser, Longshore, & Anglin, 1994; U.S. General Accounting Office, 1991), there is no reason to believe, particularly given the rapid growth in the number of substance-abusing women offenders over the past decade, that the situation is any better for women than it is for men.

Treatment Programs for Women Offenders: A National Survey

Although the quantitative analysis provides a reasonably accurate estimate of the magnitude of the problem (i.e., the shortfall in treatment resources relative to demand), it does not provide any insight into the appropriateness of treatment programs that are available for women. To more fully understand the extent to which women's needs are being met, one must examine qualitative aspects of the treatment system for women. In other words, to what extent are treatment programs providing services that are appropriate to the needs of women clients? Because the development of treatment systems is influenced largely by organizational perceptions of client needs, it is essential to understand how programs obtain information on client needs and the kind of information they obtain. Do the methods that programs use to assess client needs provide systematic and reliable information about the various needs that clients have, or do they result in a partial picture and misinformed views? In order to answer these questions, in addition to focusing on services, the research examined the methods that programs use to assess client needs.

When we proposed the study of drug treatment for women in the criminal justice system, our plan was to assess the treatment system by conducting case studies of 20 programs clustered in several jurisdictions. The case studies were intended to obtain detailed information on the methods programs use to assess client needs and the services that are delivered to clients. It became apparent, however, that there was relatively little prior research on client assessment and service delivery for women offenders, even though a few surveys of programs had been reported in the literature (e.g., Austin et al., 1992). Accordingly, we expanded the research to include a national survey of treatment programs for women offenders to complement and augment the case studies of local treatment systems and programs.

Of 336 drug treatment programs surveyed, we were able to obtain data on a total of 234 programs (165 community-based, 16 jail-based, and 53 prison-based programs) in 40 states (including the District of Columbia). Because the goal was to survey all local and state treatment programs that serve women offenders, we first contacted the directors of all Treatment Alternatives to Street Crime (TASC) programs and all state departments of alcohol and drug

abuse and state departments of corrections to identify programs (see Wellisch et al., 1994 for an explanation of survey methods and a comparison of the survey findings with previous survey findings). Although some treatment programs for women may not have been surveyed (in particular, community-based programs may not have been identified in jurisdictions where TASC programs did not respond or where they do not exist), there is reason to believe that the sample is representative of the universe of programs. Regardless, the survey results have important implications in relation to how programs are responding to women's needs.

The main findings of the survey, which are described elsewhere by Wellisch and colleagues (1994), are as follows. Although today there are considerably more programs serving drug-abusing women offenders than there were in the 1970s, the increase in programs has not been sufficient to meet the overall need. As the authors conclude, "The number of treatment programs may have increased appreciably, but so has the number of drug-abusing women offenders, such that the percentage of those being serviced, relative to those in need, is probably no greater than it was in the late 1970s."

Although most of the programs assess the drug use history and drug treatment history of women seeking admission, they rarely use standardized methods, and they often fail to assess various areas of possible need, such as health care, psychological status, vocational skills, and difficulties in coping with problems. Most programs assess needs on the basis of a clinical intake interview, supplemented with observation and information in client records. The failure of many programs to use a standardized assessment protocol--either a published, validated instrument or one developed by the treatment staff--suggests that there are likely to be inconsistencies in the kind and quality of information obtained for various areas of need and that these programs do not have a sufficient information base to systematically plan and develop services to meet client needs.

Although the vast majority of programs provide drug treatment services such as group counseling, relapse prevention, and 12-Step support groups, most programs provide services of limited intensity and duration, despite evidence that treatment outcomes are positively related to length and intensity of treatment (Hubbard et al., 1989; Simpson et al., 1986). Furthermore, many of the programs provide a limited range of services; they fail to provide the ancillary services that women need. Some of the services that are often not provided despite the need include: training in parenting, hygiene, nutrition, empowerment; family planning; vocational counseling and training; prenatal and post-partum medical care; child care; transportation; and help with post-discharge housing arrangements. An important finding in this regard is that, unlike programs serving both men and women, those that serve only women tend to provide services that meet the particular needs of women.

One of the main obstacles to women entering and staying in treatment is the fact that the majority of programs do not provide any care for infants or children. Nursery and childcare facilities and live-in care for mothers and children are provided in less than half the community-based drug treatment programs. Though we recognize the difficulties and tradeoffs involved in providing services for children--cost, staffing, space, community acceptance, occasional disruptions--it is important to note that nurseries and/or child care are provided by over two-thirds of the women-only outpatient programs, which is twice the rate for programs that serve both sexes. This suggests that the main obstacle may be attitudinal, that is, a male-oriented attitude that is unresponsive to women's needs.

TREATMENT SYSTEMS FOR WOMEN OFFENDERS: A CASE STUDY

To explore in greater depth how the system responds to the needs of women offenders, we conducted case studies of 30 drug treatment programs. Our primary interests had to do with how organizations in the criminal justice and drug treatment systems assess women's needs and the kinds of programs and services available to women offenders. Our strategy for selecting sites was to cluster as many programs as possible in several jurisdictions. We did this partly to maximize the number of treatment sites that we could afford to visit, but primarily because our main interest was in treatment systems.

A Systems Perspective

There are several reasons why we thought it was crucial to focus on treatment systems. First, and most important, is that women offenders have multiple needs, and a variety of organizations are involved in the referral and service delivery processes. The primary organizations are criminal justice agencies, Treatment Alternatives to Street Crime (TASC) programs, and community-based drug treatment programs. All these organizations are part of a system in that they are interconnected in various ways (Falkin, 1993). Jails and prisons are open systems in which treatment programs are linked both to other correctional organizations (e.g., mental health, schools, job training) and community-based treatment providers.

In the community, various government agencies (e.g., child welfare, mental health, public assistance agencies), voluntary associations (e.g., Alcoholics Anonymous, Narcotics Anonymous, church groups), and other organizations (e.g., hospitals, local colleges, vocational training institutes) are involved in providing services to drug treatment clients. Treatment programs also rely on one or more health care organizations to provide a variety of services, such as medical evaluations, detoxification, AIDS testing, counseling for victims of sexual abuse, and general medical care. From a systems perspective, the main concerns have to do with how the various organizations collectively provide women with the services they need, and the degree to which the system is succeeding in this regard.

A second reason for focusing on systems is that there is no prior research on how systems are organized to deliver treatment services for women offenders; there is no informed assessment of how well they are working. Prior to beginning this research, we completed a study of three state and local treatment systems for offenders, focusing on linkages between the criminal justice agencies and drug treatment agencies and providers (Falkin, 1993; Falkin et al., 1993). It also seemed important to focus on women's issues from a systems perspective in order to understand how the various organizations are involved in providing a range of treatment services. Ultimately, the important question is, how well is the system organized to deliver the range of services that women offenders need? Is there a continuum of treatment for women at various stages of both the criminal justice and the recovery processes; is there a comprehensive array of services to meet the various needs that women have? Or, are there significant performance gaps (i.e., vital services that are not available for drug-dependent women offenders)?

Third, there is considerable interest in improving the treatment system for this population. Government agencies, such as the Federal Center for Substance Abuse Treatment and state alcohol and drug abuse agencies, have made treatment for women offenders a priority, and

national criminal justice and drug treatment associations have similarly supportive positions. To understand how to improve the system, research needs to address a few basic questions about how positive system-wide changes are occurring. What are the indications that systems have been moving in the direction of expanding their capacity and enhancing their ability to respond to the needs of women offenders? Have treatment services and methods become more gender-sensitive, or do treatment programs for men and women follow the same format? Are the various organizations involved in the referral and service delivery processes attempting to improve the way they function collectively?

To enhance women offenders' prospects for recovery, we must understand the main performance gaps in relation to serving women offenders. What are the obstacles to closing these gaps, and what strategies have the potential to improve the system? Accordingly, we studied several systems that we were led to understand were in the process of developing a continuum of programs and services for women offenders. As we shall see, the various programs are part of systems that are in the process of becoming more integrated and gender-sensitive. Although it is beyond the scope of this study to determine the extent to which the treatment systems and programs are meeting the needs of women offenders, we can provide some insight into this phenomenon of change.

Research Methods

All the sites were selected on the basis of information that we had (e.g., survey data, prior contacts, expert recommendations) that suggested that criminal justice and treatment organizations in these jurisdictions had been in the process of developing a system of treatment responsive to the needs of women offenders and that the programs represented the state-of-the-art in this regard. At each local site (system), we visited a variety of programs that serve women offenders (including community-based outpatient and residential treatment programs, jail-based programs, and TASC); we also visited treatment programs in three prison systems, as depicted in Table 1.[2] (Because of differences in jurisdiction, we make a distinction between the prison system and the local treatment system; however, the two are inter-connected.) In some jurisdictions, we visited all or almost all of the programs available to women offenders; in other, larger jurisdictions, we visited only some of the programs that serve women offenders--the particular community-based programs were selected mainly on the recommendation of TASC. At each program, we interviewed the director and/or senior staff, who often wore two or three hats--administrator, intake interviewer, and counselor. At most programs, we also met with counselors and some clients.

The following sections describe (1) the structure of the treatment systems, (2) the methods of assessing client needs and procedures for matching/referring clients to programs and services, and (3) the kinds of treatment services delivered to women offenders, focusing on gender-sensitive services, service delivery linkages, and performance gaps.

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[2] Detailed descriptions of the programs, upon which the systems analysis is based, are available from the authors.

Description of the Treatment Systems and Programs

The local treatment systems have a number of similarities and differences. Chief among their similarities is the high rate of substance abuse among women offenders, the availability of a range of programs and services intended to meet the needs of this population, and, despite recent efforts to expand and enhance treatment services for women offenders, various performance gaps, especially a sizable unmet demand for drug treatment. The main differences have to do with the number and kinds of programs available to women offenders. Rather than describe the structure of each treatment system separately, the following paragraphs discuss several themes that emerge when one examines various aspects of the systems' structure. Readers interested in fuller descriptions of particular systems and programs are referred to Appendix A. The main aspects discussed below have to do with changes in the system of treatment in relation to the range of programs available to women, linkages among organizations involved in the referral and service delivery processes, and the development of gender-sensitive programming.

Summary of the Trends

In general, the main trends appear to be as follows. First, there has been a considerable expansion in treatment capacity (i.e., the number of programs and slots) for women offenders. Second, there has been considerable progress in developing a continuum of treatment options for women offenders in various stages of both the criminal justice and recovery processes. This continuum includes both institution-based treatment programs and alternative to incarceration programs. Third, organizations have increased their efforts to improve system linkages. This can be seen in various efforts aimed at improving cooperation, coordination, and service delivery networks between criminal justice agencies and treatment providers and among treatment programs and other social service organizations.

Finally, and perhaps most importantly, service delivery has become more gender-sensitive in each of the systems. This can be seen in a variety of ways. New programs have been created exclusively for women, and some programs treat only certain groups of women, such as offenders, pregnant or postpartum addicts, or particular ethnic minorities. Most programs now attempt to empower women, to provide them with coping skills and a greater degree of social stability, and to help them become self-reliant and independent. This requires significant changes on the part of women who are dependent on men, social institutions, and drugs. Programs are attempting to provide women with comprehensive services by linking them to the various providers that can assist them. In some cases, innovative service delivery strategies are being tried.

System-wide Structural Changes

Until the late-1980s, options for treating drug-involved offenders, especially women, were relatively limited. For example, about the only options available specifically for offenders in Santa Clara County were Alcoholics Anonymous and Narcotics Anonymous meetings in the jail. As in most localities, criminal justice authorities, primarily probation officers, had to refer offenders to community-based treatment programs. These publicly funded programs served clients from a variety of referral sources, and sometimes they did not admit criminal justice clients, fearing that offenders might disrupt the therapeutic process for others.

The situation was similar in the other jurisdictions, including large cities such as New York and Chicago. Although these cities had a large number of community-based drug treatment programs, there were relatively few programs specifically for substance-abusing offenders or for women. Except where TASC programs existed--in our study sties, until about 1990, only Chicago and Birmingham had TASC programs--linkages between criminal justice agencies and drug treatment providers were not well formed (Falkin, 1993; Falkin et al., 1993). For these reasons, only a small percentage of women offenders who needed drug treatment received it, and community-based programs rarely tailored their services to meet the needs of this population.

Largely because of the influx of drug cases in the criminal justice system and jail overcrowding, local officials began, in the late-1980s, to expand alternatives to incarceration, in particular drug treatment programs (Falkin et al., 1993). Table 2 shows recent data on the prevalence of drug use among women arrestees in all of our local study sites.[3] As officials in each of the jurisdictions became aware of the increasing prevalence of drug use among women offenders and the unmet need for drug treatment, existing programs were expanded and new programs and services were developed.

For example, in 1988, Santa Clara County created the DEUCE program, an eight-week life-skills training program for women incarcerated in the jail. (A program for men was opened a couple of years earlier.) In 1990, Federal Anti-Drug Abuse block grants were used to start two community-based programs: (1) the Treatment Alternatives Program (TAP), an outpatient program for men and women, including criminal justice clients as well as others (e.g., voluntary admissions), and (2) the Women's Relapse Prevention program (WRPP), an outpatient program for women who have completed their primary treatment and are involved in the Santa Clara County criminal justice system. As part of its plan for developing a system of services for criminal justice clients, the county created Comprehensive Offender Drug Abuse Programming (CODAP), a program modeled after TASC. In 1992, Santa Clara County became one of five counties in the Bay Area Service Network, which was organized to systematically link parolees returning to the area to drug treatment programs. Also in 1992, the Sobriety Through Education and Prevention Services (STEPS) program expanded its services to provide outpatient counseling to women in all stages of the criminal justice process.

There was a similar expansion of treatment programs in the last several years in each of the other systems, including the creation of new programs specifically for women offenders. These include criminal justice treatment programs, such as those in the Federal and state prison systems and local criminal justice systems (e.g., jail-based programs, probation and parole revocation facilities). Most of the local study sites expanded or established TASC or TASC-like programs (e.g., the TAIP program in Texas) to link criminal justice agencies and community-based treatment providers. Treatment options at the local level have also increased and now typically include a range of community-based programs (residential, intensive outpatient or day treatment programs, outpatient drug treatment programs, and 12-step support groups) to which criminal justice agencies refer women offenders.

The three prison-based drug treatment programs included in the case study are part of the California, Ohio, and Federal prison systems. The Forever Free substance abuse program was

[3] It was serendipitous that the treatment systems that we selected for the case study were DUF sites.

created in 1991 at the California Institute for Women (CIW). Modeled on the 12-step philosophy, Forever Free is a four- to six-month program with a capacity of 120 inmates. It provides drug education, relapse prevention, aggression replacement training, women's workshops, 12-Step groups, case management, and transitional planning. Forever Free contracts with several residential treatment programs to provide aftercare treatment to women paroled in their area. The Tapestry program was established in 1990 at the Ohio Reformatory for Women. Modeled after the Stay'n Out program in New York (Falkin, et al., 1992), Tapestry is a therapeutic community intended to provide about nine months of treatment (the program has capacity for 80 women). The Atwood program was created in 1989 at the Lexington Federal Correctional Institution as part of a Bureau of Prisons research and demonstration program initiative. The Atwood program, with a capacity for 84 women, is one of three pilot programs that provide comprehensive drug treatment services based on both 12-step and therapeutic community concepts and practices. Key aspects of the intervention are a low inmate-staff ratio (12:1), long-term treatment (12 months), intensive programming (about 20 hours per week), and transitional services.

In nearly all the localities (i.e., New York City, Chicago, Santa Clara County, and San Antonio), drug treatment is available in the jails. Birmingham does not provide treatment in the jail because of a policy that emphasizes alternatives to incarceration. The jails operate separate programs for women who are usually housed in units separate from the general inmate population. The main differences among these programs, however, have to do with their treatment philosophy and practice. The Cook County jail has two drug treatment programs for women. Gateway, a multi-site therapeutic community based in Chicago, operates a therapeutic community for women serving jail sentences. The Sheriff's Furlough Program, staffed by TASC, provides daytime treatment activities in the jail to eligible pre-sentenced women and permits them to return home afterwards with electronic monitoring. The program is intended to enhance the women's ties to the community. About five outside providers enter the jail each day to help the women and set them up with supportive services in the community. Gateway provides two to three hours of drug abuse treatment each day. The DEUCE program in Santa Clara County and La Mariposa in San Antonio are both drug education programs based on the 12-step approach. The SAID program in New York City is a modified therapeutic community.

TASC or TASC-like programs are the main link between criminal justice agencies and local treatment programs. These programs assess clients' needs, refer clients to treatment programs, and provide case management services (e.g., referring clients to other, ancillary service providers, monitoring client progress in treatment, and reporting client progress to criminal justice authorities). The TASC programs in Birmingham and Chicago are two of the oldest and most highly regarded TASC programs in the nation (both were established in the mid-1970s). TASC-like programs were recently created in Bexar (San Antonio) and Santa Clara (San Jose) Counties. The Treatment Alternative to Incarceration Program (TAIP) was established in the Bexar County Detention Center as part of a state-level initiative of the Texas Commission on Alcohol and Drug Abuse (TCADA). TAIP screens individuals for drug abuse and recommends drug treatment as an alternative to pretrial detention for individuals whom it believes can benefit from treatment. As part of the CODAP program mentioned above, Santa Clara County also created a TASC-like program.

TASC and TASC-like programs are especially important from a systems perspective because they link criminal justice agencies with treatment providers. They serve an especially important function for women since criminal justice authorities usually do not have the expertise to assess their service needs, and they often have inadequate knowledge of and access to treatment resources.

Gender-sensitive Systems. Perhaps the most important changes have been the increase in women-only programs and the general trend toward gender-sensitive programming, especially in the community. Programs created in the last few years specifically for women offenders include: (1) the Crossroads program, a women-only drug treatment program established in New York City as part of the Mayor's alternative to incarceration initiative, (2) the WRPR program in Santa Clara County, and (3) all the jail- and prison-based programs. Moreover, in most of the local systems, there has been an increase in the number and size of women-only programs that serve offenders and other populations (e.g., Alethia House, Amethyst, Alpha House).

Although there is considerable diversity in terms of the approaches to treatment found in each system, there is general agreement that treatment should address women's issues and that services should be gender-relevant.[4] In the view of most of the treatment providers we interviewed, the main problems the women confront stem from the fact that their lives tend to be disorganized or unstable, that they have serious relationship problems, especially with men, and that they have multiple commitments (to children and families, and to human service and criminal justice agencies). These women tend to be dependent on men and social institutions, as well as on drugs. Moreover, many of the them were victims of physical and sexual abuse as children and continue to be victimized as adults. Partly because their lives are disorganized, this population of women typically has commitments to several authoritative agencies--criminal justice, child welfare, social service, and public assistance agencies. Many of these women have great difficulty meeting their commitments (including several weekly appointments with agency staff), and they need considerable support (especially support from treatment programs) to fulfill their obligations.

Because of these problems, most staff felt that the recovery process for women is different from the recovery process for men. For women to stay off drugs, it is essential that programs empower them, teach them coping skills, and help them develop support networks. In the view of many of the treatment providers we interviewed, drug abuse makes it difficult for individuals to function effectively--to earn a living, to find adequate housing, to extract oneself from abusive relationships, to obtain proper medical care. Conversely, women whose lives are characterized by dependencies and disorganization use drugs. Thus, recovery from drug use cannot be achieved unless their lives become more stable, especially in the areas of housing, income, family, and physical condition. Thus, most of the programs place a special emphasis on providing services to meet these basic needs.

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[4] The diversity can be seen by the fact that treatment systems may include residential programs based on the 12-Step philosophy, the therapeutic community concept, and various eclectic approaches. Although outpatient treatment programs tend to utilize a variety of methods and interventions to influence behavioral change, programs tend to differ in terms of the emphasis they have on certain treatment philosophies and therapeutic approaches, such as self-help strategies, relapse prevention, cognitive therapy (e.g., rational emotive therapy, correcting criminal thinking errors), drug education, family involvement, vocational training, or spirituality.

Programs had different approaches to helping women gain independence. For example, staff at Haymarket House and LSSI's Women's Residence in Chicago said that women need to learn how to make their own arrangements for baby-sitting, jobs, education, and transportation themselves. According to LSSI, the women need to learn to "reach out to peers." The Alpha Home in San Antonio attempts to separate women from men, especially from men they have trouble with; the Patrician Movement requires family members to be involved in the therapeutic process (i.e., family therapy). The WORC program emphasizes job training and placement; the Sheriff's Furlough Program emphasizes the development of community ties and support networks. Later, we describe in more detail these and other gender-relevant services and the service delivery strategies that link clients to various providers in the system. Regardless of the different views staff hold about women clients and the services they need, all share a holistic approach to treatment. In our view, the emphasis on providing gender-relevant services transcends whatever differences one can point to in the specific approaches to treatment.

Although most of the individuals we interviewed spoke at length about the importance of various aspects of gender-relevant treatment, some did not seem to share this view. Those relatively few individuals were men or women working in some of the correctional facilities we visited. Interestingly, despite their adherence to traditional, male-oriented approaches to treatment, these programs were part of larger systems that were moving in the direction of becoming more sensitive and response to women's needs.

Performance Gaps

Although some jurisdictions have made more progress in enhancing the treatment system for women offenders, there continue to be performance gaps and, therefore, areas for further improvement. Even where capacity has increased significantly, it still falls far short of demand. Although the range of treatment options for women offenders has increased considerably in some systems, many women are still excluded from treatment (e.g., because eligibility criteria exclude pregnant addicts, dually diagnosed clients, or offenders charged with or convicted of certain offenses). Furthermore, women are sometimes unable to access services that they need because of obstacles such as a lack of child care and transportation or bureaucratic red-tape. Although there is clearly a trend toward making service delivery more gender-sensitive, there are still some mixed gender programs and some women-only programs that have a male-oriented approach to treatment.

Client-Treatment Matching

Whether women receive the services they need depends not only on the availability of appropriate services but also on the ability of organizations to identify clients' needs and match clients to services. In general, the processes for matching men and women offenders to treatment programs are much the same; however, there are a few important gender-related considerations. These have to do primarily with whether organizations are able to identify the specific needs of women and match women to appropriate treatment services. Accordingly, this section describes several themes related to how referral and intake procedures, needs assessment methods, and admission eligibility criteria influence the kinds of treatment services that women offenders receive.

The main themes that emerge from the case study are (1) that organizations must make a special effort to recruit women offenders, particularly in jails, if they are to enter treatment; (2) that there is no uniform method of identifying women's needs and no commonly accepted theory for determining the appropriateness of services; (3) that assessment methods, nevertheless, have been able to identify gender-specific needs and facilitate the delivery of services that women need; (4) that there are different viewpoints on the appropriateness of women-only programs; and (5) that certain women are excluded from treatment because the criteria for referral or admission make them ineligible.

The Importance of Recruitment

From a systems perspective, decisions are regularly made to match clients to treatment programs and services (McLellan et al., 1983). In the case of offenders, matching decisions are made by criminal justice authorities or their intermediaries (e.g., TASC), who refer clients to treatment programs, or by treatment providers during the intake process. For example, prison and jail officials (e.g., classification committees, medical personnel, and correctional officers) may refer substance abusers to treatment programs within a prison or jail, and TASC case managers and probation and parole officers refer clients to treatment programs in the community. At this level, the client is matched to a program, and although decisions about the particular services clients receive are basically left to program staff, the decision to refer a client to a particular program determines the range of services the client is likely to receive. At the program level, intake staff assess clients to determine the kinds of services they need. If a program is not able to provide certain services, clients are either referred to another program, or they are admitted and services are brokered with other providers.

Because of the complexity of this process, procedures are developed to identify individuals who need treatment and to refer them to appropriate programs.[5] As we described in an earlier report (Falkin 1993), criminal justice agencies in some of the jurisdictions have begun to screen offenders and refer them to TASC or to drug treatment programs as an alternative to prosecution or incarceration. In most cases, however, these efforts are not sufficient to engage offenders in treatment, and programs need to reach out to recruit clients from various groups of offenders. This is a common practice among prison and jail programs, which recruit from the general inmate population, but some community-based programs also send staff into jails to recruit clients. For example, programs such as WORC and CROSSROADS in New York, and the TASC programs in Birmingham and Chicago, screen jail inmates either for the purpose of recommending treatment as an alternative to pretrial detention or as an alternative to incarceration. Unless programs such as these have adequate resources to recruit clients on a routine basis, women who could otherwise be placed in community-based treatment programs remain in jail.

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[5] One should make a distinction between (1) a *screening*, which is done to determine whether an individual needs drug treatment and whether a particular program is suitable for her needs, and (2) a clinical *assessment*, which is a more detailed exploration into client needs for the purposes of determining whether a client should be referred or admitted to a particular program (e.g., some programs exclude clients after a diagnosis of mental illness), identifying the services a client needs (e.g., medical care, housing assistance, vocational training), and developing a treatment plan.

Lack of Uniform Assessment Methods/Matching Procedures

The methodology for assessing client needs and matching clients to treatment programs and services is far from standardized. There are two problems with this. First, one cannot be sure that women's needs are always being identified. Although some of the programs used standardized assessment instruments (e.g., TASC in Birmingham, TAIP in San Antonio, the treatment program at the Atwood Correctional Facility), most of the programs did not. Most programs use instruments that they developed themselves, and some community-based programs have trained and experienced staff conduct clinical intake interviews without any assessment instruments. In Chicago, for example, five of the programs that we visited developed their own instruments for conducting psychosocial assessments; one program used the ASI. In programs that conduct a clinical intake interview without any instrument, one cannot be certain that possible areas of need are being explored consistently for all clients.

Staff at most of the programs we visited tended to have mixed feelings about using standardized assessment instruments for screening or evaluating clients. In their view, standardized instruments were either too long to screen clients or not flexible enough to assess client needs. Some programs, such as WORC, have only about 10 minutes to screen prospective clients in jail. After judges refer women to the program based on WORC's recommendation, client needs are carefully assessed using a protocol developed by the program. While it is understandable that programs may not have sufficient time to adequately assess client needs in many instances that screenings are conducted, certain standardized instruments can be administered in a matter of minutes. These include the Michigan Alcohol Screening Test (MAST) and the Substance Abuse Subtle Screening Inventory (SASSI; copyright by Glen A. Miller, 1983). The TAIP programs in Texas use the SASSI instrument because it can be administered in about 10 minutes, and it can distinguish whether an individual is dependent on drugs and needs treatment. Perhaps a more serious concern expressed by some staff is that standardized instruments are not sensitive enough to cultural and gender differences.

Although some staff were concerned that standardized instruments might add paperwork, most thought they might be helpful, especially if staff could write notes that were of special interest to them. Thus, the efforts of the Federal government, in particular the Center for Substance Abuse Treatment, to develop and disseminate screening and assessment protocols may enhance the prospects of identifying women's needs. Given the reluctance of many programs to use standardized instruments, however, a more pragmatic strategy might be for the Federal and state alcohol and drug abuse agencies to offer technical assistance to programs to help them improve their assessment protocols, and training to sensitize intake staff to gender-related issues.

Second, there is no commonly agreed upon theory for matching clients to treatment programs. The OPI was developed on the basis of the theory that individuals with lower stakes in conformity need more structured and intensive treatment. Thus, TASC clients in Birmingham are referred to residential or outpatient treatment depending on whether their stakes in conformity are relatively low or high, respectively. In contrast, the TASC program in Chicago, which was also a study site in the project that developed the OPI, refers clients to residential or outpatient treatment depending upon the level of resources available to the client in terms of family support and support in the community. The TAIP program in San Antonio, which uses the SASSI, makes the distinction between residential and outpatient treatment based on the severity of the drug

problem. (The SASSI distinguishes between drug abuse and drug dependence, with the latter requiring residential treatment.) Other domains related to social support and social functioning may be considered, but there is no theory or method for systematically integrating them into the referral decision.

Because there is no commonly agreed-upon theory or set of goals for matching clients to programs and services, it is difficult to assess the system's performance in matching women offenders to appropriate treatment programs and services. At best, one can attempt to assess the merits of individual approaches, and perhaps make recommendations about which aspects should be standardized.

Assessment Methods Appear to be Adequate for Matching Clients to Treatment Programs and Services

Despite the diversity in assessment methods and matching criteria, it is our impression that treatment programs are generally evaluating clients for the full range of possible service needs. Most treatment programs conduct a thorough psychosocial assessment during the intake process or shortly after admission. These assessments usually delve into all the areas of need found in standardized instruments, such as the OPI and the ASI. These include drug use and drug treatment history, criminal justice involvement, psycho-social functioning, interpersonal relationships, education, employment history, housing situation, health status, and other areas relevant to treatment planning.

Programs do not always have time to fully explore all these areas during intake, and counselors obtain additional information during the treatment orientation phase, as well as the therapeutic process generally. Furthermore, most programs do not have the expertise to conduct psychiatric diagnoses, medical examinations, vocational assessments, and other evaluations requiring specialized training. Most of the programs have developed procedures to ensure that clients are thoroughly evaluated. In the WORC program, for example, clients are initially assessed by a counselor who is also a registered nurse, and vocational training plans are developed after vocational counselors conduct further, detailed assessments of clients' vocational needs. A number of other programs have medical and mental health specialists who conduct clinical evaluations. For example, the Haymarket House in Chicago has a part-time psychiatrist who evaluates and treats clients, and the LSSI Women's Residence has a doctor to conduct physical examinations. After admission, clients in all the programs we visited in Chicago are routinely referred to Central Intake, which does medical screenings and checks for communicable diseases and other medical problems. Central Intake is a unit of Interventions, a major therapeutic community based in Chicago.

Referrals to Women-only Programs

The individuals we interviewed expressed different views about placing women in women-only programs. For example, staff in Chicago TASC believe that women's programs tend to emphasize family issues and exhibit greater sensitivity to women's issues. In particular, women's programs protect women from physical and sexual harassment and from the discrimination that sometimes occurs in mixed-gender programs, and they provide a safer environment in which women can talk about sexual issues and the physical and sexual violence they have experienced.

The Director of the Alpha Home in San Antonio articulated what many individuals who favor women-only programs feel--that the women need to be separated from men because they are dependent on them and because their problems are tied to relationships with men, and that substance-abusing women cannot stay sober unless they become self-reliant.

On the other hand, the Director of the Patrician Movement, a mixed-gender program in San Antonio, expressed the opposing view. For recovery to last, in his view, treatment programs cannot create an artificial environment; rather, women must learn to live lives of sobriety with men around. Sometimes there are practical considerations and certain obstacles to placing women in women-only programs. For example, although Alethia House staff generally agree that women are better off in the program's separate counseling track for women, some women do not join the women's group. Certain women prefer to engage in treatment with men, and the program respects client desires in this regard. Also, the women's group meets in the morning, and women who have jobs at that time attend the men's group in the afternoon or early evening. (TASC generally refers working women to the University of Alabama at Birmingham's outpatient substance abuse treatment program, which has a more flexible counseling schedule.)

Lack of Treatment Because of Eligibility Criteria

Women are excluded from treatment either because the communities do not have programs to provide these services to offenders or because programs do not accept women with particular problems. It is quite likely that the eligibility criteria for referral and admission to treatment exclude many women who would benefit from drug treatment.

Treatment programs often exclude pregnant and postpartum women because they do not have facilities for infants. The Hitchcock program, for example, specifically excludes pregnant women in their third trimester from long-term treatment because it does not have facilities for babies. While the program has the option of admitting these women to its short-term treatment component, research on treatment effectiveness suggests that long-term treatment is necessary to prevent some of these women from recidivating. Similarly, treatment options appear to be limited nearly everywhere for dually diagnosed individuals. On the other hand, it should be noted that most of the programs we visited give priority to women who are HIV-positive.

Women in certain legal statuses are sometimes excluded from treatment. In Chicago, for example, TASC excludes individuals convicted of violent crimes, major drug dealers, and, according to statute, offenders convicted of residential burglary with a prior felony conviction. Most jurisdictions commonly exclude violent offenders and other categories of offenders from treatment in community-based programs, despite the fact that research has demonstrated that treatment can be effective with them (Falkin, et al., 1992; 1993). In California, for example, the Phoenix House program for women accepts individuals with a history of violence. Some drug abusers are excluded from long-term treatment in prison-based therapeutic communities because they do not meet admission criteria (e.g., inmates may be required to have at least nine months left to serve). If they are to receive treatment, these women will have to wait until they are released to the community. For some, this represents a missed opportunity because these programs have been shown to be highly effective in reducing recidivism, even among women with histories of violence (Falkin et al., 1992).

Service Delivery

In addition to drug treatment services, most of the programs also provide a variety of other services intended to meet the various needs of women. The basic treatment protocol consists of drug education, individual and group counseling, and involvement in 12-step support groups, and programs often supplement these services with relapse prevention counseling, acupuncture, urine testing, and other support services, including medical care, remedial education, and job training. Drug treatment programs have traditionally delivered these support services or brokered for them with other providers. Recently, programs have also begun to provide new services for women, such as support groups for survivors of rape and incest. This section discusses three aspects of the services women offenders receive: (1) the kinds of services delivered to meet the particular needs of women, (2) service delivery strategies and practices, and (3) the gaps that still exist between the services available in the treatment systems and the needs that women have.

Gender-relevant Treatment Services

As we stated earlier, programs in all the treatment systems, especially at the local level, are providing women with gender-relevant services. The main ones that influence the recovery process, in the view of treatment providers, are: (1) housing assistance, (2) child care, (3) counseling for relationship problems (e.g., for physical and sexual abuse), (4) income and employment assistance, and (5) medical care. The provision of these services, in conjunction with the drug treatment protocol, is intended to help the women lead stable, drug-free lives with a sense of empowerment, effective coping skills, and a strong support network.

Housing. Finding adequate housing for women was repeatedly mentioned as a primary concern of the treatment providers that we interviewed. At the time they are arrested, many drug-abusing women do not have adequate living arrangements. They may be living in cramped and poorly equipped apartments with their children; they may be sharing space with partners who are abusive; they may be in public housing or in other areas that are not safe from drugs and violence; or they may be homeless, staying temporarily in shelters, with friends, or on the streets. If they are released from jail or sentenced to probation with a condition of drug treatment, finding adequate housing is often crucial to the recovery process, especially for outpatient treatment. Residential drug treatment is often indicated for individuals who do not have adequate housing, but this only solves the problem temporarily. Similarly, although it is not an issue for individuals while they are incarcerated, many offenders, especially women, do not have suitable housing to return to after they are released.

Most of the systems had a variety of options to assist women with housing while they are in the recovery process. Some of the systems had a range of residential treatment options that could be used to remove women from detrimental environments. In Chicago, for example, there are several large therapeutic communities (e.g., Interventions, Gateway); Haymarket House is a comprehensive residential treatment facility that has separate components for prenatal and postpartum women, a short-term treatment program, and a recovery home; the Alcohol and Drug Dependence program of Lutheran Social Services of Illinois operates the Women's Treatment Center, which has a group home for pregnant and postpartum substance-abusing women, and the Women's Residence, a treatment facility for employed and employable women; and Human Development Resources Institute (HDRI) operates a residential treatment program for African-

American women. Thus, in Chicago, there is a range of residential treatment options for women in various stages of the recovery process.

In other areas, such as Birmingham and Santa Clara County, residential treatment is quite limited. In Birmingham--as in nearly all localities--outpatient drug treatment is the main modality, and although there are a number of halfway houses and recovery homes, they are mainly for men. Nonetheless, there are some residential options for women, and TASC is able to keep women clients in supportive housing for up to a year after release from prison by moving them from one facility to another. For example, women can be placed in St. Ann's halfway house and moved to Fellowship House's supervised dormitory and then to the apartments managed by graduates of Fellowship House. This approach has the advantage of gradually reducing structure (and resources) while increasing the individual's self-reliance; however, it requires case management. In Santa Clara County, as in many other areas, there is a paucity of residential drug treatment facilities for women.

Although residential treatment programs usually require women to have suitable housing before they are discharged, it should not be forgotten that some women drop out of treatment, and they are likely to return to poor living arrangements.

Children and child care. Arranging for the care of children, especially babies and preschool children, while their mothers are in drug treatment or incarcerated is a major problem. Some of the communities had residential treatment programs for mothers and their children. For example, when we visited Haymarket House in Chicago, we saw the children who were living with their mothers in the postpartum program, and we learned that LSSI's Women's Treatment Center also allows preschool-age children to live with their mothers. Staff care for the children while the mothers are in treatment. These arrangements are the exception to the rule, since most residential programs do not have living areas for children.

In San Antonio, neither of the two main programs that provide residential drug treatment to women offenders have facilities for children, nor do they provide day-care or baby-sitting for mothers in their outpatient treatment components. In 1992, a small residential treatment program opened for pregnant women and mothers with children up to three years of age. The ARC-WC program--currently the only residential treatment program in San Antonio with facilities for women and their children--housed 14 women and 11 children at the time of our site visit. The situation is much the same in Birmingham and Santa Clara County, where there are no residential treatment programs for mothers and their young children. Although Alethia House has a residence in Birmingham for pregnant drug abusers, the women have to move to other housing after they give birth. The lack of residential treatment for mothers and their young children is one of the main factors that makes it difficult for many women to enter residential treatment, especially long-term treatment programs.[6] To overcome this obstacle, some of the programs,

[6] Women with dependent children often fear that they will lose custody if they admit that they use drugs. Some women prefer to stay with their children rather than enter residential treatment--only to lose custody later on, after becoming severely dysfunctional (Wallace 1991). Criminal justice clients may not have a choice in the matter in that once they are identified as drug users, they can be mandated to treatment. After being convicted and mandated to treatment, especially to residential treatment, there is a risk that they will lose custody.

such as Alpha House in San Antonio, help mothers find caretakers for their children so that the mothers can enter residential treatment.

The difficulty in finding care for the children of mothers in outpatient drug treatment is also a serious problem. Without baby-sitting or daycare arrangements, mothers with young children are usually unable to attend outpatient treatment. A number of the outpatient programs that we studied (e.g., TAP and WRPP in Santa Clara County; Project Success in Chicago) provide these services on the premises. In the absence of such services, mothers have to arrange for child care in order to attend outpatient treatment. In the view of a number of providers, women in treatment usually do not have the skills and stability to handle all the arrangements, and the lack of child care--a serious problem even in large cities such as Chicago--is one of the main deterrents to regular participation in outpatient treatment. Because many daycare programs take children only within a certain age--in Chicago, it appears that none of them take infants--a mother with four children, for example, may have to drop off her children at two or three different locations before taking a bus to school or the treatment site. In the evening, she has to reverse the procedure.

We learned of several innovative approaches to dealing with the problem of child care. In Chicago, the Department of Children and Family Services (DCFS) has funded Project S.A.F.E., an intensive outpatient treatment program that arranges for outreach workers to pick up mothers and bring them to treatment and to take the children to daycare. It operates at a number of sites in the city, including Project Success and Haymarket House. Amethyst, one of the residential programs in Cleveland, is currently collaborating with the local YWCA to create a "therapeutic daycare" program for its clients' children. Two of the jails also had innovative programs for mothers and their children. The jail in San Antonio created the MATCH program, which provides mothers with training in childrearing and with extended visitation. Program staff meet separately with MATCH clients and their children after contact visitation to help them clarify and deal with issues that arise during visitation (other inmates see their children through glass partitions in the visiting area). The Women and Infant Nurturing Services (WINGS) program at the Rikers Island jail enables mothers to live with their newborn infants (up to one-and-a-half years old) and receive training in infant care and postpartum care.

Services for Relationship Problems. Because so many of the women currently in drug treatment are victims of physical and sexual abuse, programs have begun to provide services to address these issues. In the view of most of the providers that we interviewed, drug treatment cannot succeed unless these underlying problems are addressed. There are a number of ways that programs help women to deal with abusive partners: (1) they teach women how to avoid being abused and/or how to cope with abusive partners, (2) they provide counseling to the abusive partners (e.g., family counseling and men's groups), and (3) they encourage the women to separate from their partners.

We found services to support each of these approaches. Some of the programs have support groups for survivors of rape and incest; some provide group counseling specifically for women living with abusive men. HDRI, for example, refers severe sexual abuse cases to the Cook County Hospital, which has an intensive program for sexually abused women. Many of the programs also provide education and training in family planning and the prevention of sexually transmitted diseases (STDs). Staff at a number of the programs (e.g., Project Success, Patrician

Movement) expressed the view that unless the men are also involved in the treatment process, no progress or change will be possible for the women (some programs had the opposite view). To confront the fact that some women cannot readily leave abusive partners, some programs, such as Project Success in Chicago, also have a group for men that focuses on issues of abuse, as well as on family planning and the role of the man in the household. Some of the women in outpatient treatment live in shelters for battered women.

Income and Employment Assistance. One of the main issues related to long-term recovery is economic independence. The vast majority of the women in publicly funded treatment programs are indigent and have limited marketable skills. There appear to be several approaches to dealing with this problem. These include providing clients with help in obtaining public assistance, requiring clients to work while they are in treatment, referring them to vocational training and placement agencies, and providing job training at the primary treatment site.

Although some programs emphasize vocational training and job placement, others do little to assist their clients in gaining vocational skills or jobs. Either work is not a viable option for their clients, in their view (e.g., they may have too many children or be unable to readily learn marketable job skills), or the programs do not have the resources to assist clients with jobs (e.g., some residential treatment programs cannot provide vocational training while clients are in residence). In these cases, programs usually help clients obtain adequate public assistance (e.g., food stamps, welfare, Medicaid). With additional support throughout the recovery process, these individuals may be able to live on public assistance without committing crimes or using drugs.

Among the programs that placed an emphasis on employment, some of them, such as Alpha Home and Lutheran Social Services of Illinois (LSSI) Women's Residence, required that clients be employed as a condition of living in the treatment facility/halfway house. These programs believe that work is essential to the recovery process, and all clients are required to have jobs within a few weeks after admission. (No one has been discharged from treatment at Alpha House because of failing to obtain employment; the program has a large network in the community and provides clients with assistance in finding jobs.) The only service provided by these programs, and by some of the other outpatient programs that also place an importance on work, is assistance in finding a job. Program staff use their network of associates in the community to help clients find jobs. Other programs, such as HDRI and Amethyst, refer clients to community agencies (e.g., DOORS in Chicago, and the Private Industry Council and the Urban League in Cleveland) for job placement and/or vocational training services.

Some residential treatment programs help clients develop job skills on-site. The WORC program in Nassau County and the Patrician Movement in San Antonio are two notable examples. The Patrician Movement offers 75 classes, of which each client is required to take 32 classes as indicated in her treatment plan. In addition to classes in AIDS prevention, relapse prevention, and other therapeutic issues, individuals can take classes in remedial education (to obtain a GED, for example). A computer-assisted learning lab is available, which provides immediate feedback. Clients have responded quite favorably to this, and PM has been able to use the technology to teach some of the clients basic word processing and data entry. While these skills prepare some clients for work, the Patrician Movement views them as incidental to substance abuse treatment. About one month prior to transfer from the residential center, the vocational counselor assists the client in obtaining vocational training, employment, or further education. Clients are referred to

community resources such as Texas Vocational Rehabilitation. During a two- or three-week transition period, clients go to school or work, and the vocational counselor can assist them with any difficulties related to work.

The WORC program in Nassau County is probably the most innovative program, among the ones we studied, as far as work is concerned. The primary mission of this program is to help women offenders develop job skills and find work. This outpatient program offers vocational training in a variety of areas (e.g., computer word processing, data entry, business administration), and clients receive drug education and counseling from another provider (Jewish Community Services). While the program helps clients develop fairly conventional job skills, using traditional training methods, it sets an important example for two reasons. First, it is training women for employment in jobs that are in demand and that pay reasonably good wages. Second, most drug treatment programs do not provide job training (Wellisch et al., 1993).

Gender-specific Medical Care. Many of the women who enter treatment for drug abuse have serious physical problems; some also have mental health problems. Programs refer clients for a variety of gender-specific medical services, including prenatal and postpartum care, gynecological examinations, and treatment for STDs. AIDS prevention is a major concern because this population is at high risk for contracting and transmitting HIV through sexual activity and by sharing injection needles. In Chicago, the TASC program's Health Education and Support (HES) unit has an HIV prevention program. The program has four components: education, follow-up, HIV prevention case management, and emergency assistance. The follow-up component consists of individual counseling, behavior modification, and other support services such as providing clothing to clients and helping clients obtain SSI.

Most of the treatment programs also have AIDS prevention components, which include education and group counseling for all clients and referrals to specialized services for HIV-positive clients. Programs such as Project Success distribute condoms and bleach. (The distribution of bleach is controversial both because recent evidence indicates that it may not be effective using previously recommended procedures (Centers for Disease Control, 1993; Shapshak et al., 1993) and because some programs believe that it is counter to the recovery process.)

Strategies for Enhancing Service Delivery Linkages

It is rarely if ever the case that a program--whether in the community or in an institution--is able to meet all the needs of its clients. Most often, programs have the ability to provide a limited range of services, and they must align with other providers to obtain the full range of services that their clients need. Prison- and jail-based treatment programs nearly always have to coordinate with other units within the institution for medical services, psychiatric care, and job training, and they have to develop ties with community providers if clients are to continue in aftercare treatment upon release. Although some community-based programs have the resources to provide for a broad range of client needs, even programs that are considered comprehensive usually depend on other organizations to deliver specialized services (e.g., medical and psychiatric care, Medicaid and other forms of public assistance, GED and job training). As the previous description of treatment services indicates, most community-based programs need to cooperate with a range of organizations to obtain the services their clients need.

From a systems perspective, the better connected the various organizations in the system are, the better able they are, collectively, to provide clients with needed services. In theory, the more integrated the system is, the smaller the performance gaps are likely to be. That is, the more the various service providers work together, the more likely it is that they will meet the specific needs vital to the recovery process. This section discusses several strategies that organizations use to link clients to other service providers in the system (both community- and institution-based). The main strategies seem to be: (1) *individual assistance* to help clients obtain services (usually on an ad hoc basis), (2) *case management* (which is a more formal and systematic approach), and (3) *networking* and *brokering* with other programs to enhance existing services and obtain additional services for clients. We have identified these strategies by examining service delivery to women offenders in the study sites. They are not intended to be mutually exclusive or exhaustive. Rather, they illustrate a variety of ways in which organizations can--and do--improve their system's capacity to meet women's needs.

Individual Assistance. "Individual assistance" refers to various methods by which program staff, usually counselors, help clients obtain services from other organizations in the system. For example, counselors in jail and prison programs often refer clients to the mental health unit for psychiatric care or specialized counseling (e.g., for victims of sexual abuse). Most prison-based treatment programs provide clients with assistance in aftercare planning. In many cases, this simply involves connecting the client with an AA or NA sponsor; in some cases, prison staff coordinate with parole agents to place clients in community-based treatment programs. The SAID program created a Discharge Placement Unit (DPU) to enable clients leaving Rikers Island to continue in treatment. The DPU contacts community-based treatment providers and refers clients to them.

In the community, programs assist clients in dealing with government bureaucracies by referring them to other service providers and sometimes by providing transportation. Staff at Project Success mentioned that they often provide TASC clients with extra help in obtaining child care because they know that without child care these clients are at risk of failing in outpatient treatment, and they will be returned to jail. Thus, individual assistance can be provided on an informal and ad hoc basis, or it can be provided systematically to all clients for a particular service (e.g., aftercare).

Case Management. A particularly important strategy for women offenders is case management. Case management is especially important for individuals, such as offenders, who are involved in multiple systems. Case managers work directly with clients to assist them in obtaining services from a variety of organizations and to help them meet obligations that government agencies impose. Thus, case management is a systematic approach that both provides clients with individual assistance and assists criminal justice and other agencies in managing clients. Some of the treatment programs, such as Crossroads, assigned clients to case managers in addition to primary counselors, but most treatment programs do not have the resources to employ case managers. Although counselors perform some case management functions, the extent of this activity is often not sufficient for clients involved in the criminal justice system.

In our view, therefore, it is essential for communities to have a TASC program or some other program that can provide the full range of case management functions for offenders, especially women. The case management services that TASC provides for women offenders are crucial not only because many treatment programs do not have the resources, but also because women's success in the recovery process usually depends on case management. Furthermore, case management functions are often more involved and more specialized for offenders than staff at most treatment programs are able to perform. In addition to dealing with a variety of private providers and government agencies (for social services, public assistance, child custody matters, etc.), offenders are under the authority of criminal justice agencies, which usually have special requirements (e.g., urine testing, court hearings, reporting on client progress in treatment).

Brokering Services. In brokering, the primary service provider acts as an intermediary to assist clients in obtaining services from other organizations. There are several methods of brokering services. These include formal methods for coordinating the delivery of services (e.g., contracting, written service agreements) and informal arrangements, such as negotiating with outside agencies on behalf of clients and having voluntary groups work with clients on-site. Informal relationships have traditionally been the main approach in service delivery. In this approach, the primary program provides clients with individual assistance by negotiating or otherwise intervening directly with other agencies. The more recent trend has been to develop formal linkages for the delivery of services.

Examples of formal agreements can be found both in institution- and community-based programs. For example, the New York City Department of Corrections contracts with Montefiore Hospital for detoxification, methadone maintenance, the WINGS program, and medical care generally. In the Sheriff's Furlough Program, a number of community agencies enter the jail to provide treatment and help the women establish ties in the community. Another particularly good example of multiple agencies coordinating to deliver services to women in jail is the ADAPT program in Portland, Oregon, which serves pregnant substance abusers, and which we reviewed in an earlier study (see Wellisch, Prendergast, & Anglin, 1993).

In the community, HDRI, for example, has a service agreement with Cook County Hospital so that it can refer clients to the hospital's program for sexually abused women, as mentioned above. It also has a service agreement with Interventions for certain services, such as medical assessments, detoxification, and second-stage housing. Both HDRI and Haymarket refer clients to Interventions for second-stage housing (i.e., a halfway house where recovering women can live with up to three of their children), and Haymarket refers clients who need additional treatment after completing its short-term (28-day) treatment program to HDRI for long-term residential treatment.

The primary treatment provider can either have outside organizations deliver services in its facility, or it can refer clients to services off-site. In providing clients with support services, the primary program negotiates or otherwise intervenes directly with other agencies. Sometimes clients are referred to programs for specialized services. Several programs referred clients to other organizations for medical care and vocational assistance (e.g., for job placement, HDRI refers clients to DOORS and Amethyst refers clients to the Private Industry Counsel and the Urban League). At other times, programs bring specialists in (e.g., a psychiatrist from the state hospital in San Antonio provides clients at Alpha Home with alcohol and drug education classes).

Programs often broker with local colleges to provide clients with remedial education, either by having faculty deliver services on-site or by having clients attend classes at the college. Whether clients receive services off-site or on-site, the important point is that brokering is a more formal and systematic approach than individual assistance because the primary provider has agreements from other agencies that they will deliver services to its clients.

Brokering is a particularly important strategy for developing service delivery linkages because (1) programs do not have the resources to deliver comprehensive services, especially those services that only a small proportion of clients need, (2) organizations tend to specialize in providing certain services, and therefore they have become dependent on one another, and (3) women offenders need multiple services.

Networking. Networking is a strategy for developing knowledge of additional resources and programs with which providers can broker for services, and a way of learning about innovative service delivery practices that a program can adopt for the benefit of clients. In each of the systems, treatment providers cited examples of how they used their professional networks, either formally or informally, to help their clients. For example, counselors who attended training sessions networked with other counselors. In Santa Clara County, WRPP staff are involved in training and meetings sponsored by the County Bureau of Alcohol and Drug Abuse Programs, and they interact with service providers in the community on a case-by-case basis.

We also learned of the existence of formal networks of human service providers in several sites. On the Southside of Chicago, a coalition of treatment providers meets monthly and offers opportunities for networking and developing service agreements. In Santa Clara County, the several community agencies are part of the AIDS Service Provider and Perinatal Substance Abuse Network. To the extent that networks of service providers exist, system linkages can develop, and, as systems become more integrated, the potential for closing service delivery gaps increases.

Performance Gaps

In general, there are two kinds of gaps in the systems' performance: (1) women in different stages of the recovery process are unable to receive treatment when they need it (because of a lack of treatment resources, exclusionary criteria, waiting lists, and other procedural constraints), and (2) those in treatment are not able to have some of their vital needs met. We conclude by highlighting the main performance gaps that still exist in the systems visited.

It should be noted that in discussing these gaps our intention is not to be critical of the study sites, but rather to point to areas in need of further improvement. If anything, the extent of the problems in these sites is less serious than in many other locations. That is because we selected the sites on the basis of their gender-sensitive and state-of-the-art treatment.

First, there is a significant lack of treatment resources for women offenders relative to the demand. In particular, there is a lack of residential treatment beds and supportive housing in the community. Drug treatment is especially limited for women who are pregnant, postpartum, mentally ill, homeless, or violent because many programs do not admit such women. Although criminal justice agencies can mandate drug treatment, the lack of options acts as a constraint that

in effect leads judges to incarcerate some women who might otherwise be placed in the community.

In many areas there are long delays before women can enter residential treatment. In Chicago, for example, waiting lists are five to six months for residential programs, and six weeks or longer for some outpatient programs. About one-third of the individuals who qualify for treatment remain in jail either because they cannot afford a bond or because the judge wants them to remain incarcerated until a treatment slot is available. To close the gap, TASC has a pre-treatment program for the other two-thirds. This program provides a modest level of services and contact with case workers (e.g., group counseling once a week, referrals to self-help support groups, random urine testing at least once a month). More of such programs are needed in addition to expanding the system's treatment capacity.

Second, most jurisdictions lack adequate case management services for women offenders. Although TASC programs existed in most of the study sites, the large majority of jurisdictions throughout the country do not have TASC programs. Even in New York City, TASC operates in only three of the five boroughs. In jurisdictions that have TASC programs, additional resources are needed to reduce caseloads. In jurisdictions that do not have TASC programs, probation and parole agencies need to create specialized units that provide case management services for women. Without programs such as TASC, linkages between criminal justice authorities and community-based treatment providers cannot be adequate.

Third, there is a lack of support services that women need if they are to succeed in the recovery process. In particular, the main support services that need to be enhanced are child care, transportation, vocational training, and transitional services for women leaving institutions. Although some programs have facilities for children, the facilities are often limited (e.g., Project Success provides baby-sitting for children up to two years old, but it has no facilities or staff for nursery services or daycare). Many programs do not provide any services for children. Furthermore, in many cities, including large urban areas like Chicago, very few programs are available, especially in low-income neighborhoods, for babies and older children of mothers who need treatment.

Although it is impossible to estimate how many drug-involved women in the criminal justice system fail to enter treatment because of the lack of child care services, the more important point is that for mothers who do enter treatment, participation in program activities is inevitably more difficult because of this lack. The obstacles to arranging for child care, as Project Success staff pointed out, also make it difficult for women to attend self-help support groups in the evening, which is a near universal requirement for clients in outpatient treatment programs. For mothers, we believe that the lack of child care services is the biggest obstacle to entering and completing treatment.

The lack of adequate public transportation in some communities (e.g., Birmingham), and the fact that many programs do not have the resources to provide clients with transportation, make it difficult for clients to access services, attend GED classes or go to work, and meet other commitments.

Although there has been a significant increase in the last few years in the number of jail- and prison-based drug treatment programs, relatively few of these programs have strong transitional components. Furthermore, a large proportion of drug abusers do not enter treatment while incarcerated, and though some of these women may be mandated to treatment as a condition of probation or parole, there are virtually no formal transitional services linking them to the community.

Although vocational training is crucial for most women to develop marketable job skills, their ability to become self-supporting is limited by general economic conditions. Thus, while we believe that programs should encourage clients to work or to engage in vocational training, we also recognize that this can lead to frustration if women are not able to obtain jobs. Therefore, all the service gaps that need to be corrected must be viewed in a larger social context. The success of drug treatment efforts for women offenders depends not only on the ability of agencies to develop strong linkages, but also on the ability of society in general to provide adequate housing and jobs.

REFERENCES

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

Austin, J., Bloom, B., & Donahue, T. (1992). *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.

Ball, J.C., Shaffer, J.W., & Nurco, D.W. (1983). Day to day criminality of heroin addicts in Baltimore: Study in the continuity of offense rates. *Drug and Alcohol Dependence*, 12, 119-142.

Belenko, S. (1990). The impact of drug offenders on the criminal justice system. In: R. Weisheit (Ed.), *Drugs, Crime and the Criminal Justice System* (pp. 27-78). Cincinnati: Anderson Publishing Co.

Brownstein, H.H., & Goldstein, P.J. (1990). A typology of drug related homicides, In: R. Weisheit (Ed.), *Drugs, Crime, and the Criminal Justice System* (pp. 171-192). Cincinnati: Anderson Publishing Co..

Bureau of Justice Statistics (1990). *Women in Prison: A Special Report*. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice.

Bureau of Justice Statistics (1993). *Survey of State Prison Inmates, 1991*. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice.

Centers for Disease Control (1993). Use of bleach for disinfection of drug injection equipment. *Morbidity and Mortality Weekly Report*, 42(21), 418-9.

CJN Drug Letter (1993). Criminal justice groups urge new focus on drug treatment. *CJN Drug Letter*, 2(2), 3. Washington, DC: Pace Publications.

Cuskey, W. (1982). Female addiction: A review of the literature. *Journal of Addictions and Health*, 3, 3-33.

Daley, B., & Przybycin, C. (1989). Cocaine-dependent women have unique treatment needs. *Addiction Letter*, 5(10).

De Leon, G., & Jainchill, N. (1982). Male and female drug abusers: Social psychological status two years after treatment in a therapeutic community. *American Journal of Drug and Alcohol Abuse*, 9, 465-497.

Dunlap, E. (1992). Impact of drugs on family life and kin networks in the inner-city African-American single-parent household. In: A. Harrell & G. Peterson (Eds.), *Drugs, Crime, and Social Isolation: Barriers to Urban Opportunity*. Washington, DC: Urban Institute Press.

Fagan, J. (1992). Drug selling and licit income in distressed neighborhoods: The economic lives of street-level drug users and dealers. In: A. Harrell & G. Peterson (Eds.), *Drugs, Crime, and Social Isolation: Barriers to Urban Opportunity* (pp. 99-146). Washington, DC: Urban Institute Press.

Falkin, G.P. (1993). *Coordinating Drug Treatment for Offenders*. New York: National Development and Research Institutes, Inc.

Falkin, G.P., Lipton, D.S., & Wexler, H.K. 1992. Drug treatment in state prisons. In D.R. Gerstein and H.J. Harwood (eds.), *Treating Drug Problems*. Vol. 2. Washington, DC: National Academy Press.

Falkin, G.P., Prendergast, M., & Anglin, M.D. (1993). Drug treatment within the criminal justice system: Research in brief. New York: National Development and Research Institutes, Inc.

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

Gerstein, D.R., & Harwood, H.J. (Eds.) (1990). *Treating Drug Problems.* Vol. 1: *A Study of the Evolution, Effectiveness, and Financing of Public and Private Drug Treatment Systems.* Washington, DC: National Academy Press.

Harlow, C.W. (1991). *Drugs and Jail Inmates, 1989* (BJS Special Report, NCJ-130836). Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice.

Hser, Y., Chou, C., & Anglin, M.D. (1990). The criminality of female narcotics addicts: A casual modeling approach. *Journal of Quantitative Criminology*, 6(2), 207-228.

Hser, Y., Longshore, D., & Anglin, M.D. (1994). Drug use prevalence among criminal offender populations: Implications for control, treatment, and policy. In: D.L. Mackinzie and C.D. Uchida (Eds.), *Drugs and the Criminal Justice System: Evaluating Public Policy Initiatives.* Newbury Park, CA: Sage Publications.

Hser, Y., Prendergast, M., Anglin, M.D., Chen, J., & Hseih, J. (1994). A regression analysis for estimating the number of drug-using arrestees in 200 U.S. cities. Manuscript submitted for publication, UCLA Drug Abuse Research Center.

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

Inciardi, J.A. (1979). Heroin use and street crime. *Crime and Delinquency*, 25(3), 335-346.:

Inciardi, J.A. (1986). *The War on Drugs: Heroin, Cocaine, Crime, and Public Policy*, Palo Alto: Mayfield.

Johnson, B.D., Goldstein, P., Preble, E., Schmeidler, J., Lipton, D.S., Spunt, B., & Miller, T. (1985). *Taking Care of Business: The Economics of Crime by Heroin Abusers.* Lexington, MA: Lexington Books.

Kleber, H.D. (1989). Interview--From theory to practice: The planned treatment of drug users. *International Journal of the Addictions*, 24(92), 123-166.

Lord-Zankowski, G. (1988). Responsive programming: Meeting the needs of chemically dependent women. *Alcoholism Treatment Quarterly*, 4(4), 53-66.

McBride, D.C. & Swartz, J.A. (1990). Drugs and violence in the age of crack cocaine, In: M. Tonry and J.Q. Wilson (Eds.), *Drug Use and Crime* (pp. 141-169). Chicago: University of Chicago Press.

McLellan, A., Luborsky, L., Woody, G., & O'Brien, C. (1983). Predicting response to alcohol and drug abuse treatment: Role of psychiatric severity, *Archives of General Psychiatry*, 40, 620-625.

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

Pearlman, P., West, K., & Dalton, J. (1982). Mothers and children together: Parenting in a substance abuse program. In G.M. Beschner, B.G. Reed, & J. Mondanaro (Eds.), *Treatment Services for Drug Dependent Women* (Vol. 2; Treatment Research Monograph Series). Rockville, MD: National Institute on Drug Abuse.

Prendergast, M., Hser, Y., Chen, J., & Hsieh, J. (1992). Treatment need among offender populations. Paper presented at the 44th Annual Meeting of the American Society of Criminology, New Orleans, LA, November 4-7, 1992.

Ryan, V.S. (1980). Differences between males and females in drug treatment programs. In A. Schecter (Ed.), *Drug Dependence and Teratology*, 9, 295-299.

Sanchez, J.E. & Johnson, B.D. (1987). Women and the drug-crime connection: Crime rates among drug-abusing women at Rikers Island. *Journal of Psychedelic Drugs*. 19(2), 200-216.

Shapshak, P., McCoy, C.B., Rivers, J.E., et al. (1993). Inactivation of human immunodeficiency virus-1 at short time intervals using undiluted bleach. *Journal of Acquired Immune Deficiency Syndromes*, 6, 218-219.

Simpson, D.D., Joe, G.W., Lehman, W.E.K., & Sells, S.B. (1986). Addiction careers: Etiology, treatment, and 12-year follow-up outcomes. *Journal of Drug Issues*, 16(1), 107-121.

Sutker, P.B., DeSanto, N.A., & Allain, A.N. (1985). Adjective self-descriptions in antisocial men and women. *Journal of Psychopathology and Behavioral Assessment*, 7, 175-181.

U.S. General Accounting Office (1991). *Drug Treatment: State Prisons Face Challenges in Providing Services* (GAO/HRD-91128). Washington, DC: U.S. General Accounting Office.

Wallace, B.C. (1992). Crack cocaine: What constitutes state of the art treatment? *Journal of Addictive Diseases*, 11(2), 79-95.

Wallen, J. (1992). A comparison of male and female clients in substance abuse treatment. *Journal of Substance Abuse Treatment*, 9, 243-248.

Wellisch, J., Anglin, M.D., & Prendergast, M.L. (1993a). Numbers and characteristics of drug-using women in the criminal justice system: Implications for treatment. *Journal of Drug Issues*, 23(1), 7-30.

Wellisch, J., Prendergast, M.L., & Anglin, M.D. (1993). Jail: A found opportunity for intervening with drug-abusing pregnant women. Submitted for publication. Los Angeles: UCLA Drug Abuse Research Center.

Wellisch, J., Prendergast, M., & Anglin, M.D. (1994). Needs assessment and services for drug-abusing women offenders: Results from a national survey of treatment programs. (Project report submitted to the National Instititute of Justice). Los Angeles: UCLA Drug Abuse Research Center.

Wells, D.V.B., & Jackson, J.F. (1992). HIV and chemically dependent women: Recommendations for appropriate health care and drug treatment services. *International Journal of the Addictions*, 27(5), 571-585.

Table 1
Study Sites (N=30)

Treatment System	Treatment Modality/ Setting	Program
Local System		
San Antonio	Jail	Treatment Alternative to Incarceration Program
		La Mariposa
		MATCH
	Probation	Probation Violation Program
	Parole	Parole Violation Program
	Residential	ARC-WC
	Residential & Outpatient	Patrician Movement (PM)
		Alpha Home
New York City and Nassau County	Jail	Substance Abuse Intervention Division (SAID)
	Outpatient	CROSSROADS
		Women's Opportunity Resource Center (WORC)
Santa Clara	Jail	Deuce
	Outpatient	Treatment Alternative Program (TAP)
		Sobriety Through Education & Prevention Service (STEPS)
		Women's Relapse Prevention Project (WRPP)
	Residential	Casa Esperanza
	Linkage	Comprehensive Offender Drug Abuse Planning (CODAP)
Chicago	Jail	Sheriff's Furlough Program
	Linkage	TASC
	Residential	Haymarket House
		LSSI Women's Residence
		Human Resources Development Institute (HDRI)
	Outpatient	Substance Abuse Services Inc.--Project Success
Cleveland	Residential & Outpatient	Hitchcock
		Amethyst
Birmingham	Residential & Outpatient	Alethia House
	Linkage	TASC
Prison System		
Federal Bureau of Prisons	Lexington, KY	Atwood Program
California DOC	Frontera	Forever Free
Ohio DOC	Cleveland	Tapestry

Table 2

Prevalence of Drug Use Among Women Arrestees in Study Sites

Study Site	Positive (in percent) 1988	1990
Birmingham		
Any drug	65	67
Cocaine	38	43
Chicago		
Any drug	77	n.a.
Cocaine	70	n.a.
Cleveland		
Any drug	n.a.	73
Cocaine	n.a.	65
New York City (Manhattan)		
Any drug	80	71
Cocaine	75	64
San Antonio		
Any drug	51	41
Cocaine	26	23
San Jose		
Any drug	n.a.	57
Cocaine	n.a.	27

Source: National Institute of Justice, DUF Annual Report, March 1990 and August 1991