189584

Dwight Correctional Center
Evaluation of the Residential Substance Abuse Treatment for State Prisoners (1997)

Funded through the National Institute of Justice
Grant #16.560

FINAL REPORT Closeout

Approved By: _____

Date: 8/1/01

ACCEPTED AS FINAL REPORT

Approved By: _____

Date: 8/01/01

Evaluation conducted by:
Center for Addiction Technology, Education, and Evaluation (CATEE)

Cheryl Mejta, Ph.D.
Executive Director

Jacqueline M. Mullany, Ph.D.
Director of Research
Project Evaluator

Deborah Michalski, M.A.
Research Associate
Statistician

Draft And Final Product 97-RT-VX-K017

ACKNOWLEDGMENTS

Report Prepared by: Jacqueline M. Mullany, Ph.D.
Deborah Michalski, M.A.

Data Collection by: Deborah Michalski, M.A.
Jeff McKenzie, M.A.

Special thanks to IDOC and Gateway staff who assisted in this project:

Dorene Gilman, Ph.D.
Substance Abuse Services
Illinois Department of Corrections

Steve Karr
Research and Planning Unit
Illinois Department of Corrections

Denise Perry
Site Supervisor
Gateway Foundation/Dwight Correctional Center

TABLE OF CONTENTS

I. INTRODUCTION

A. Statement of the Problem

The link between criminal activity and substance abuse is well documented. About fifty percent of inmates in federal facilities, state prisons, and local jails are estimated to have substance abuse problems (Scheckel, 1993; U.S. General Accounting Office, 1991). Substance abuse problems among incarcerated women is a particular concern. Wellisch, et.al. (1994) reported that the fastest growing population within the criminal justice system is women arrested on drug charges. In an attempt to break the substance abuse-criminal activity cycle, substance abuse treatment programs found to be effective in the community, have been adapted to correctional settings.

Evaluation research on correctional-based treatment, however, remains minimal and focuses primarily upon male offenders. Little is known about the impact of correctional-based substance abuse treatment programs on female offenders. Research on community-based substance abuse treatment programs has highlighted the need for the implementation of gender-specific substance-abuse treatment.

This report is a summary of the evaluation conducted of the residential substance abuse treatment program offered at Illinois' Dwight Correctional Center, a 670-bed prison for women. Forty-three percent of the women in Illinois prisons are sentenced for drug offenses. Of that 43 percent, 62 percent indicated that they would enter treatment voluntarily while in prison (Nicklas, 1997).

As a result of the demand and need for substance abuse treatment, Gateway Foundation established a controlled drug treatment program at the Dwight Correctional Facility in September, 1998. The designated housing units conduct group, individual, and peer counseling sessions. Support group participation includes Alcoholics Anonymous and Narcotics Anonymous.

During fiscal year 1995, funding for a 448 bed, treatment housing unit had been approved and scheduled for construction in April, 1996. It formally began accepting clients as of December, 1998 and services 109 women at any given time, Expansion of the Gateway Foundation drug treatment services included the Kankakee program for approximately 80 beds. This evaluation provides a better understanding of the program and provides a "picture" of the women entering into treatment versus those who choose against treatment.

B. The Link Between Criminal Activity and Substance Abuse

Substance abuse is at the heart of much of the crime that plaques our communities. For some offenders, substance abuse is just one of the many behaviors reflecting a criminal lifestyle.

For other offenders, criminal behavior arises directly from their substance abuse. Crime, including robbery, burglary, theft, prostitution, possession and sales of illegal substances and credit card and check fraud are among the principal means to support substance abuse habits. And, substance abusers who also deal drugs often employ violence to protect their "turf."

A critical step in reducing drug-related crime is to treat the offender's substance abuse disorder. By offering treatment, we may be able to break the cycle of further criminal activity.

The relationship between substance abuse and subsequent criminal activity is highly pronounced throughout the entire system. Perhaps the greatest example of this relationship can be seen in the influx of substance-abusing offenders within our correctional institutions.

> "Nationwide, over 500,000 of the 680,000 inmates in State prisons [are estimated to] have substance abuse problems." (U.S. General Accounting Office, 1991)
>
> "Drug offenders accounted for over 56 percent of the population of Federal correctional facilities in 1991, up from 25 percent in 1979." (Scheckel, 1993)
>
> "And, in our local jails, over half of the inmates reported being under the influence of drugs or alcohol at the time of their offense, with over 70 percent of offenders in many metropolitan areas testing positive for drugs. " (Scheckel, 1993)

According to Lipton (1996: 13), when not incarcerated, drug-abusing offenders are neither interested in treatment nor do they seek treatment. This fact, coupled with the escalating numbers of substance-abusing offenders within our correctional facilities, suggests that our correctional institutions may provide the perfect opportunity to provide treatment to its' substance-abusing population.

Despite this research, the number of inmates receiving treatment within our correctional facilities has been inadequate. While the number of criminal justice agencies offering treatment has increased throughout the past several years, "the sheer volume of addicted offenders combined with cuts in local budgets has placed tremendous strain on these programs" (Scheckel, 1993). "Fewer than 20 percent of State correctional inmates are receiving any type of drug treatment in prison." (U.S. General Accounting Office, 1991). Without treatment, substance-abusing offenders probably will continue to move through the revolving doors of our criminal justice system with increased frequency.

C. Correctional-based Substance Abuse Treatment for the Female Offender

The problem of substance abuse and its impact on our correctional institutions is most evident within our female correctional institutions. Between 1980 and 1992, there was a 276 percent increase in the female prison population ("Drug Treatment for Women Reported to be Inadequate." October 17, 1996). Within Illinois, the number of women incarcerated has almost quadrupled in 10 years, presently exceeding 2100 women (Illinois Department of Corrections, 1997).

Women arrested on drug charges constitute the fastest growing population within the criminal justice system. According to Austin, et.al. (1992), the number of women arrested for drug law violations increased by 307 percent between 1980 and 1989. Forty-three percent of the women in Illinois prisons have been sentenced for drug offenses; of that, 62 percent indicate that they would enter treatment voluntarily while in prison (Nicklas, 1997).

Despite these increases, little information exists which pertains to the unique treatment needs of the substance-abusing female offender population. While evaluations of substance abuse programs do exist, most results are generalized to include the effectiveness of treatment for both male and females. Few evaluations are broken down by gender.

It is important that evaluations be conducted on treatment programs within our female correctional facilities. Treatment needs of women are different than that of men. Women have different criminal and life profiles, different substance abuse histories, different reasons for engaging in substance abuse, and different responses to treatment.

The criminal profile of the female offender is different from that of the male offender. The typical female offender is charged with non-violent, property or drug offenses and possesses a non-violent criminal history. She enters the correctional facility with a host of unique medical, psychological, and financial problems. She is often under the age of 30, a single mother, welfare recipient, and sole supporter of her children. She tends to be unemployed and undereducated, with few marketable skills. She is generally from a dysfunctional family, has been a victim of sexual and physical abuse, was raised in a single parent household, and had parents who used drugs and alcohol. In addition, she often exhibits serious, even crippling dependencies on men, drugs, and welfare. Furthermore, intravenous drug use remains a major source of growth in HIV infection among women.

Differences between men and women offenders' substance abuse histories are well documented. Women tend to have higher rates of drug dependency than men (Loucks and Zamble, 1994; Snell, 1992). Compared to male inmates, females in jail were more involved in illegal drug use (Snell, 1992). Moreover, they were about twice as likely as men to report having used a major drug the month before their arrest (Snell, 1992).

Research also demonstrates that treatment needs for women substance abusers are different from those of male substance abusers. Compared to men, "women have higher physical vulnerability to substances and a shorter interval between first problem and first treatment episode (el-Guebaly, 1995). Nelson-Zlupko, et. al. (1995) argue that traditional treatment programs (within and outside correctional institutions) are designed to treat male addicts and fail to address the treatment needs of women.

While research and statistics suggests that drug use among women inmates is a problem of severe magnitude and agree that women with substance abuse issues present unique needs, treatment for this population remains inadequate. According to a study by the U.S. Sentencing Project (1995), a Washington, D.C. based research and policy advocacy group, there are not enough treatment programs in prisons and jails to accommodate the number of women who need treatment. This study argues that "despite the fact that women involved in the criminal justice system are more likely than men to use drugs and use more serious drugs, existing treatment models have not always been designed...to incorporate the multiple needs of these women [in contact with the criminal justice system] - women who are apt to be indigent, undereducated, cut off from family networks, and who suffer disproportionately from histories of family violence, incest, rape, and mental illness" (U.S. Sentencing Project, 1995). The development of female specific treatment is critical to the recovery of women offenders within our prisons.

In order to develop effective programs for women, evaluations of existing treatment programs needs to be conducted. Currently evaluation research on the effectiveness of treatment programs for women inmates is minimal at best. This lack of gender-specific data drastically impedes any efforts to modify existing programs and/or create new programs which best meets the needs of this population.

D. Effectiveness of Correctional-based Substance Abuse Treatment

While evaluation research on correctional-based treatment, for both men and women, remains minimal, recent findings suggest that treatment can have a substantial impact not only on the offenders, but on the correctional institution and the correctional staff.

For the substance-abusing offender, correctional-based treatment programs are successful in providing a pathway out of a lifestyle of substance abuse and crime. In an evaluation of a therapeutic community program based in the New York state prison system, "The Stay'n Out Program", Wexler (1995) found program participation produced positive outcomes, with both male and female participants who completed treatment having fewer incidents of parole revocation than non-participants. The National Council on Crime and Delinquency (NCCD) and the National Institute of Justice (NIJ) conducted two separate evaluations on correctional-based treatment. NCCD conducted evaluations in 1994 on five jail-based substance abuse treatment programs, three located in California, and two in New York.

NIJ's evaluation consisted of programs in California, New York, and Delaware. According to both studies, inmates receiving treatment had lower recidivism rates that the control group who did not receive treatment. More specifically, the treatment program based in California's Amity Prison, which separates substance abusers from the rest of the prison population, has reduced the recidivism rate from 60 percent to 25 percent (NIJ, 1996).

Treatment is also shown to have a positive impact on other aspects of the inmate's life. According to the Office of National Drug Control Policy's 1996 Strategy Report, treatment leads to life improvements including increases in educational status and improvements in interpersonal relationships, health, legal status, and mental health. In one follow-up, 79 participants were employed upon release (Office of National Drug Control Policy, 1995).

According to some research studies, the greatest immediate effect of correctional-based treatment can be seen in the change of the institutional environment. Studies have shown that: tension is reduced, stress is minimized, cleanliness is improved, and incidents/tickets among inmates are reduced. An evaluation of the maximum security prison in Delaware found that the section of this prison which offered treatment was the cleanest section, the safest section, and most trouble-free section of the prison (Inciardi, 1996). Moreover, staff were able to conduct their job more effectively and feel an increased sense of job satisfaction.

Finally, treatment within correctional facilities is cost-effective. "Every $1 invested in treatment programs net a $4 return through the decrease in drug-related crime, crime justice processing costs, and theft" (Scheckel, 1993).

II. PARTICIPATING AGENCIES

National Institute of Justice

The National Institute of Justice (NIJ), a component of the Office of Justice Programs, is the research agency of the U.S. Department of Justice. It was created by the Omnibus Crime Control and Safe Streets Act of 1968. The National Institute of Justice is authorized to support research, evaluation, and demonstration programs, development of technology, and both national and international information dissemination.

IDOC

The Illinois Department of Corrections operates adult and juvenile institutions and provides parole/aftercare supervision through its Community Services and Juvenile divisions. The Director of Corrections is appointed by the Governor with approval of the Senate. Within the Adult Division, twenty-six centers hold approximately 44,000 residents. Nearly 31,000 adult offenders are supervised through the PreStart program. Ninety-four percent of the adult population are male; 6 percent are female (Illinois Department of Corrections, Inmate Data, 1999).

Dwight Correctional Center

The Dwight Correctional Center, located approximately 75 miles south of Chicago, is the primary state correctional/reception and classification facility for adult female offenders. The facility was opened on November 24, 1930, as the Oakdale Reformatory for Women. Subsequently, the facility was renamed the Illinois State Reformatory for Women and again renamed the Dwight Correctional Center in August, 1973.

The Center has a design capacity for 670 inmates; with an average daily population of 750 inmates. The average age of the inmate is 32. And, the average annual cost per inmate is $21,329.00. Dwight was reaccredited in1993 by the American Correctional Association.

Services offered at Dwight through various programs include:

- educational programming
- cosmetology classes
- vocational programming, including computer technology, commercial art and photography, secretarial science, and restaurant management
- parenting classes
- interpersonal communication
- family relations
- drug and alcohol treatment
- medical services
- mental health services
- religious programming
- dietary services

Gateway Foundation

Gateway Foundation was founded in 1968 as an Illinois based, private, not-for-profit organization. Gateway has grown to a multiple-service organization, with services including residential and outpatient treatment, prevention programming for high-risk persons, comprehensive services for HIV-positive recovering drug users, and DUI assessment and educational programs.

Gateway now provides therapeutic community treatment in correctional facilities in five states: Illinois, Texas, Missouri, Kansas, and Virginia. In Illinois, Gateway provides TC treatment for men and women at the Cook County Jail, and in Illinois Department of Corrections facilities; for men at Graham, Jacksonville, Lincoln, Logan, Taylorville, and Sheridan, and for women at Dwight, Kankakee and Logan.

Through its various services, Gateway reaches more than 20,000 people each year with prevention programs, adolescent and adult outpatient programs, adolescent and adult residential programs, and programs in correctional institutions.

Center for Addiction Technology, Education, and Evaluation (CATEE)

The Center for Addiction Technology, Education and Evaluation (CATEE0, established by Federal Grant #5 U98 T100859-05, produces and delivers professional development and continuing education programs for professionals working with clients affected by addictions, participates in research efforts which investigate innovative approaches to treatment and prevention of addictive disorders, and disseminates advancement in addiction technology through special training initiatives, participation in national forums, and collaborative partnerships within a wide spectrum of academic, criminal justice, medical and community-based organizations.

CATEE is housed at Governors State University with its grant activities; funded by the U.S. Department of Health and Human Services, and administered by the Center for Substance Abuse Treatment. Governors State University was one of only eleven institutions nationwide to receive an addiction training center grant to increase the number of new addictions treatment professional and to enhance the competencies of existing addictions treatment professionals.

Governors State University, accredited by the North Central Association of Colleges and Secondary Schools, is a public university founded in 1969. It houses four colleges: the College of Arts and Sciences, the College of Business and Public Administration, the College of Education, and the College of Health Professions. Bachelors degrees are offered in 17 undergraduate majors, including Criminal Justice. Masters degrees are offered in 18 majors, including Addictions Studies and a masters of Political and Justice Studies. An undergraduate minor is also offered in Addictions studies.

III. PROGRAM DESCRIPTION

During fiscal year 1995, funding for a 448 bed, treatment housing unit had been approved and scheduled for construction in April, 1996. It formally began accepting clients as of December 1998 and services approximately 109 clients at any given time. As of June 30, 2000, the program has served 321 women since grant inception. Women stay in the program anywhere from six to 12 months.

The following paragraphs outline the structure of the Gateway treatment program. Most of the information was extracted from the"Guide to Therapeutic Community Treatment" (Hess, 1998) produced by the Gateway Foundation and from an interview with Denise Perry, site supervisor of the Gateway Substance Abuse Program at Dwight Correctional Facility..

Therapeutic Community Structure:

Gateway's therapeutic communities utilize four tools: constant, everyday reminders of appropriate behavior, a structure that rewards effort and appropriate behavior and fosters responsibility and teamwork; education about the skills, attitudes, and behaviors the individual will need in order to build a substance-free and crime-free life and that enable individuals to identify and address the effects of their chemical dependency; and the opportunity to practice appropriate behaviors and experience the consequences of failure and success. These tools are used in the context of various meetings, offenders work responsibilities, group and individual therapy, and group education; the tools enable the participants to experience a community that is both demanding and supportive and that will enable participants to begin the process of recovery from chemical dependency

Phases of Treatment

Phase I - Orientation: Clients remain in Phase I for approximately 14 to 30 days and participate in 24 to 45 hours of service each week. The focus in Phase I is assessment and diagnosis of the client's condition, development of a treatment plan that identifies each client's needs and the activities that will address those needs, and orientation to the therapeutic community and to the cognitive self-change process. Clients are expected to learn the rules and tools of the community, and utilize them correctly. They learn about the structure board and are assigned a job within the community.

Upon entering the TC, staff perform an assessment with the client, and based on the information gathered, the counselor works with the client to develop an individualized treatment plan. The assessment typically documents identifying information, social, family, and educational history, vocational history, substance abuse history, and prior substance abuse, and/or psychiatric treatment history. The clinical assessment process at Gateway focuses on obtaining information that enables staff to determine the severity of the client's chemical dependency, the effects of the client's substance use on other areas of the client's life, and the client's comprehensive treatment needs.

In Phase I, clients learn self-observation. They learn to identify target behaviors, behaviors that cause them trouble in life, like drug use, problems with authority, or criminal activity. They also learn to identify the thoughts that are associated with those behaviors, and they learn to identify specific instances or situations of those behaviors.

In Phase I, a client must demonstrate an understanding of the rules and tools of the therapeutic community and have begun to use them, and she must have begun the process of engaging in recovery. In order to move from Phase I to Phase II, clients must:

- attend orientation education
- complete all assessments
- complete the Step I worksheet or an equivalent acceptance of his/her addiction
- accurately recite the Gateway philosophy in front of peers and staff
- demonstrate knowledge of the treatment course, therapeutic tools, and clients' responsibilities by passing the orientation test and making the minimum number of announcements and pull ups
- become familiar with the continuum of care process via lectures and handouts
- demonstrate assimilation into the therapeutic community environment by following house rules and engaging in community involvement
- demonstrate understanding of the connection between thoughts, feelings, and behaviors
- demonstrate the ability to do a thinking report

Phase II - Intensive Treatment: Clients remain in Phase II for approximately six to nine months. The major focus of Phase II is to engage in the recovery process and begin to build the knowledge base, skills, and insight necessary to remain crime-free and drug-free, In order to accomplish this, clients participate in intensive treatment activities, strengthen autonomous decision-making skills, develop a capacity for self-management, and take a participatory role in peer support group and therapeutic community activities. Therapeutic activities include individual and group therapy, group education, participation in AA/NA and other support groups, and participation in the activities of the therapeutic community.

As they progress through Phase II, clients become able to take on increasingly responsible jobs within the therapeutic community. Clients begin to work through the twelve steps or to utilize the principles of a secular peer support group; they are able to identify thinking errors, and to use journaling and thinking reports to change their habitual thinking and behavior patterns. In counseling sessions, they begin to understand the connection between their criminal behavior and substance abuse and are able to identify attitudes and behaviors that must be changed.

In cognitive self-change therapy sessions, clients utilize two tools: thinking reports and journals. Thinking reports are a report on a specific situation in which a client had trouble of some kind. The client identifies the situation, records all thoughts during that situation, and identifies the feelings, attitudes, and beliefs that underlie the thoughts and behaviors. As clients provide these thinking reports, they begin to identify the thought patterns that get them into trouble, and they begin to learn how to intervene in this thought process and change it.

The focus in Phase II is on learning, developing, and practicing the skills needed to build a healthy, positive life. In order to move from Phase II to Phase III, a client must:

- participate in group and individual counseling and group education
- participate in indirect services, including recreation, work, and peer support meetings
- complete worksheets for recovery-oriented peer support groups
- complete all assignments in a timely manner
- attend assigned educational activities as required
- demonstrate knowledge of the disease concept
- increase ability to accept positions of greater responsibility within the community
- demonstrate knowledge of the connection between substance use and criminal behavior
- demonstrate the ability to utilize thinking reports and journals to identify thinking errors

Phase III - Transition: Clients remain in Phase III for approximately two to three months. The major focus of Phase III is the implementation and further development of relapse prevention plans and the beginning of planning for release into the community. Clients learn to further enhance and capitalize on growth they have made and skills they have gained. Group sessions and positions of responsibility within the community encourages clients to develop their social and personal growth skills. Clients develop increased psychological awareness. Clients also become adept at using the cognitive self-change skills developed through the treatment program. Group education and life skills classes focus on relapse prevention, family services, and preparing clients for transition to the community. At this Phase, clients are in a position of responsibility within the community. These job positions further enhance clients' vocational skills, as well as their confidence in their abilities.

The client's primary counselor works with the clients to formulate individualized aftercare plans immediately upon entry to this phase of treatment. The written aftercare plan includes any referrals to community-based treatment, contacts with Probation and Parole or other Department officials, and detailed relapse prevention plans.

Phase III clients facilitate the rules and tools education groups for new clients and the client-led evening seminars account the additional insights gained from counseling and positions of responsibility within the community. Clients remain in this Phase until their release from the facility.

In order to graduate from the treatment program, clients must:

- meet with primary counselor to develop a written discharge and aftercare plan
- compete all educational requirements
- complete a personal relapse prevention plan
- demonstrate ability to be a role model to new clients
- demonstrate ability to accept positions of highest responsibility within the community
- demonstrate progress in all treatment plan goals and objectives
- demonstrate ability to carry out relapse prevention plan
- demonstrate understanding of connections between substance use and criminal behavior
- demonstrate ability to identify thinking errors and develop cognitive interventions to correct thinking errors

In addition to the formal criteria described above, there are other signs of improvement that successful clients tend to display. Typically, as clients become engaged in the recovery process, they begin to be able to make the connections between their substance use and life problems. They demonstrate understanding of the first three steps; they participate in counseling groups; they ask questions to help them understand their addiction; their appearance and hygiene improves; they show up on time; they share and self-disclose in group sessions; they talk about their own usage; and they take an interest in the group process. Their self esteem improves, as do their decision-making and problem-solving skills. They formulate realistic vocational plans. And, they become able to look realistically to the future: they can think about where they want to be in five years and formulate realistic plans to get there..

Finally, successful clients become less concerned with "making it" - they are less concerned with relapse, because using is removed from the list of options in their lives. They are able to recognize mistakes and analyze how the mistake happened. They are able to determine when they need help addressing a problem, even if they can't solve the problems themselves. At this stage, clients are ready to graduate.

Treatment Components

Treatment components include ***individual counseling, group therapy, and group education***. ***Individual counseling*** is a goal-oriented, face-to-face session between the client and the primary counselor. The primary counselor works closely with the client to help her become acclimated and learn the basics of the community.

There are four primary ***group therapeutic activities***: morning or afternoon development groups, encounter groups, seminars and static groups. Morning development and afternoon development groups - also known as AMD and PMD - serve as a way for the therapeutic community- members to improve and maintain communication among themselves. All clients attend at least one each day. Group activities typically include clients' learning experiences; a thought for the day, presented by a members of a group; push-up or pull-ups; the introduction of any new client on the unit; any announcements; a "give away"; and a group recitation of the Gateway philosophy.

Encounter groups enable members of the therapeutic community to address negative behaviors and attitudes displayed by one or more members of the community when other methods have not effected the desired behavior change.

Static groups are similar to traditional group therapy; it is called a static group because the population of the group is based on the counselor's caseload and therefore remains static.

Although counselors differ somewhat, a typical static group counseling session may begin with any issues from previous session: problems resolved or unresolved since the last meeting, issues remaining, additional information about a subject or problem,

Group education addresses a variety of topics. Education about substance abuse and chemical dependency familiarize clients with the disease concept of chemical dependency and helps them explore and understand the interaction between their life problems and their chemical use.

Clients whose mental health or medical conditions require medication receive counseling on managing their medications while in recovery.

Education about life management and employability skills familiarizes clients with the processes of building or rebuilding a sober, crime-free, responsible life.

Clients who do not have a high school diploma or GED generally are able to work toward a GED at the program. Counselors also help clients develop realistic vocational goals and develop the skills and abilities to meet those goals.

Clients are also provided with relapse prevention skills. Relapse prevention focuses on developing stabilization management skills; clients become aware of and record their individual relapse triggers. Clients then develop a detailed plan for participating in healthy, prosocial activities and cultivating associations with people who are recovering and/or who live drug- and crime-free lives and they begin to act upon these plans.

Cognitive and emotional skills development takes place throughout the treatment program's activities as well as in education groups. Clients learn cognitive interventions to identify faulty thinking patterns and belief systems and to replace these errors with rational thinking and behavior.

Life skills classes teach clients health and nutrition, including how to adopt a healthy diet that maximizes health and recovery maintenance. HIV/AIDS education teaches clients about HIV/AIDS and teaches clients how to avoid contracting and transmitting HIV, and life skills classes in health, nutrition, and hygiene help clients begin to take better care of themselves.

Clients also learn techniques for managing stress and anger. The practices of the therapeutic community encourage and assist them in this process.

Group education about relationships and sexuality is threefold: to help a client identify dysfunctional family systems in his or her own life; to help repair relationships damaged by substance abuse; and to help him or her build healthy relationships, including healthy sexual relationships, in the future.

Education about family systems and relationships help clients learn and practice functional and healthy interactions and help clients achieve and maintain the pro-social behavior expected by the program.

Another aim of group education is to make the client aware and educated about domestic or family violence. The aim here is to help women and men recognize such violence, to be able to identify it in their own lives, to share their experience, to begin the process of healing, and to build a knowledge base about appropriate relationships.

Finally, in order to further facilitate long-term recovery, counselors provide orientation to 12-step programs and other self-help groups through 12-step education groups and through 12-step meetings. Gateway believes that 12-step groups provide clients with helpful techniques to achieve and maintain a recovery-oriented life.

IV. EVALUATION DESIGN

Phase 1:
A quasi-experimental design was used for the evaluation of the corrections-based substance abuse treatment program offered at the Dwight Women's Correctional Facility. Research participants (i.e., treatment group) were randomly selected from those female offenders entering the residential substance abuse treatment program at Dwight Correctional Center. The comparison control group was compromised of a group of randomly chosen female offenders from the general population. The control group women were randomly selected from the following correctional facilities: Decatur, Dwight, Dixon, and Logan. Each group consisted of a sample size of n=40; less than n=40 is noted at each occurrence.

The groups are similar considering two variables: gender, all 80 are female, and current status; all 80 were incarcerated at the time of the evaluation.

A static-group comparison approach (matched-groups design) was used to determine any differences between other variables measured within the two groups. An analysis of central tendency along with the statistical procedures of Pearson correlation and Paired Samples t-test were used to determine the significance of the results.

Questions to be addressed through this evaluation include:

- Who receives the program's services/Who does not receive these services?
- Are there some residents who benefit more than others from these services?
- What makes the treatment group amenable to treatment?
- What factors differentiate those who volunteer from the program from those who decline services?
- What differentiates those who successfully complete the program from those who do not?

Methodology/Data Collection
The data used for this study was collected from client files. The treatment group data is from automated data maintained by the Illinois Department of Corrections (IDOC), from self-report forms completed by the client at admission, and from Gateway forms that are completed at monitoring intervals during their stay in the substance abuse treatment program. The treatment group attendance records were not used in this analysis due to the fact that the subjects are incarcerated and attendance is mandatory.

Forms reviewed within the Gateway case files included:

- Initial Interview Form
- Initial Clinical Assessment: Diagnostic Summary
- Initial Clinical Assessment: Client Self-Report
- Client Information (Intake Form)

Forms reviewed from the IDOC case files included:

- Sentence History
- Inmate Overview Screen

Record keeping is the responsibility of Gateway Foundation; the files are kept on the IDOC premises.

Data for the control group were collected from IDOC case files maintained at various IDOC sites. Data collection took place at: Decatur, Dixon, Dwight, and Logan Correctional Facilities.

Forms reviewed included:

- Initial Classification Report
- Classification Summary Report
- Mental Health Evaluation
- Admission Review/Intake Form

Analysis

The first part of the findings are descriptive in nature. They provide a descriptive summary of the results of the data collection; there is no actual interpretive statistical analysis.

The second part of the findings include the qualitative analysis of the quantitative data. The two groups are compared and contrasted considering a number of variables. The data sources revealed a group of twenty-one (21) like variables (i.e. variables measured for both samples) that are reported within the evaluation report; the results are interpreted. The results are presented qualitatively by reviewing the data and compiling client profiles for each group.

The third part of the findings includes the quantitative analysis. The quantitative results were achieved by conducting the statistical procedures of Pearson Correlation and Paired Samples t-test. The Pearson correlation results in a coefficient between -1 and +1 and is used to determine the strength of the relationships among variables. The paired samples t-test is used to measure differences between two separate groups of participants considering the same, non-manipulated variables.

Phase II:

Phase II of the evaluation consisted of one-on-one interviews with the Gateway Site Supervisor and four (4) participants of the program. The interviews were voluntary and were conducted with the full consent of the participants being interviewed. Each participant was informed that their agreeing to participate in the interview would not hinder nor assist in their program stay.

All participants signed a consent to participate form and were informed of the purpose of the study. The women were offered a summary of the questions and were instructed that they did not have to answer questions they felt inappropriate. They were also informed that they could terminate the interview at any time.

They were told that all information was confidential,, and that their identity would not be revealed anywhere within the report. Each participant was interviewed individually.

Questions addressed through this phase of the evaluation include:

- What are the credentials of staff?
- Are there some staff who are more successful in working with residents than others
- What factors differentiate those staff who are highly affective from those who are not?
- What staff characteristics are most helpful?
- What is the most helpful aspect of the program?
- How has the program benefitted the participants?
- How has the program assisted the participants with:
  - adjusting to prison life?
  - mental health well-being?
  - ability to have healthy relationships?
  - attitude toward others?
  - attitude toward one self?

Data Collection

Interviews took place at the Dwight correctional facility through one-on-one personal interviews. Interview questions were both structured and unstructured.

V. FINDINGS - PHASE I - CASE FILE REVIEW

This section is broken down into three components: descriptive statistics, qualitative analysis, and quantitative analysis. The descriptive statistics summarizes client data retrieved from the case files of the two sampled populations (treatment and control). The purpose is to review the demographics and personal characteristics of these women. It is important to gather baseline demographic information to ensure that the appropriate target population is being served and to determine if necessary modifications are required. This information is also important to determine the profile of the women who enter into treatment and to be able to compare it to the profile of women who opt out of treatment.

The qualitative analysis summarizes the quantitative data and compiles clients profiles for each group.

The quantitative analysis determines the strength of the relationships among the variables and measures differences between the treatment and the control samples.

Questions addressed through this component include:

- Who receives the program's services/Who does not receive these services?
- What makes the treatment group amenable to treatment?
- What factors differentiate those who volunteer from the program from those who decline services?

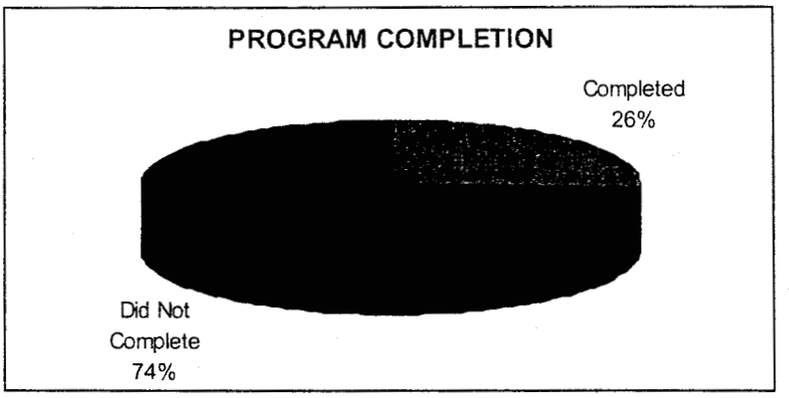
Data for the samples are analyzed and summarize separately. In most cases, a percentage is provided followed by the actual number of cases in parenthesis. The source of the data collection is in italics prior to the start of the respective data. A Discussions section follows which summarizes the findings and highlights the similarities and differences between the two samples.

This section begins with an overview of the total population of women. It provides a quick summary of the number of women who have been referred to the program and reasons for withdrawal. More specific statistics, provided for the two sampled populations, follow.

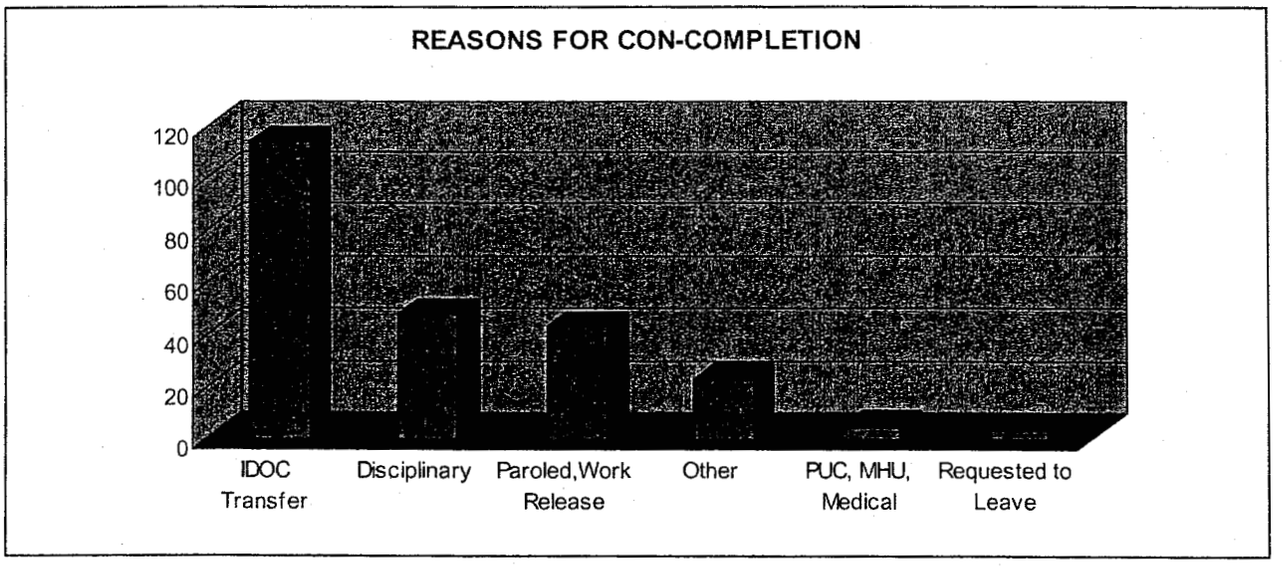
A. DESCRIPTIVE STATISTICS

1. Total Population:

Since the start of the grant through 06/30/00 (approximately 17 months), there have been a total of 321 women who have been referred to the program.



Eighty-four women (26 percent) have completed the program and 237 women (74 percent) have not completed the program.



As indicated in the chart above, the causes of non-completion include: transferred to the Illinois Department of Corrections, disciplinary, paroled/work release, mental health and/or medical reasons, requested to leave, and other. "Other" refers to those women who left the program because of security level changes and/or once the security level is confirmed, she was not able to reside at Dwight. She may have also qualified for other programs.

Of the reasons cited above, only two really indicate a failure in terms of program completion; disciplinary and request to leave. The other reasons are not reflective of a women's ability, or inability, to complete treatment. Hence, of the 321 women who have "passed through" the program, only 52 (16%) can be referred to as "failures."

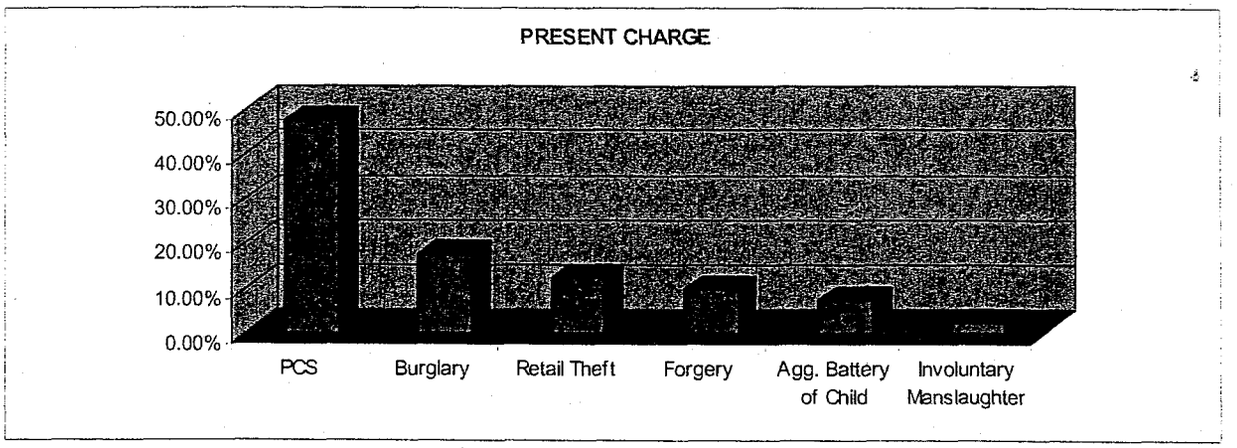
2. Treatment Sample:

Sample Size:
The total sample size for the treatment group was 40 females. All of the women resided at the Dwight Correctional Facility.

(Data provided by IDOC)
Number of days from Sentencing to Admission:
The mean (average) number of days from sentencing to admission is 62 days. This number, however, might be a bit exaggerated due to a few excessive numbers. The minimum number of days was one day and the maximum number of days was 1239. The mode, or the number which appeared most often, was eight (8) days. The mode might be the best indicator of the number of days it took from sentencing to admission.

Average Length of Stay:
The average length of stay for women in the treatment group is 950 days or 2 ½ years.

Current Charge:



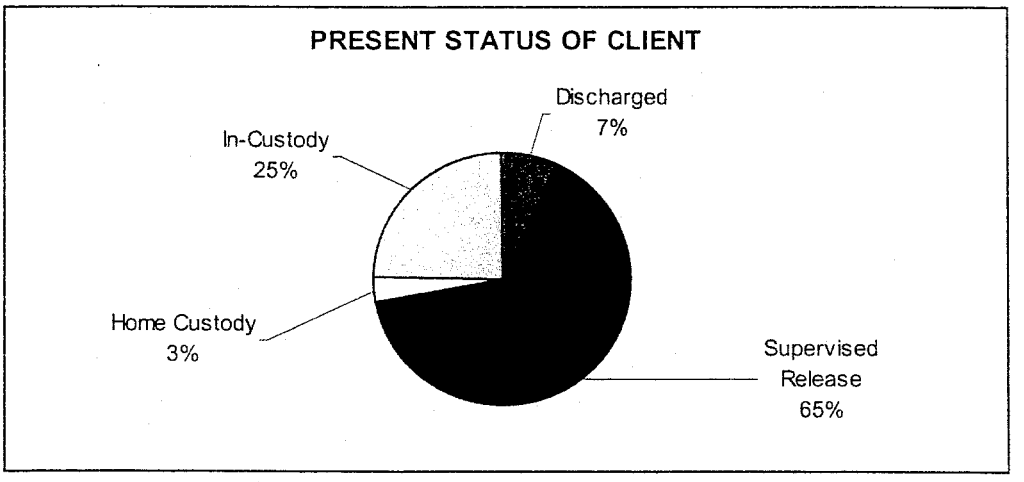
In the above chart: 47.5 percent (19) were referred to the program with a charge of Possession of a Controlled Substance (PCS), 17.5 percent (7) for burglary, 12.5 percent (5) for retail theft, ten percent (4) for forgery, 7.5 percent (3) for aggravated battery of a child, and 2.5 percent (1) for the charge of involuntary manslaughter.

Data for this sample mirrors that of national data; women offenders continue to commit non-violent crimes, with drug arrests constituting the fastest growing population of women offenders (Chesney-Lind & Immarigeon, 1990; Denno, 1994; Warren & Rosenbaum, 1987).

Prior IDOC Commitments:
Over half (52.5 percent) of the women had no prior IDOC commitments; 47.5 percent admitted to having prior commitments.

Prior Convictions:
Over half (52.5 percent) of the women have no prior convictions; 47.5 percent have been previously convicted. Thirteen percent admitted to having a prior violent conviction; 22.5 percent had a prior drug-related conviction.

Present Status of Client:



At the time of data collection, 65 percent of the women were on supervised release, 25 percent remained in-custody, seven percent had been discharged, and three percent were on in-home custody.

Institutional Restrictions:.
All of the women had institutional restrictions.

Medical Restrictions:
Sixty-five percent of the women did not have any medical restrictions, 35 percent did have medical restrictions.

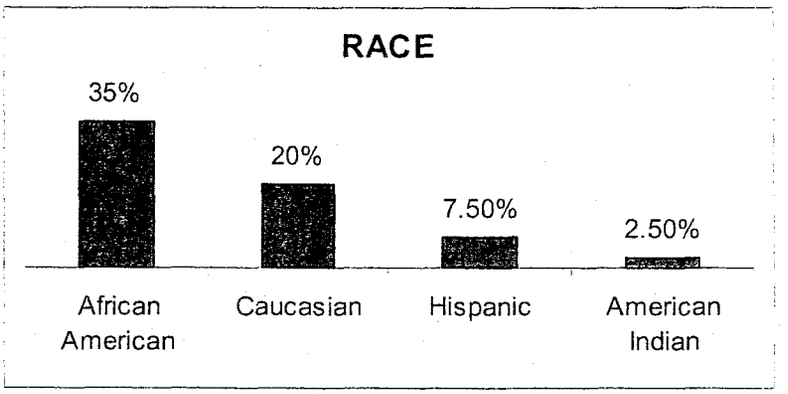
Escape Risk:
None of the women were scored as high escape risks. Ninety percent were assessed as low risk, with 10 percent being assessed as medium risks.

Outstanding Warrants:
Only one of the women had an outstanding warrant.

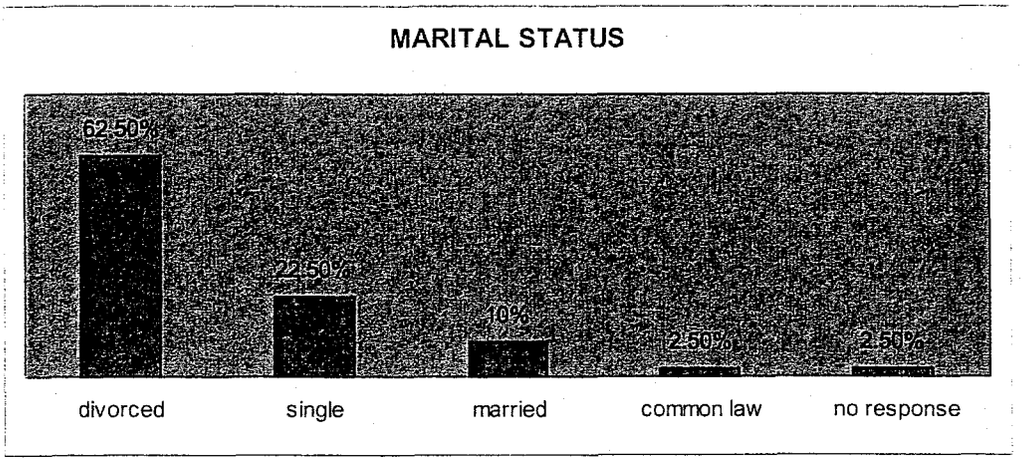
Admission Status (*collected from Gateway form: Admission/Readmission Review Form):*
Ninety percent of the women were new admissions; five percent were readmissions, and another five percent were rotations.

Age:
Data included date of birth. Age at time of placement into the program ranged from 21 to 49, with the average (mean) age being 35. This is slightly older, but fairly representative of literature which shows female offenders as typically being around the age of 30.

Race:
Thirty-five percent were African-American, 20 percent were Caucasian, 7.5 percent were Hispanic, and 2.5 percent were American-Indian. There was no response for 35 percent of the women.

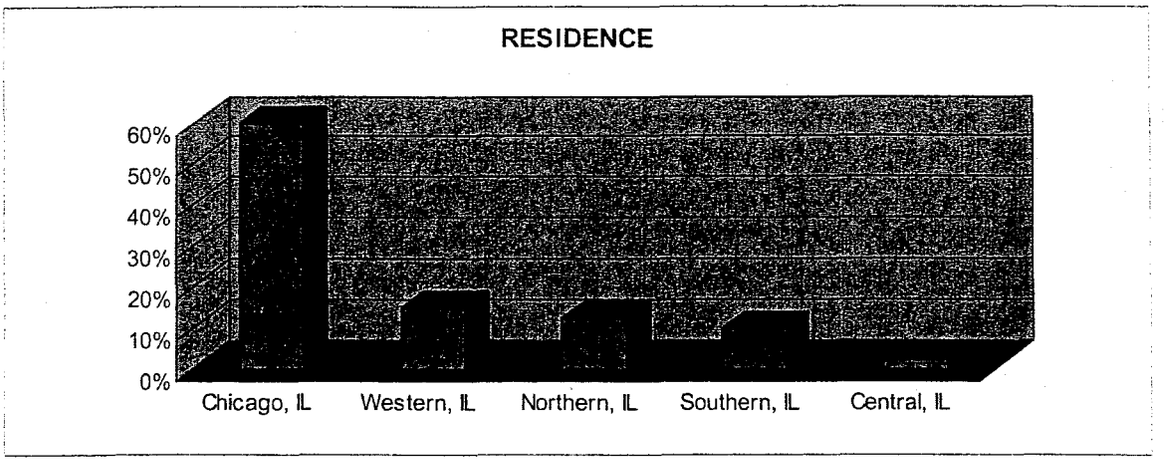


Marital Status:
Eighty-five percent of the women were single; 12.5 percent were married (including common law). There was no response for 2.5 percent. The important aspect of this variable is not so much the women's marital status as it is the stability and the impact of their relationship on their criminality. This aspect of the relationships cannot be determined through the case file review but is addressed indirectly in the interview analysis.



City of Residence:

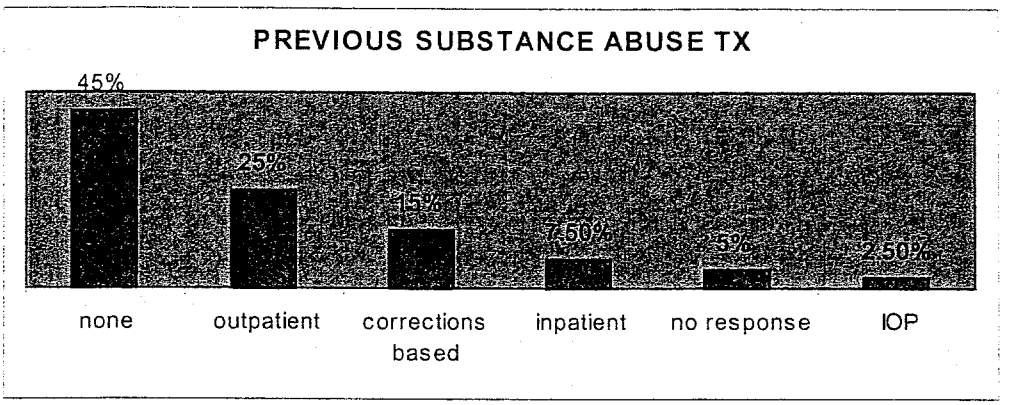
Most of the women (60 percent) resided in Chicago prior to being incarcerated. Other parts of Illinois in which they lived, in descending order include Western, Illinois (15 percent), Northern, Illinois (12.5 percent), Southern, Illinois (10 percent) and Central, Illinois (2.5 percent).



(Data collected from Gateway Form: Initial Clinical Assessment II: Diagnostic Summary)

Previous Treatment for Substance Abuse:

Forty-five percent of the women denied have any prior treatment for substance abuse. Twenty-five percent referred to attending outpatient session, 15 percent attended correctional-based treatment, 7.5 percent attended inpatient sessions, and 2.5 percent attended intensive outpatient sessions.



The low number of women who had received prior treatment is unfortunate given the data collected later in this evaluation. Fifty percent of the women in this sample indicated that they spent at least $400.00 per week to support their drug habit; 25 percent spent at least $1000.00. Seventy-two percent of the women referred to using more than three times per day and all of the women described their addiction as being severe. Despite these statistics, the low number of women receiving treatment is consistent with literature. According to one study, 71 percent of female addicts had never been in treatment and only four percent were in treatment at the time of arrest (Bureau of Justice Assistance, 1991).

Client Mental Health History:

Largely as a result of the trauma of early sexual and physical abuse, female offenders enter the system with a host of psychological issues. According to a random study of 1,300 detainees awaiting trial at the Cook County (Chicago, Illinois) jail between 1991 and 1993, more than 80 percent of female jail detainees suffered from one or more lifetime psychiatric illnesses (Teplin, Abram, & McClelland, 1996).

In the present study, 95 percent of the women indicated that they have never had any problems with mental health; 2.5 percent referred to having a history of cognitive mental health issues. (2.5 percent did not respond).

As follows are charts summarizing the various DSMIV category assessments.

DSMIV Axis I - Substance of Abuse

Substance	Frequency	Percent
Alcohol 303.9	8	20.0
Opioid 304.0	18	45.0
Cocaine 304.2	13	32.5
Cannabis 304.3	1	2.5
Amphetamine 304.4	0	0.0

DSMIV Axis I - MI Disorders

Disorder	Frequency	Percent
Alcohol	10	25.0
Opioid	1	2.5
Cocaine	12	30.0
Cannabis	5	12.5
Amphetamine	0	0.0
Cannabis	1	2.5
No Response	11	27.5

DSMIV Axis II - MI Disorders

Disorder	Frequency	Percent
Alcohol	3	7.5
Opioid	0	0.0
Cocaine	4	10.0
Cannabis	4	10.0
Amphetamine	1	2.5
Other	1	2.5
Cannabis	1	2.5
No Response	26	65.0

DSMIV Axis III

Category	Frequency	Percent
None	37	92.5
No Response	3	7.5

DSMIV Axis IV

Category	Frequency	Percent
Primary Support Group	2	5.0
Occupational	1	2.5
Access to Health Care	6	15.0
Social Environment	12	30.0
Housing	7	17.5
Legal System/Crime	6	15.0
Educational	1	2.5
Economic	1	2.5
Other	3	7.5
No Response	1	2.5

DSMIV Axis V (GAF)

Mean	Median	Mode	Minimum	Maximum
51.95	52	52	48	54

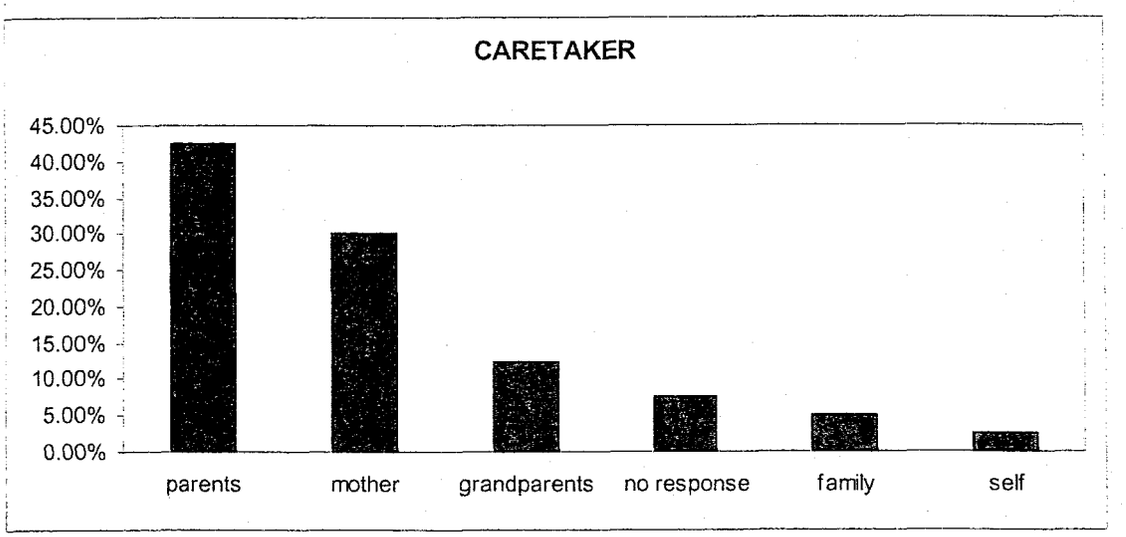
Clinical Risk:
Ninety-five percent of the women were assessed as routine risk; five percent were assessed as emergent.

Suicide Risk Level at Intake:
None of the women were assessed as being a suicide risk at Intake.

Suicide Risk Level when Using or in Withdrawal:
None of the women were assessed as being a suicide risk when using or when in withdrawal.

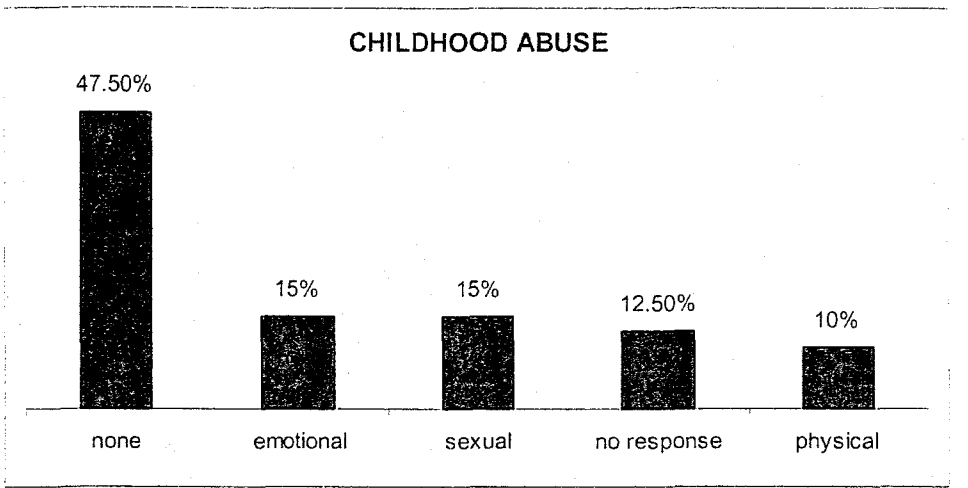
(Data collected from Gateway Form: Initial Clinical Assessment I: Client Self-Report)
Introductory Information
Have you ever done anything about your substance abuse problems before getting locked up?
Fifty-three percent of the women indicated that they had tried to stop their addictions prior to being locked up.

Growing Up Information
Who raised you?
Forty-three percent were raised by their parents, 30 percent were raised by their mother, 12 percent were raised by their grandparents, and 2 percent were raised alone.



How many children were raised with you?
Two of the women were raised with no other children. Thirteen of the women were raised with one to three children, 13 were raised with four to six children, and there was no response for 12 of the women.

Did you experience any abuse as a child?
Nearly 50 percent indicated that they were not exposed to any abuse as a child. Fifteen percent indicated that they were a victim of sexual abuse, 15 percent indicated that they were a victim of emotional abuse, and 10 percent referred to being a victim of physical abuse.



The low numbers of women admitting to being abused is surprising given the preponderance of the research which suggests that female offenders, including those who use alcohol and/or drugs, typically suffer from child abuse. One study noted that more than 43 percent of female inmates said they had been physically or sexually abused before their admission into prison (Morash, Bynum, & Koons, 1998).

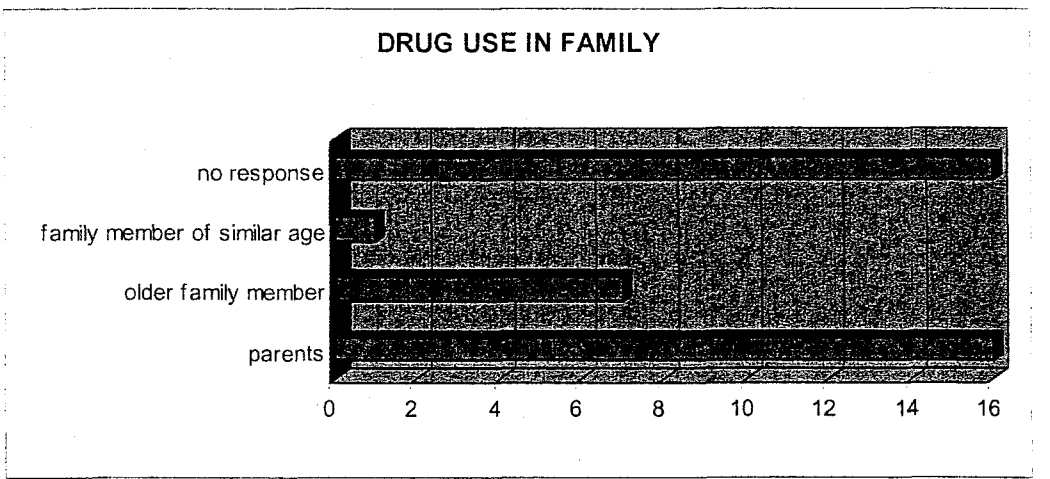
The low numbers reported in this present study could be more of a result of the timing of the initial assessments. They are generally done in the beginning of the client/counselor relationship. Open dialogue about abusive backgrounds might not result until after this relationship has been better established.

Besides abuse, are there any painful experiences from childhood that still bother you?

Female offenders are likely to have grown up in dysfunctional, often violent, households where family members have been incarcerated, where alcohol and/or drug use was prevalent, and/or in which they were victims of some form of abuse. By way of example, in a survey conducted on a sample of females in U.S. prisons, 47 percent of female inmates reported having had at least one member of their immediate family who had been incarcerated (Snell & Morton, 1994). In that same study, it was reported that a third of female inmates reported having lived with a parent who had abused drugs or alcohol while the inmate was growing up (Snell & Morton, 1994).

The responses to this question, as well as the following questions, closely follow the literature. In this present study, over 50 percent of the women admitted to being plagued by painful childhood experiences. These experiences may or may not include such incidences as the presence of alcohol and/or drugs in the household, or experiences with domestic violence.

Did anyone who raise you use alcohol or drug?
Sixty percent of the women admitted that someone in their family had used drugs or alcohol when they were growing up, with parents and/or guardians comprising 40 percent of that total.



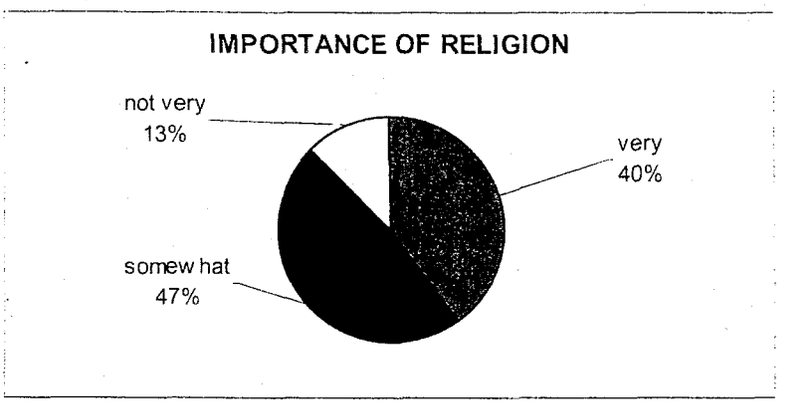
Did your biological parents use alcohol or drugs (either past or present usage)?
(Note that the numbers do not equate to the above question, because in some situations, the biological parents may not have been the adult who cared for the women as a child). Over 50 percent (52.5 percent) of the women indicated that their biological parents used or uses alcohol and/or drugs.

Were your biological parents ever treated for emotional problems (past or present)?
Eighty percent of the women indicated that their parents were never treated for any emotional disorder; 17.5 percent admitted that their parents had received treatment. There was no response for 2.5 percent of the women.

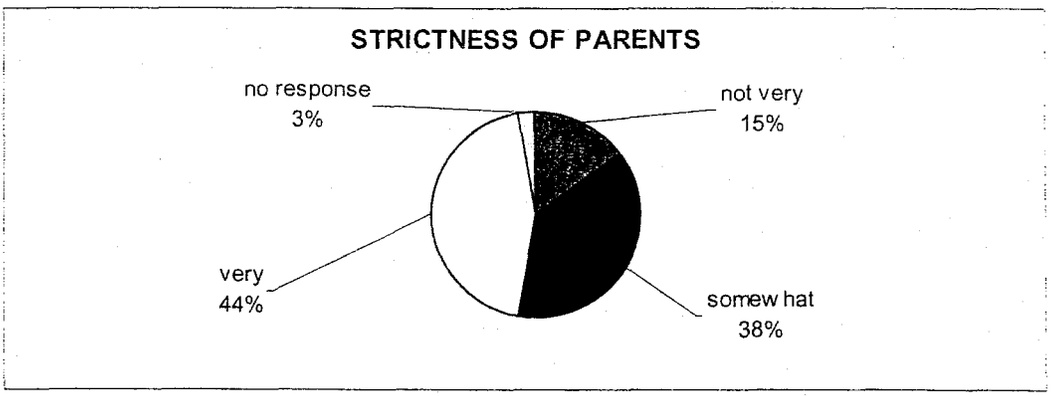
Did you have any learning problems in school?
Slightly over 37 percent of the women indicated that they had learning problems in school: 20 percent had problems with math, 12.5 percent for behavioral problems, 2.5 percent were in a learning disabilities class, and another 2.5 percent responded "other." There was no response for 62.5 percent of the women. None of the problems were directly related to substance abuse.

How much school have you completed?
The average highest level of education completed was the 10th grade. This is consistent with literature, which shows that only about 23 percent of female inmates had completed high school (Snell & Morton, 1994).

How important was religion to you when growing up?
Eighty-seven percent of the women referred to religion being an important part of growing up.



How strict were your parent(s)/guardian(s)?
Eighty-seven percent indicated that they grew up either in a somewhat or very strict household. Only 15 percent stated that their parents and/or guardians were not strict.



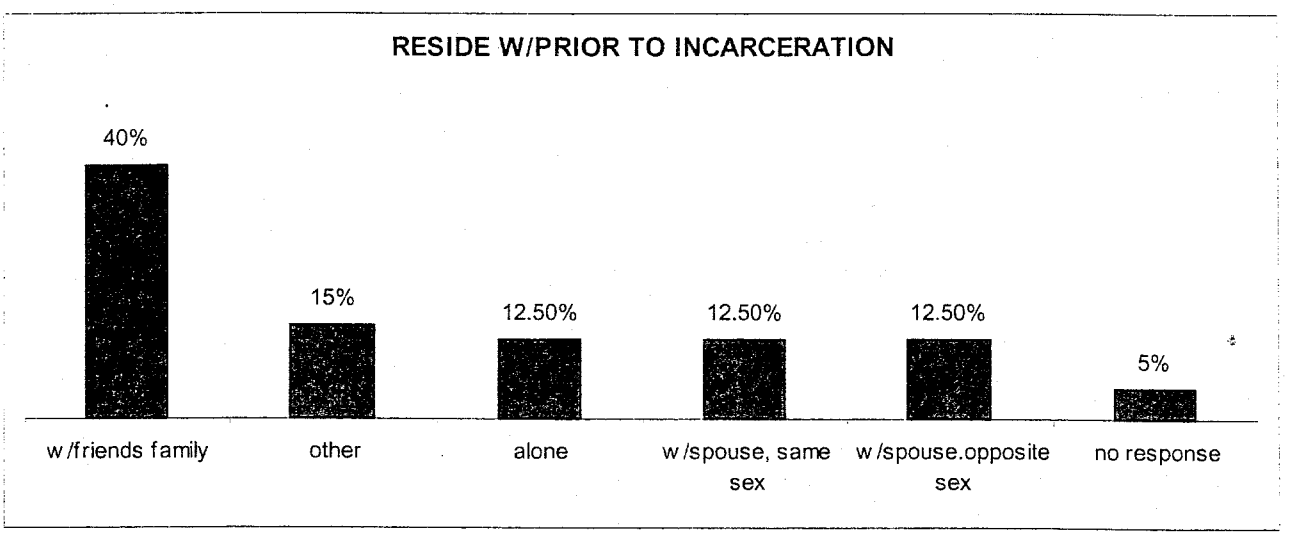
Do you have any current health problems?
According to the literature, women inmates tend to have ongoing health issues due to lack of appropriate health care (Center for Substance Abuse Treatment, 1994).

For this question, the responses were equally distributed; nearly 48 percent each indicated that they either did or did not have health problems. There was no response from five percent of the women.

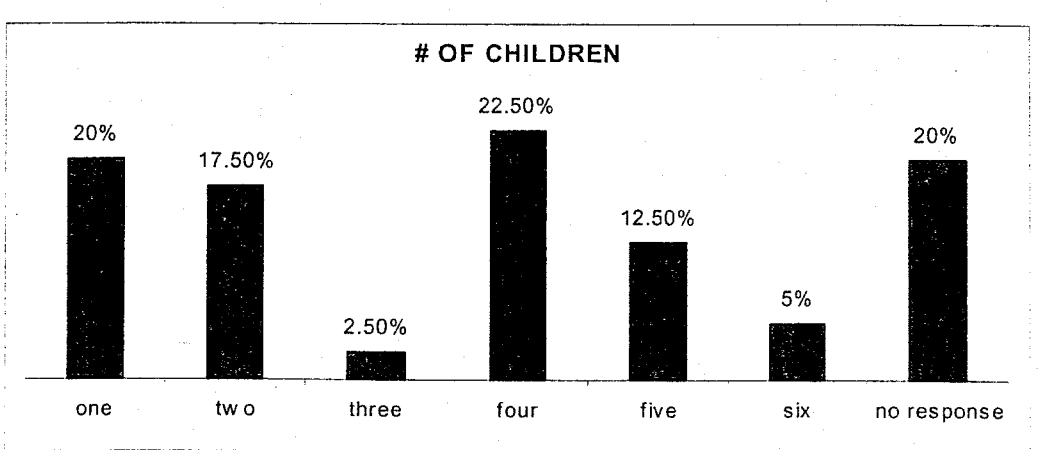
Are you receiving treatment for these problems, including medication?
It appears as if those women who admitted to having health problems are also receiving treatment; 45 percent of the women referred to receiving treatment for health problems, 45 percent indicated that they do not receive any medical treatment, and another 10 percent did not respond.

Current Living Situation

With whom did you live before incarceration?
Forty percent of the women stated that they resided with friends of the family. Slightly over 12 percent each indicated that they either lived alone, lived with a spouse of the same sex, or lived with a spouse of the opposite sex. Fifteen percent responded as "other" and five percent of the women did not respond.

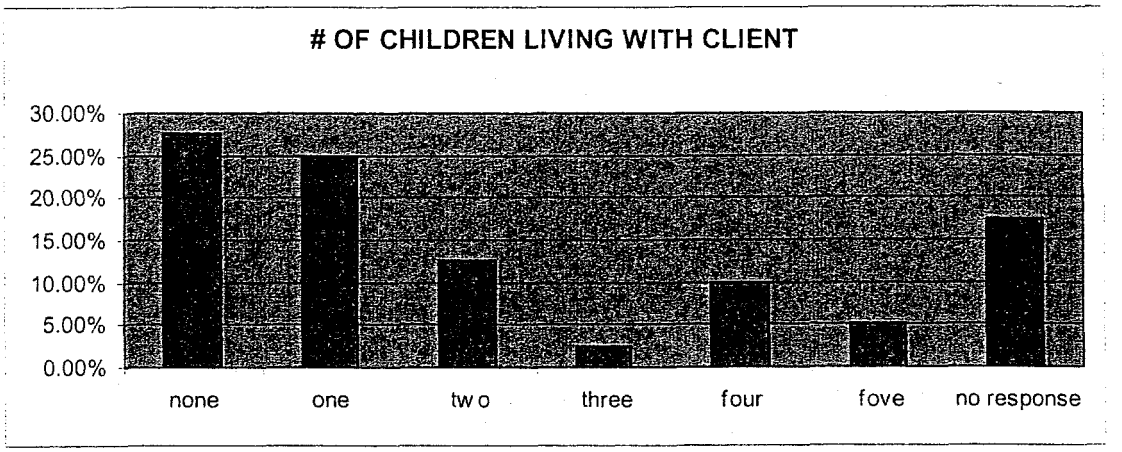


Number of children you have:

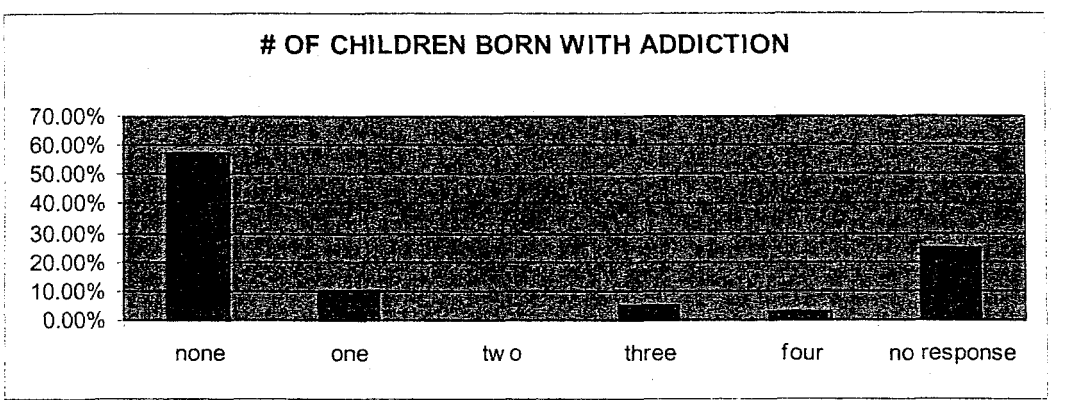


Note that no response is considered zero children. Eighty percent of the women have children, with 60 percent having more than one child.

Number of children that live with you:
Slightly over 27 percent of the women do not have their children living with them.



Number of children born with addiction:
Seventeen percent or seven of the women referred to having children born with addiction. This number becomes important as drug treatment programs attempt to significantly reduce the number of drug-addicted babies born to women.



How many close friends do you have?
Fifty percent of the women referred to having at least one close friend; 35 percent stated that they had none.

How close are you/how well do you get along with your: spouse/significant other, other family members, children, friends?
The responses to the above question are summarized in the following chart.

	very close	somewhat close	not very close	lots of conflict	no response
spouse	40%	25%	2.5%	17.5%	15%
other family members	50%	30%	2.5%	5%	12.5%
children	60%	22.5	0%	5%	12.5%
friends	22.5%	30%	15%	10%	22.5%

The women felt most close to their family (not including spouse) and their children. Sixty-five percent of the women referred to feeling at least somewhat close to their spouse, 80 percent felt at least somewhat close to their family members, 82 percent felt at least somewhat close to their children, and only 52 percent of the women felt at least somewhat close to friends.

The relatively low number of women who feel a closeness to friends closely resembles that found in a number of other studies of female offenders. Klosak (1999) found that nearly every woman she interviewed said that they had very few friends. "The overwhelming feeling among this group was that it was difficult for them to develop lasting relationships with other women who will support them and not turn their backs on them" (Klosak, 1999). As a result, the women in her study expressed feelings of isolation and depression.

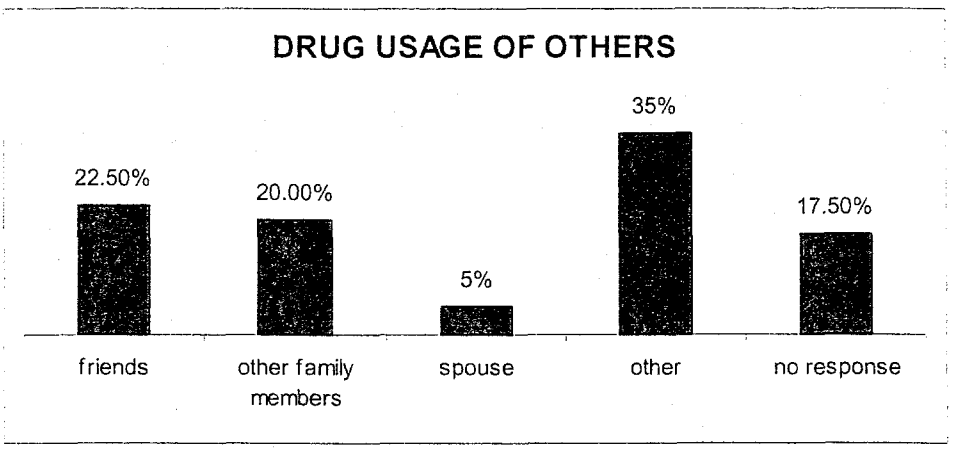
How supportive are your spouse, family members, children, and/or friends in your staying abstinent?
The responses to the above question(s) are summarized in the following chart:

	against abstinence	don't care	somewhat supportive	very supportive	no response
spouse	12.5%	10.0%	15.0%	50.0%	12.5%
family members	2.5%	5.0%	17.5%	65.0%	10.0%
children	2.5%	2.5%	10.0%	65.0%	20.0%
friends	7.5%	15.0%	17.5%	40.0%	20.0%

As with the above question, the women found their family members, other than their spouses, and their children to be the most supportive of the recovery. Eighty-two percent of the women found their family members to be supportive, 75 percent found their children to be supportive, 65 percent found their spouses to be supportive, and 57 percent found their friends to be supportive. The women also ranked their spouses as most often being against abstinence.

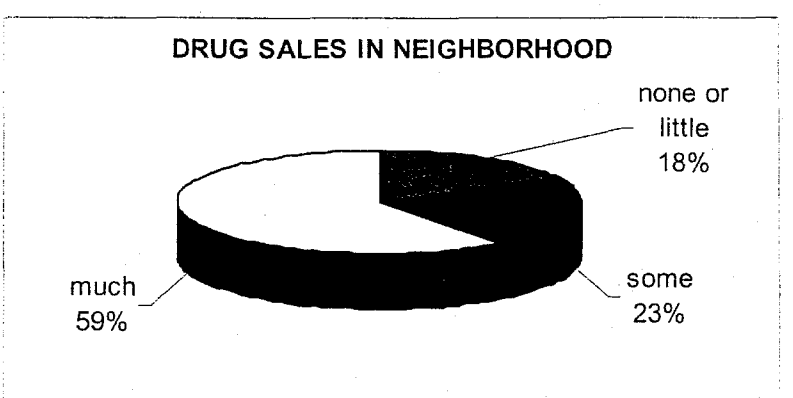
Do any of them use alcohol/drugs?

Nearly 23 percent of their friends use alcohol and/or drugs, 20 percent of their family, and five percent of their spouses or significant others.



To what extent are drugs sold in the area where you live?

Approximately 82 percent of the women responded that there is some or much selling of drugs in their neighborhoods: 17.5 percent indicated no or little selling, 22.5 percent referred to some selling, and 60 percent stated that there was a lot of selling.



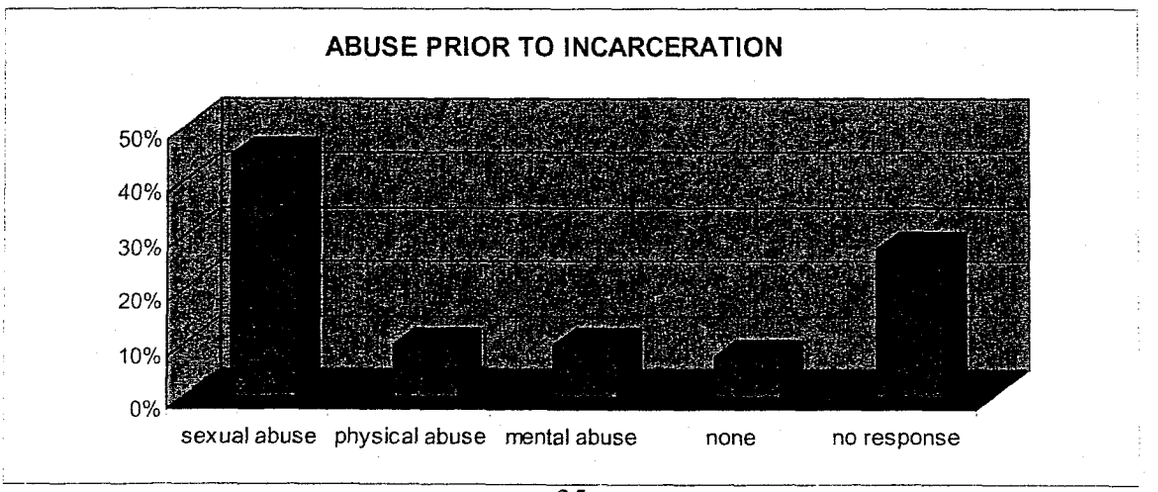
Have you, if ever, conducted any of these behaviors? (There are more than 40 responses because some women responded to more than one category; hence, the percentages do not equal 100)

	Frequency	Percent
physically assaulted someone	14	35.0%
be physically or sexually abused	7	17.5%
violently blowing up at others	15	37.5%
stealing, robbing, illegal activities	23	57.5%
thinking of killing myself	8	20.0%
being totally out of control	19	47.5%
physically hurting someone	5	12.5%
using a gun or knife	6	15.0%
losing control and hurting a child	2	5.0%
driving a car recklessly	5	12.5%
no response	6	15.0%

Over fifty percent of the women indicated that they had be involved in stealing, robbing and/or illegal activities. The other categories which earned 20 percent or more of the responses include, in order of hierarchy: being totally out of control, violently blowing up at someone, physically assaulting someone, and thinking of killing myself.

Was there any abuse in your living situation before incarceration?

Sixty-five percent of the women indicated that they had been exposed to abuse prior to incarceration, with sexual abuse being the most prevalent.



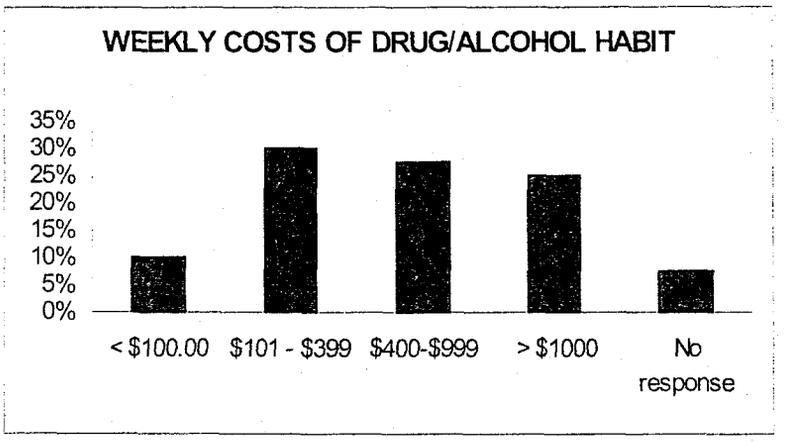
Are there any problems in your current living situation?
Fifteen percent of the women indicated that they had a problem with their current situation, 57.5 percent said they were satisfied, and 27.5 percent did not respond.

Substance Abuse and Treatment History

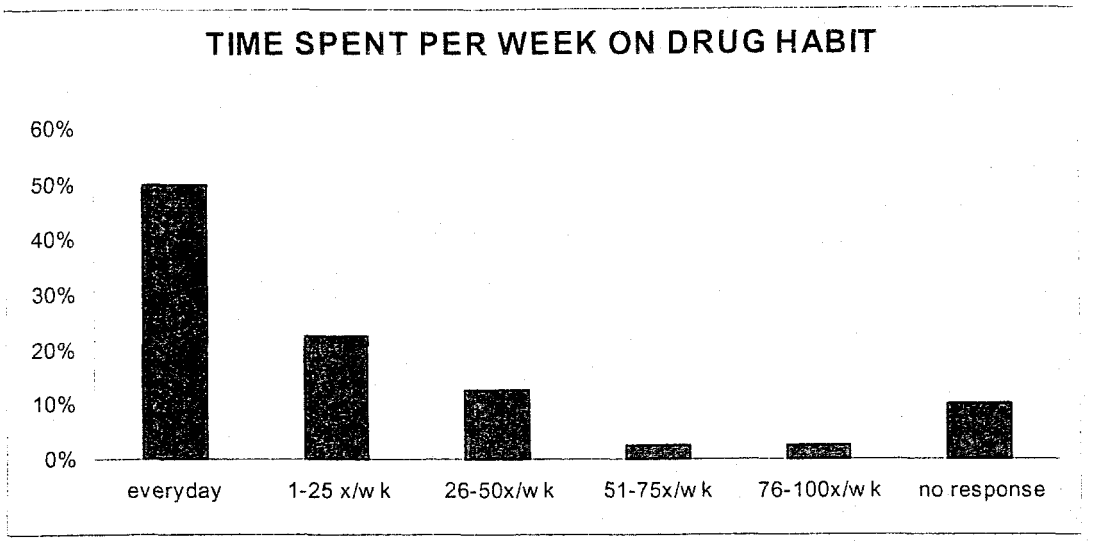
Have you ever been involved with child protective services?
Only 2.5 percent of the women admitted to involvement with child protective services.

Have you ever had any bad withdrawal problems, including seizures?
Eighty percent of the women denied having any severe withdrawal problems; 17.5 percent indicated that they had such problems. There was no response from 2.5 percent of the women.

How much money do you spend on alcohol and drugs (weekly basis)?
Over 50 percent of the women indicated that they spend at least $400.00 per week to support their drug habit; 25 percent of them spend at least $1000.00 per week.



How much time do you spend getting and using alcohol/drugs (weekly basis)?
Fifty percent of the women indicated that their drug habit consumes all of their time. Another 17 percent said that their drug habit consumed them at least 26 times per week.

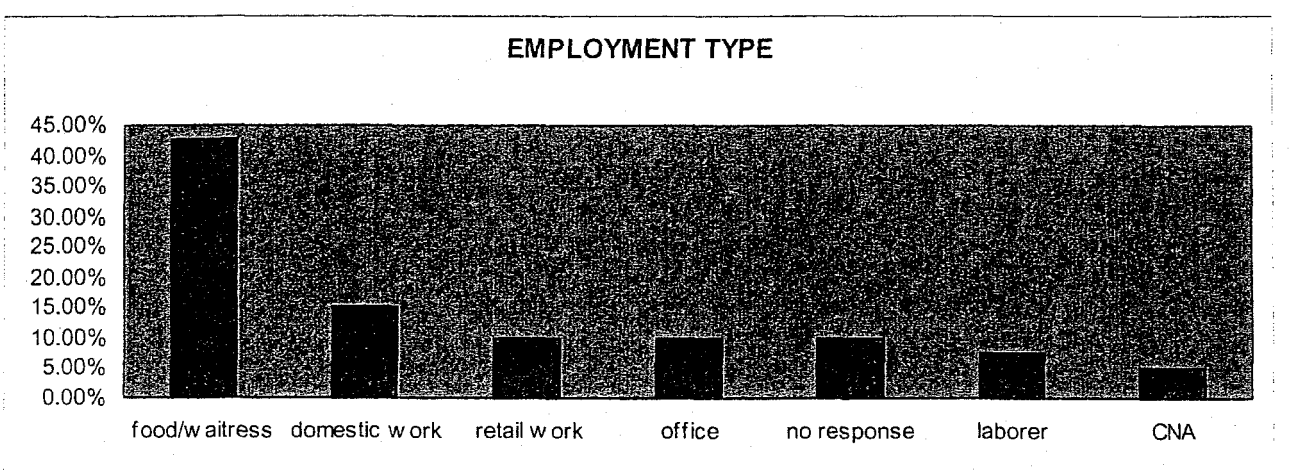


Occupational/Legal/Financial Issues

Had you ever worked before incarceration?

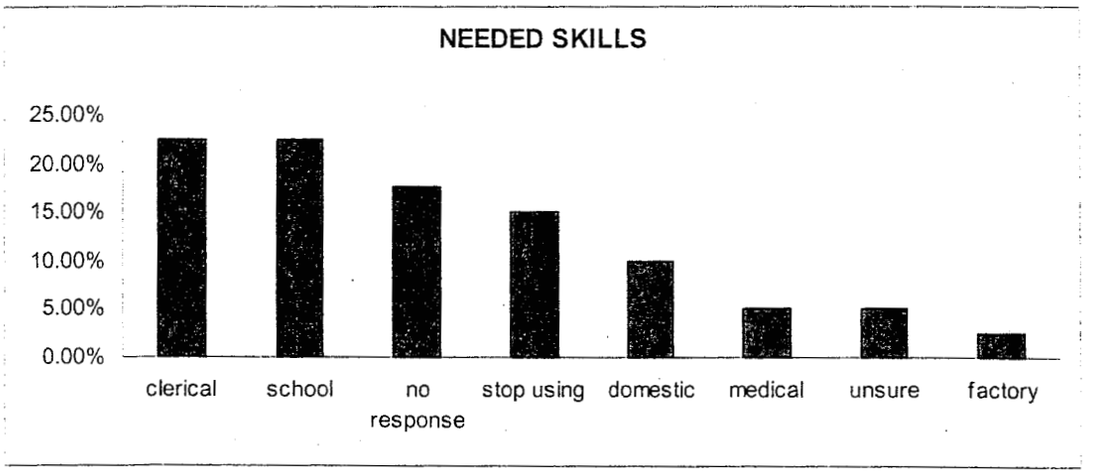
Seventy-seven percent of the women referred to working prior to being incarcerated; 55 percent of them on a full-time basis. This number is much higher than that reported in the literature. Women offenders portrayed in national research are typically underemployed; less than 50 percent of the women in one study were working in the month before their arrest (Greenfeld & Minor-Harper, 1991). However, the above question does not really address length of time of employment or the date of their last employment. A later question in this evaluation shows that only 20 percent of the women were supported by regular wages the year prior to incarceration.

Describe your last job.



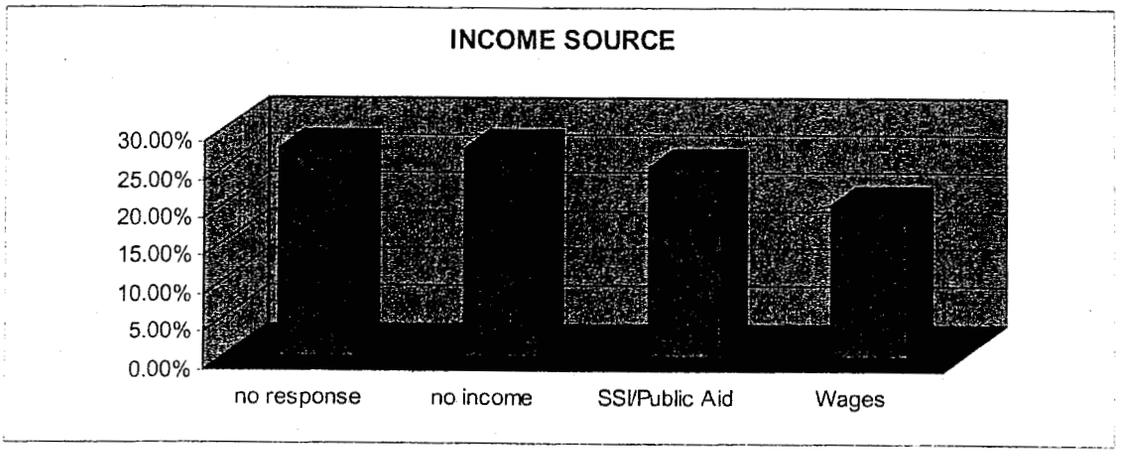
The category of employment which elicited the most responses was in the food industry, with 42 percent of the responses.

What skills would help you keep work or find a better job?
Women most often indicated that they either needed to complete their education or receive some type of clerical/computer skills. Other responses included domestic skills, and for them to keep clean.



Have you ever served in the Armed Forces?
Only one of the women indicated she had served in the Armed Forces.

What was your income (source) for the year before incarceration?
Only 20 percent of the women indicated that they were supported by regular wages. Twenty five percent were supported by public aid, and 27.5 percent referred to having no income. Another 27.5 percent did not respond.

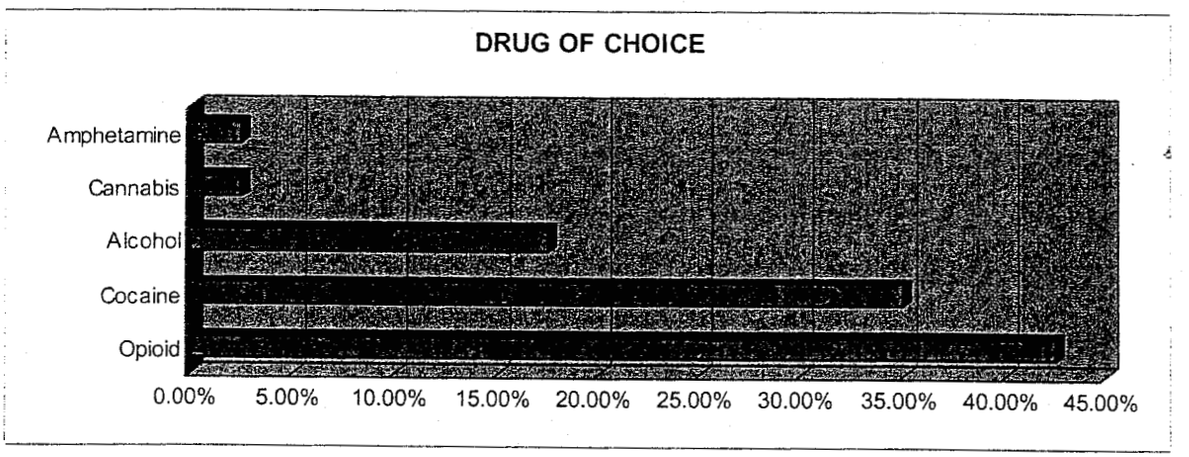


Do you have any other legal issues pending?
Seventy-five percent of the women did not have any legal issues pending; 17.5 percent did. There was no response from 7.5 percent of the women.

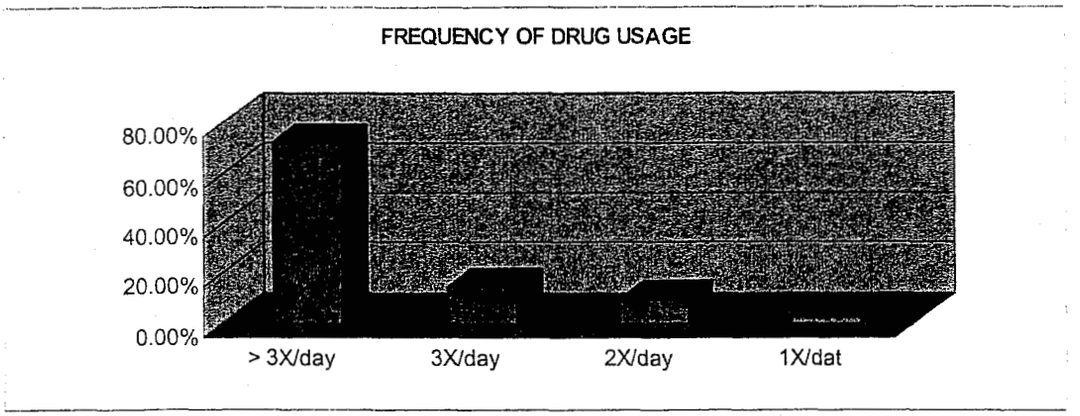
Corrections Information
Were you ever a gang member?
Twenty percent of the women admitted that they had been a gang member.

(Data collected from Gateway Form: Client Information Sheet - Drug History)
Age when first using:
The average age of first use was 18 years old.

Primary Drug of Choice:
Forty-two percent of the women referred to using opioids; 35 percent, cocaine; 17 percent alcohol; 2.5 percent cannabis; and 2.5 percent amphetamines.

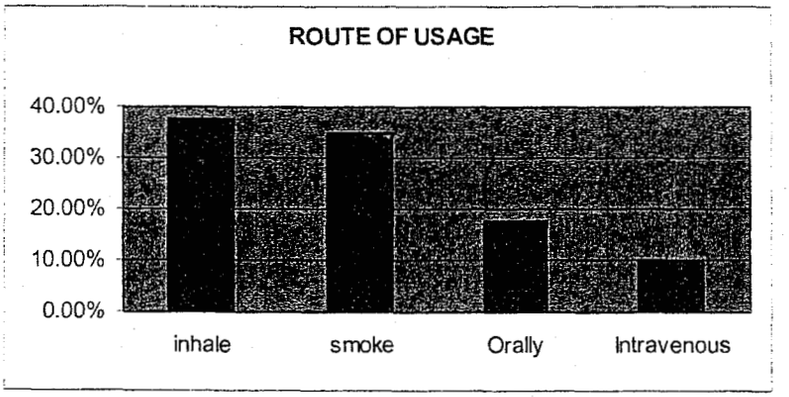


Primary drug frequency of usage per day:
Slightly over 72 percent of the women referred to using more than three times per day.



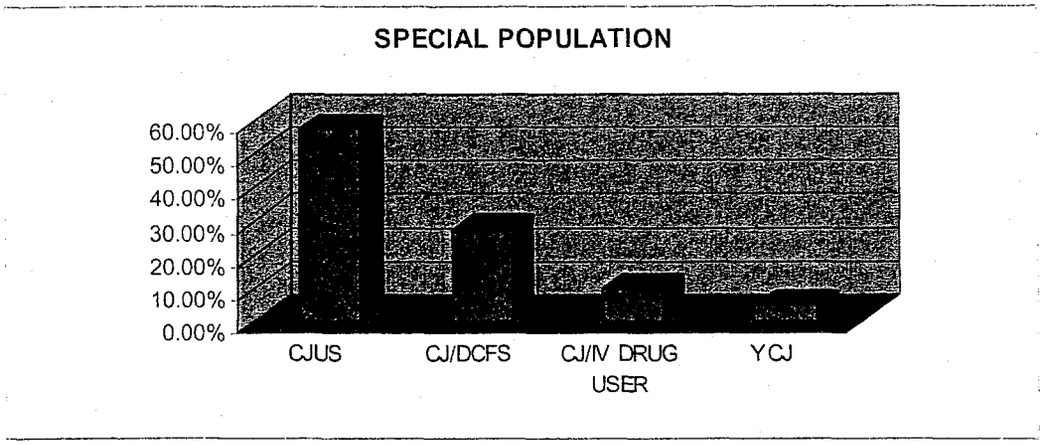
Primary drug dependency severity level:
Nearly 100 percent (97.5%) of the women referred to their drug dependency as being severe.

Primary drug route of usage:
Thirty-seven percent inhale, 35 percent smoke, 17.5 percent take drugs orally, and 10 percent use their drugs intravenously.



(Data collected from Gateway Form: Gateway Initial Interview Supplementary Form)
MAST (Score >5 means client is likely to have a problem with alcohol):
The mean MAST score was 12.84.

Special Population:
Fifty-seven percent were part of the criminal justice population, 27.5 percent were part of the DCFS population, 10 percent were part of the IV drug user population, and five percent were part of YCJ.



Pregnant:
Only one of the women in the treatment group was pregnant.

3. Control (Comparison) Sample:

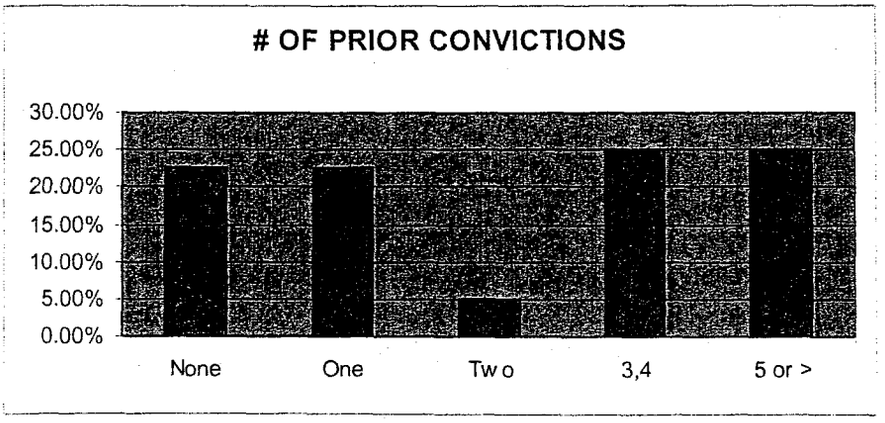
Location of Client:

	Frequency	Percent
Dwight	16	40.0%
Logan	14	35.0%
Dixon	4	10.0%
Decatur	6	15.0%

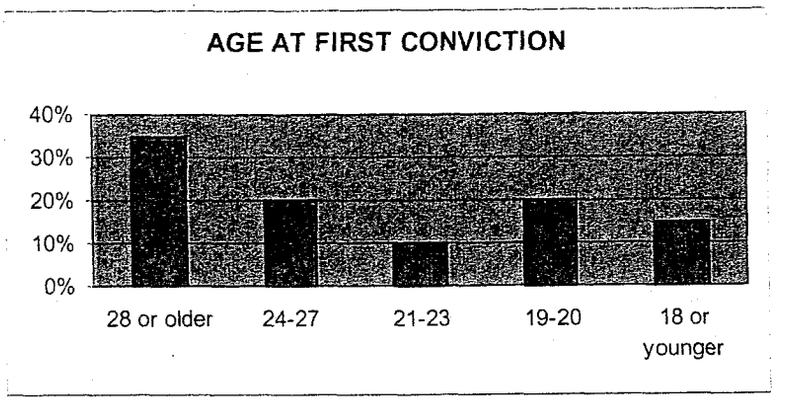
(From IDOC Form: Initial Classification Report-Offender Tracking System)
Age at Admission:

	Frequency	Percent
30 or older	26	65.0%
26 - 29	9	22.5%
23 - 25	2	5.0%
21 - 22	3	7.5%
20 or younger	0	0.0%

Number of Prior Convictions:
Only 22.5 percent of the women had no prior convictions; fifty percent had more than three.

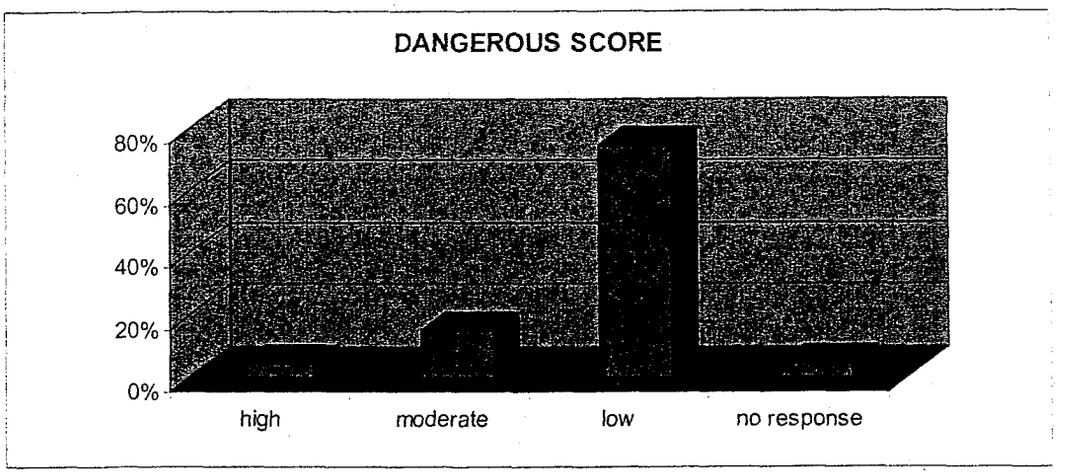


Age at First Conviction:



The majority of the women were young, generally under 28, at the time of their first conviction.

Dangerousness Score:
Seventy-five percent of the women were assessed as low.



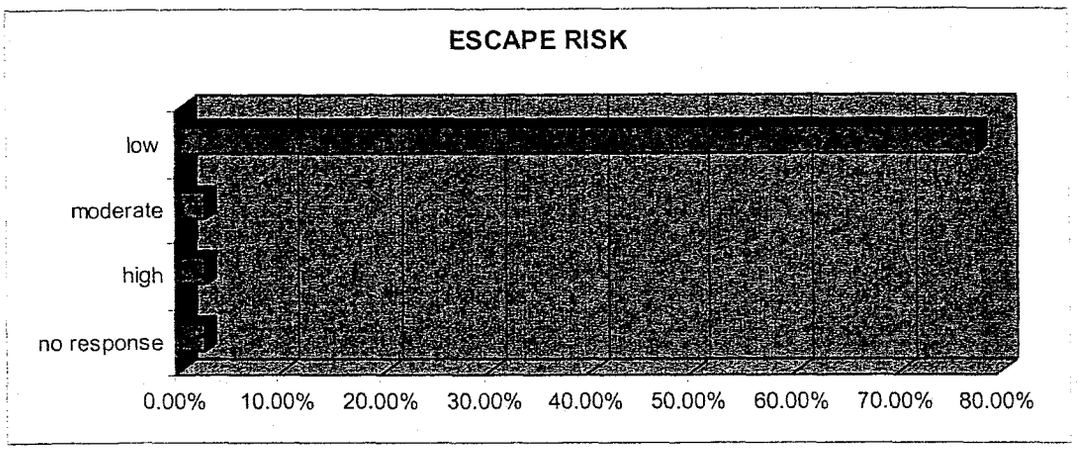
Security Designation:
Fifty percent of the women were in medium security, 40 percent were at low security, and five percent were at high security. There was no information on five percent of the women.

Escapes from Confinement:
Ninety-three percent of the women were assessed as no risk or having no escapes. Only two women or five percent were assessed as moderate risk.

Indication of Desire to Escape:
None of the women had an indication of a desire to escape.

Outstanding Warrants:
None of the women had outstanding warrants.

Escape Risk:
Seventy-eight percent of the women were assessed at low risk.



(From IDOC Form: Classification Summary Report)
Gang Affiliation:
Ninety-five percent of the women had no gang affiliation; only 1 women admitted to prior gang activity.

Prior Incarceration:
This was somewhat evenly distributed. Fifty-two percent of the women had prior incarcerations, 42.5 percent did not. There was no response from five percent of the women.

(From IDOC Form: Mental Health Evaluation)

Mental Health History:

Twenty-two percent of the women admitted to having a mental health history; seventy-five percent did not. There was no response for 2.5 percent of the women.

Physical/Sexual Abuse:

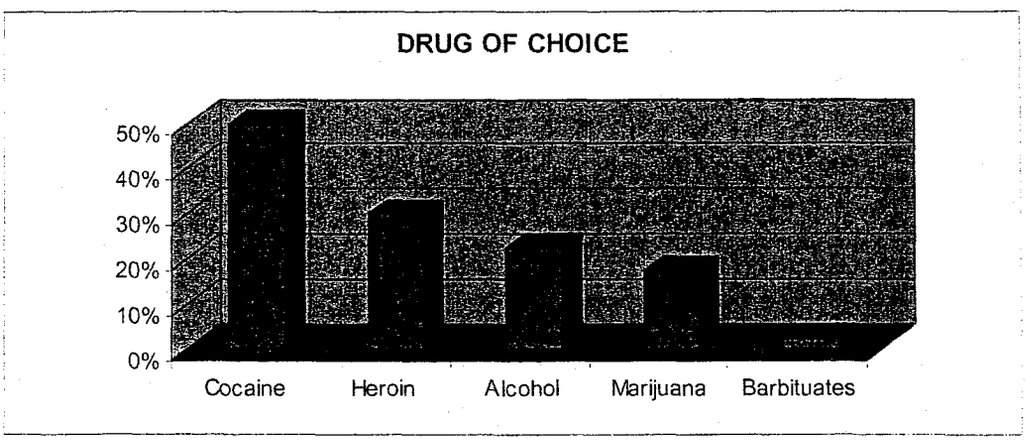
Seventy-seven percent of the women indicated that they had not been abused; twenty percent were abused. There was no response from 2.5 percent of the women.

History of Drugs or Alcohol:

Sixty-two percent referred to having a history of alcohol or drugs; 35 percent did not. There was no response from 2.5 percent.

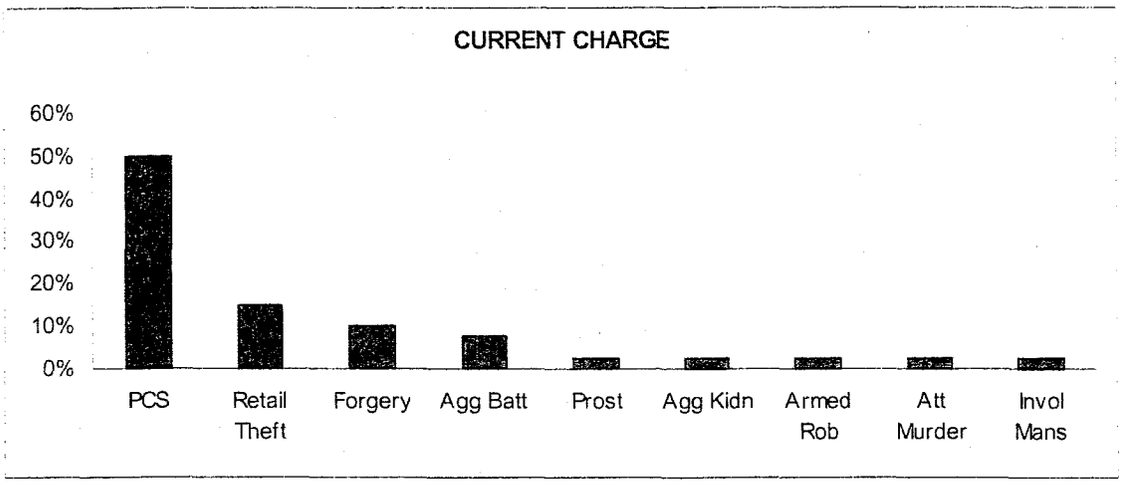
Drugs of Choice:

Type of Substance	Percentage
Marijuana	17.5 %
Cocaine	50.0%
Heroin	30.0%
Barbiturates	2.5%
Alcohol	22.5%



Prior Substance Abuse Treatment:
Over fifty percent (55.5%) of the women had never received treatment. Forty-three percent indicated that they had been in prior treatment; there was no response from 2.5 percent of the women.

(From IDOC Form: Intake Form/Admission Review)
Current Charge:
As expected, the most frequent charge is Possession of a Controlled Substance, followed by retail theft and forgery.



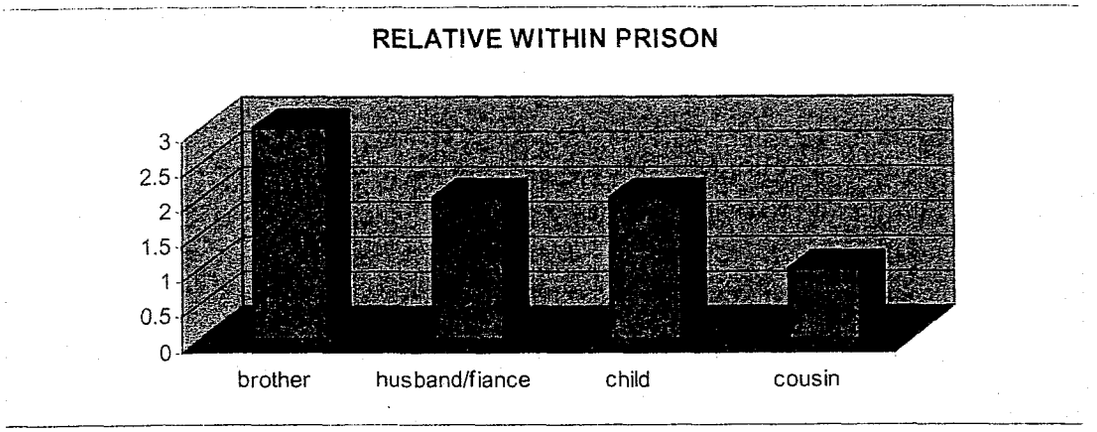
Length of Stay (in months):
The average length of stay is 53 months, ranging from a minimum of 24 months to a maximum of 108 months.

History of Assaultive Behavior:
Sixty-eight percent of the women indicated that they did not have a history of assaultive behavior; 32 percent did.

Has Enemies within DOC:
Twenty percent (or 8) of the women indicated that they had enemies within the Department of Corrections.

Has Relative(s) within DOC:
Again, twenty percent (or 8) of the women admitted that they had family members within the Department of Corrections.

Of those with family members, three had a brother, 2 had a husband or a fiancé, 2 had a child, and 1 had a cousin within the Department of Corrections.



Inmate has Serious Medical/Emotional Problems:
Sixty-three percent stated that they had no serious emotional problems; 37 percent did.

As follows are charts summarizing the various DSMIV category assessments:

DSMIV Axis I

	Frequency	Percent
None	13	32.5%
Cocaine	14	35.0%
Heroin	10	25.0%
Cannabis	2	5.0%
No Response	1	2.5%

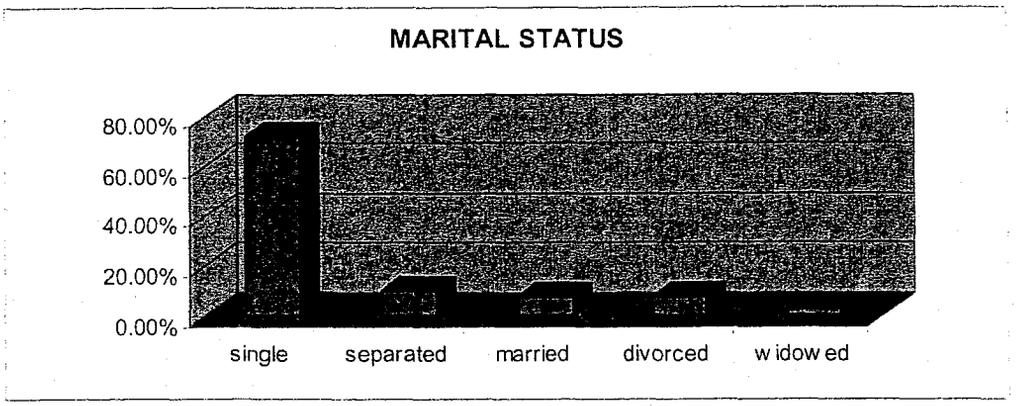
DSMIV Axis II

	Frequency	Percent
None	31	77.5%
Manic Depressive	2	5.0%
Anti-Social Behavior	3	7.5%
Depression	3	7.5%
No Response	1	2.5%

DSMIV AxisIII

	Frequency	Percent
None	36	90.0%
Asthma	1	2.5%
Herpes	1	2.5%
Obesity/Hypertension	1	2.5%
No Response	1	2.5%

Marital Status:
Nearly 93 percent of the women were single.



Number of Children:

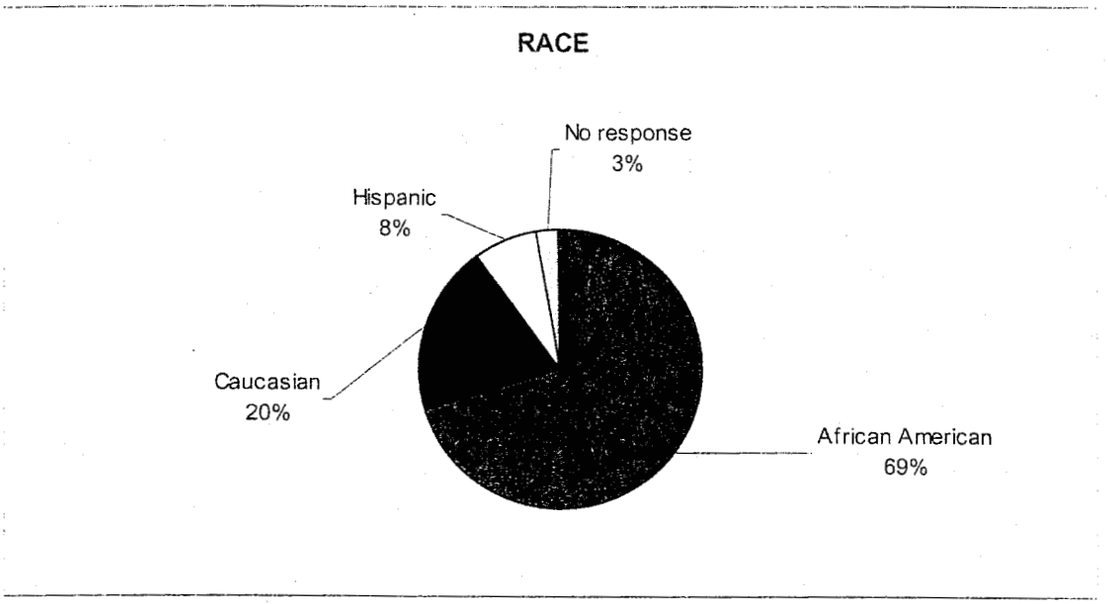
	frequency	percent
no children	7	17.5%
one children	5	12.5%
two children	7	17.5%
three children	7	17.5%
four children	5	12.5%
five children	4	10.0%
six children	2	5.0%
seven children	1	2.5%
eight children	1	2.5%
nine children	0	0.0%
ten children	1	2.5%

Only 17.5 percent of the women have no children. Forty-seven percent have one to three children, 27.5 percent have four to six children, and eight percent have between seven to ten children.

Education Level:
The average educational level was the 11th grade.

Age:
The mean (average) age was 34 years old. Ages ranged from 34 to 52.

Race:
Seventy-percent of the women were African American, 20 percent Caucasian, and three percent Hispanic.



Physical Abuse:
Nearly 83 percent of the women denied being a victim of physical abuse; 12.5 percent had been a victim of such abuse. Five percent of the women did not respond.

Sexual Abuse:
Eighty percent of the women denied being a victim of sexual abuse. Fifteen percent had been a victim of such abuse. Five percent did not respond.

B. QUALITATIVE STATISTICAL ANALYSIS

1. PROFILES OF THE TWO SAMPLES

As follows are general profiles of the treatment group and control group as taken from the data collected from the case files. These profiles are based on averages and reflect that of the general sample group; there may be some clients that do not fit into this "typical" profile.

a. Treatment Sample:

A women from the treatment group is generally a 35-year old, African American , divorced, female, who has experienced a mean of 62.38 days from sentencing to admission and has an estimated length of stay average (mean) of 950 days (or approximately 2.6 years). She is most often charged with a non-violent, drug-related charge, most likely Possession of a Controlled Substance.

Prior IDOC stays and convictions are estimated at a fifty percent likelihood; however, she most likely does not have any prior violent convictions. She has no outstanding warrants.

Her present status is either mandatory/supervised release or in-custody. Institutional restrictions result from being incarcerated. She generally does not have any medical restrictions.

She is part of the Criminal Justice special population. She is viewed as a routine clinical risk. Her suicide level is none for both intake and during withdrawal measurements. There is no follow-up on mental health/medical issues.

She was raised is Chicago or in the Chicago area by her parents, in a home with many other children. She has a fifty percent chance that she did not experience any abuse as a child; however, there are painful childhood experiences that still bother her. The neighborhood she grew up in contained a vast amount of drug sales.

Her parents and older family members used alcohol and drugs; however, they did not seek any treatment. Her parents were somewhat strict and religion was a very important part of growing up.

She finished the 10^{th} grade of school; problems in school were related to school, not substance abuse.

While she has worked at some point, she probably was not employed prior to being incarcerated. When employed, she typically worked in the food industry. The wages though were spent to support her drug habit, which generally was about $500 per week. She was not a member of a gang.

Prior to incarceration, she lived with friends and family. She has at least one child, not born addicted, that may or may not have lived with her. She has not been involved with child protective services. She was not pregnant at intake.

She does not consider anyone a "close" friend. However, she considers her relationships with her significant other, other family, children, and friends as being close and feels that they are all very supportive of her decision to stay abstinent.

Emotionally, she gets "out of control" more often than any other disturbing behavior. She has probably experienced or witnessed some abuse just prior to incarceration while living with family and/or friends.

She generally does not have a mental health history. She has a fifty percent chance of having a current mental health problem.

The DSMIV Axis I results are evident of large usage of alcohol, opioids, and cocaine.
The DSMIV Axis II MI Disorders show both alcohol and cocaine as problems.
The DSMIV Axis II MI Disorders results indicate both alcohol and cannabis problems.
The DSMIV Axis III results are none or no response.
The DSMIV Axis IV results indicates "social environment" as the result.
The DSMIV Axis V mean is 51.95
The MAST score mean is 12.84 - a score greater than 5 indicates an alcohol problem.

She was approximately 17 years old when she started using alcohol and her primary drug of choice was cocaine. She is dependent on cocaine and would use by snorting or smoking more than three time a day.

She has typically not received any prior treatment for substance abuse; however, if she did, it was likely to be one time as an outpatient client.

She believes that more school, completing her GED, and/or learning clerical skills will help her find and maintain work in the future.

To summarize, the typical female client at the Gateway Program at Dwight is often charged with a nonviolent, drug-related offense and has had a nonviolent criminal history. She is often around the age of 35, and from a racial or ethnic minority. She generally is from a dysfunctional family, where her parents had used alcohol and/or drugs. She is often divorced, albeit a single mother, and the sole supporter of her children. She has more than one child. She is unemployed and undereducated. She has substance abuse problems, with her primary drug of choice being cocaine. Although she refers to her addictions as being severe and she spends most of her time involved in drug use, she had not always sought treatment.

b. Control Sample:

A woman from the control group is typically an African American women, 33.7 years old, residing in the Dwight or Logan facility. Her current charge is drug-related, most often Possession of a Controlled Substance. She is absent from supervision. She has an average of 52.25 months as her length of stay.

She has a low dangerous and security level. She is not considered an escape risk, nor does she indicate a desire to escape. She does not have any outstanding warrants.

There is a slight indication of her having a history of assaultive behavior. She denies having enemies within IDOC. She generally has no relatives within the institution.

She has prior convictions and was about 28 years old at the time of her first conviction. She typically has prior incarcerations.

She is single and typically has more than one child. She was unemployed prior to incarceration and has a 10^{th} grade level of education.

She does not have any serious emotional or mental health problems and she probably did not experience much physical or sexual abuse. However, she will comment on various abusive situations (sexual, physical, emotional, or substance) she may have experienced or witnessed.

The DSMIV Axis I results show cocaine and heroine prevailing.
The DSMIV Axis II results show slight depression problems
The DSMIV Axis III indicate none.

She has not been a member of a gang.

There is a history of drugs and alcohols. Her drugs of choice are cocaine and heroin. She typically has not received any prior treatment (although the numbers are fairly evenly distributed).

2. COMPARISONS OF THE TWO SAMPLE PROFILES

The two groups were compared and contrasted using a number of variables. The data sources revealed a group of 21 like variables (variables measured in both groups) that are reported on below.

The 21 variables that were used for the comparison analysis are:

1. Abuse experience: abuse = sexual, physical, emotional
2. Age at intake: treatment group is intake, control group is admission
3. Current charge: charge for which they are incarcerated
4. Drug of choice: primary drug of choice, two are listed for each group.
5. Drug history: client self-report of drug history.
6. DSMIV Axis I
7. DSMIV Axis II
8. DSMIV Axis III
9. Escape risk: determined by supervisors
10. Gang member: yes or no responses
11. Gender: all female
12. Grade level: completed educational level
13. Length of stay: incarceration term
14. Location: where incarcerated
15. Marital status: at intake/admission
16. Mental health history: self-reported and documented
17. Number of children: up to incarceration
18. Outstanding warrants: for any reason
19. Previous treatment for substance abuse: self-reported and documented
20. Prior convictions/incarcerations: documented
21. Race: as reported

Dwight Group Comparison Matrix

[redacted]		[redacted]
47.5% (19) No	Abuse Experience	77.5% (31) No
35.15 (min. 21, max 49)	Age at Intake (mean, n = 40)	33.76 (min. 21, max.52)
47.5% (19) PCS	Current Charge	50.0% (20) PCS
42.5% (17) Opiate	Drug of Choice	35.0% (14) None
35.0% (14) Cocaine	Drug of Choice	30.0% (12) Heroin
77.5% (31) No	Drug History	62.5% (25) Yes
45.0% (18) Opiate	DSMIV Axis I	35.0% (14) Cocaine
10% (4) each/Cocaine,Marij	DSMIV Axis II	77.5% (31) None
92.5% (37) Deferred	DSMIV Axis III	90.0% (36) None
90.0% (36) Low	Escape Risk	77.5% (31) Low
72.5% (29) No	Gang Member	95.0% (38) No
100% (40) Female	Gender	100% (40) Female
10.73	Grade Level (Mean)	10.88
79.16 months	Length of Stay	52.25 months
100% Dwight	Location	40$ (16) Dwight
62.5% (25) Divorced	Marital Status	72.5% (29) Single
95.0% (38) None	Mental Health History	75.0% (30) None
22.5% (9) Four Children	Number of Children	17.5% (7) each: None, Two, or Three
97.5% (39) No	Outstanding Warrants	100% (40) No
45.0% (18) None	Previous Treatment for SA	55.0% (22) None
52.5% (21) No	Prior Convictions/Incarceration	52.5% (21) Yes
35.0% (14) African American	Race	70% (28) African American

PCS = Possession of a Controlled Substance

The comparison of like variables among the two groups results in mostly interesting, and some contrasting results. As profiled earlier, the two groups have many commonalities and few differences.

Interpretation:
Qualitatively, a review of the comparison matrix was examined to identify differences and commonalities among the two groups. The findings are as follows:

- The majority (47.5%) of the treatment group that did not report any abuse experience was much lower than the percentage (77.5%) of the control group that reported no abuse experience.
- The mean age of the treatment group is slightly higher than that of the control group.
- The mean age of the treatment group is higher than that of the control group.
- The current charge for both groups is "Possession of a Controlled Substance"
- The treatment group self-report indicates the drug of choice as heroin (42.5%) and cocaine (35.0%)
- The control group self-report indicates the drug of choice as none (35.0%) and heroin (30.0%)
- The DSMIV Axis I results contradict the self-reports. DSMIV Axis I identifies the drug of choice. The difference in the treatment group DSMIV Axis I and the self-report is not too alarming; however, the contradiction between the control group self-reported drug of choice and the DSMIV Axis I results are very different. The majority of the control group denied having a drug of choice.
- The drug history results are interesting in that 77.5% (31) of the treatment group replied "no" when asked about drug history. These are the clients in the corrections-based treatment program. On the other hand, 62.5% (25) of the control group, the group that is incarcerated but not in treatment, responded "yes" to having a drug history.
- The risk of escape is not evident in either group.
- Interestingly, the majority of the treatment group: 72.5% (29) was not a member of a gang; however, a much higher percentage of the control group: 95.0% were not gang members.

- The mean for educational level resulted in a .15 difference. The 10th and 11th grade, when a person is just around 16 or 17 years old.
- The length of stay for the treatment group is, on average, 27 months longer than that of the control group. This makes sense since the control group is shown to have a lengthier criminal history.
- The majority of women in each group were referred to as unmarried.
- The number of children averaged higher for the treatment group than the control group.
- The majority of both groups did not seek previous treatment for substance abuse.
- 52.5% (21) of the treatment group did not have prior convictions/incarcerations, whereas, 52.5% (21) of the control group did have prior convictions/incarcerations.

The observations from the comparison chart led to further investigation and quantitative analysis of the data. In order to determine the significance of the differences, the data was analyzed quantitatively; achieved by conducting the statistical procedures of Pearson Correlation and Paired Samples t-test. The results are examined in the following section.

C. QUANTITATIVE STATISTICAL ANALYSIS

Correlations are designed to measure the strength of the relationships between two continuous variables. The Pearson correlation coefficient provides a succinct description of the degree and the direction of the relationship between two variables. The correlation always varies between -1 and +1. Significance is measured by the closeness of the coefficient to -1 and +1. A correlation of 1.00 (or -1.00) indicates a perfectly consistent relationship. When there is a perfect linear relationship, every change in one variable is accompanied by a corresponding change in the other variable. Therefore, a coefficient result of zero indicates no significant relationship.

A correlation measurement can also identify the direction of the relationship. In a positive correlation, the two variables tend to move in the same direction: when one variable increases, the other variable increases; if one variables decreases, the other variable also decreases.

In a negative correlation, the two variables tend to go in opposite directions. As one variable increases, the other variable decreases. In other words, it is an inverse relationship.

Significance tests were run at 95 percent confidence level. The computer-based statistical software SPSS (Statistical Package for the Social Sciences) used for the analysis, reports correlations at both the 95 percent and 99 percent confidence levels. The results of the treatment group and the control group are reported separately in the following charts.

It should also be noted prior to reviewing the charts, that correlation simply describes a relationship between two variables. It does not explain why two variables are related. Specifically, a correlation should not be interpreted as proof of a cause-and-effect relationship between two variables.

Significant Results for the TREATMENT GROUP (n=40, unless otherwise specified)

[illegible]	[illegible]	[illegible]	[illegible]
Prior drug history/Prior convictions	.566	.000	.99
Prior drug history/previous treatment	-.356	.028	.95
Previous treatment/biological parents previously treated	-.426	.009	.99
Previous treatment/who did you live with prior to incarceration	.450	.006	.99
Previous treatment/support from family	-.326	.046	.95
Previous treatment/drugs sold in area	-.333	.041	.95
Withdrawal seizures/time spent using (n=4)	.994	.006	.99
Age/current charge	-.350	.027	.95
Age/close to spouse, significant other	.520	.002	.99
Race/prior convictions	.333	.036	.95
Race/where you were raised	.408	.009	.99

Interpretation:

The Pearson correlation indicates the relationship of the variables as they pertain to the treatment group. For example, prior drug history has a positive relationship to prior convictions, Pearson = 566; meaning that as one has a more severe drug history, the more likely they are to have prior convictions. However, prior drug history has a negative relationship to previous treatment, Pearson= -.356; meaning that the more of a drug history one has, the less likely they are to have received prior treatment. Previous treatment has a negative effect, Pearson = -.426, if biological parents received previous treatment; yet, it is positively effected by who you lived with prior to incarceration (friends/family), Pearson = .450. A positive correlation, then, implies that both variables are moving in the same direction, whereas a negative correlation indicates that the variables are moving in the oppositive direction (i.e., as one goes up, the other goes down). This method of interpretation can be used for the entire table.

Significant Results for the CONTROL GROUP (n=40, unless otherwise specified)

Age/age 1st convicted	.389	.013	.95
Prior incarcerations/# of convictions (n=38)	-.822	.000	.99
Site location/escape risk (n=39)	-.409	.010	.99
Age/marital status	-.324	.042	.95
Mental health history/abuse experience (n=38)	.608	.000	.99
Drug history/drug of choice (n=39)	-.877	.000	.99
Drug history/age 1st used drugs (n=32)	-.750	.000	.99
Drug history/previous treatment (n=39)	.658	.000	.99
Current charge/emotional, medical problems (n=38)	.412	.010	.95
Race/length of stay (n=38)	.553	.000	.99

Interpretation:

The Pearson correlation, again, indicates the relationship of the variables as they pertain to the control group. For example, age and age first convicted are positively related, Pearson = .389; meaning that as age increases, so do the number of convictions. There is a negative relationship between the number of prior incarcerations and the number of convictions, Pearson = -.822, meaning that as the number of incarcerations increases, the number of convictions decreases. Consistent with literature, the chart also shows that as mental history increases, the more likely the women is to have experienced abuse; Pearson .608. Interestingly, there is a positive relationship between drug history and previous treatment, Pearson .658; meaning that as drug history increases, so is the likelihood for previous treatment. This is opposite of the direction of these two same variables for the treatment group, which showed drug history and treatment as having a negative relationship. This method of interpretation can be used for the entire table.

In order to then measure differences (and commonalities) between the two separate groups of participants considering the same, non-manipulated variables, the paired-samples t-test was conducted. Here, we were interested in determining which variables are significant to the client's current status of being incarcerated. While the Pearson correlation was able to identify which variables were significant for each individual group, the paired samples t-test can identify which variables are significant within both groups. The findings are summarized in the following chart.

Pair is treatment vs. control for each variable	Paired Differences					t	df (degrees of freedom)	Sig (2-tailed)
	Mean	Std.Dev	Std,Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Current Charge	-1.50	2.23	.36	-2.23	-.77	-4.152	37	.000
Age/ Admission Incarceration	1.38	10.83	1.71	-.209	4.84	.803	39	.427
Marital Status	.69	1.76	.28	.12	1.26	2.450	38	.019
Previous Convictions/Incarcerations	7.89 E-02	.75	.12	-.17	.33	.650	37	.520
Previous Treatment	.92	1.75	.29	.33	1.50	3.187	36	.003
Drug of Choice	302.3564	1.4913	.2388	301.8730	302.8398	1266.118	38	.000
Age/1st used drugs/alcohol	13.0	10.25	1.81	9.31	16.69	7.176	31	.000
Abuse Experience	-5.26E-02	.23	3.67E-02	-.13	2.17E-02	-1.434	37	.160

Interpretation:
A result is statistically significant at a 95 percent confidence interval (a=.05) when using sig. t is not greater than .1; therefore the results of comparing the treatment group to the control group on selected variables resulted in:

- current charge is significant
- age at admission /incarceration is not significant
- marital status is significant
- previous convictions/incarcerations are not significant
- previous substance abuse treatment is significant
- drug of choice is significant
- age client first used drugs/alcohol is significant
- abuse experience is not significant

The variables which proved to be significant mean that they tested significant for both groups in terms of likelihood of being arrested for a charge of Possession of a Controlled Substance. These results can be interpreted, then, as indicating that an unmarried female who uses drugs since her teens and who has attempted treatment, is likely to be arrested for possession of a controlled substance. Her age, previous convictions or incarcerations, and/or abuse experience do not have an influence on the probability of such an occurrence.

VI. FINDINGS - PHASE II - INTERVIEWS

The following interview took place at the Dwight Correctional Facility.

Interview with Denise Perry - Site Supervisor:

Interviewer: Which components do you find most beneficial to the participants?
Perry: The learning experience the women gain from the group discussion. They talk about everything from chemical dependency, to domestic violence, to sexual abuse. They learn from other women and gain respect from them and for them.

Interviewer: Are women referred to other institutional services?
Perry: Yes, women are referred to other services on an as-needed basis. For example, if they are depressed or have mental health issues, we refer them to counseling.

Interviewer: How do you define success/failure?
Perry: There are really not many failures in the program that I can account for. Even those women who are unsuccessfully discharged from the program still gain something. They leave the program either with an increased awareness of their addiction, an increased self-esteem, respect for correctional and treatment staff...something.

Interviewer: Regarding staff, who delivers the services?
Perry: Counselors

Interviewer: How many staff do you have and what are their credentials?
Perry: There are four counselors through this grant, two are certified substance abuse counselors and two are not. They are all female.

Interviewer: How do staff spend their time?
Perry: With clients, either in groups, dealing with disciplinary problems, or preparing progress reports.

Interviewer: Are there some staff who are more successful in working with residents than others?
Perry: Yes.

Interviewer: What factors differentiate those staff who are highly effective from those who are less effective?
Perry: You may think it is based on credentials, but it is not. It involves attitude - attitude of the staff. Those staff who possess a passion and zest for dealing with women who have addiction problems are more affective. Also, those staff who are able to impose boundaries with clients are more affective - you can't let the women get too close to you - need to be a bit restrictive.

Interviewer: What are the residents evaluation of staff?

Perry: Our residents do not formally evaluate the program staff, however, satisfaction surveys indicate that of all the surveys conducted, there have been only 1 to 2 complaints. Most of the complaints come from the institution part, not the program part.

Interviewer: Can you describe why you think the program works?

Perry: The women in the program want direction and discipline...they want some attention...and they want a safe place to be human. We give them all of that. The Gateway Program gives them a lot of education regarding drugs and helps them identify what their risk factors are.

This program, however, does a lot more for the women than just speak about treatment and addiction, we also address other issues these women face, such as mental health issues, violent family histories, etc... Most of our women come from histories of chemical dependency, and from environments where drug usage is prevalent. and upon release, many return back to the same environment that got them into trouble. We are careful to make sure that we help them prepare to address these issues upon release.

We also try to select effective referrals upon release, one that is appropriate to the needs of the specific woman.

We have received many phone calls from women who have succeeded, to say thanks.

Interviews with Clients

The following interviews took place at the Dwight Correctional Facility. For purposes of confidentiality, the names of the clients are coded, using pseudonyms. This also makes it easier to read, rather than giving them numerical codes.

001 - "Mary"

Mary is a 29-year old, Caucasian woman. She is single, having never been married, and has two children. She has received 15-years of formal education and worked over six years at her job, prior to being incarcerated. She denied having any mental health issues.

Mary's drug of choice is crack. She has never received drug treatment. Mary has been at Dwight since February 8, 1999. She has been in the Gateway Program since February 17, 1999. She is presently in the aftercare phase, and expects to be released on October 2, 2000.

Interviewer: What did you find most helpful about the program?
Mary: Several things. It taught me about my addiction and that when I am released, I must attend my treatment meetings. Meetings are important. So, I guess it taught me where I need to be when I am released to stay clean. It was also helpful with one-on-one counseling - even with problems that don't have anything to do with addictions - such as relationships.

Interviewer: What made you ready for treatment now?
Mary: For personal issues. First, the only time I got into trouble was when I was using. I knew I needed help. Also, I was pregnant - I came into the program while pregnant. I wanted my baby to be born drug-free. My baby was born drug-free.

Interviewer: How has the program helped you adjust to prison life?
Mary: It taught me about varieties of people and how to get along with different people. I also learned about discipline and that even in prison, there are rules you need to obey.

Interviewer: How has the program helped you with family issues?
Mary: It has brought me closer to my family. My family is completely behind my treatment.

Interviewer: How has the program helped you in your ability to have healthy relationships?
Mary: It has taught me to not have a relationship for at least one year after my recovery - that my recovery needs to be the top priority. It has also taught me to not have a male sponsor, again, because I would not focus on my recovery.

Interviewer: How has the program helped you with your attitude toward others?
Mary: I learned not to judge others.

Interviewer: How about you attitude about your self, has the program helped you with that?
Mary: Yes. I have my self esteem back up. I am highly motivated and I actually like myself.

Interviewer: Are you satisfied with the program?
Mary: Yes, very.

Interviewer: What are your plans after release?
Mary: I want to enter into a residential treatment center.

Interviewer: Do you have any recommendations on how the program can improve or perhaps how it can add something it is not offering?
Mary: Not really, perhaps more NA meetings.

002 - "Saundra"

Saundra is a 36- year old, African American woman. She is single, having never been married, and has two children. She has 10 years of formal education and, while indicating that she has held many jobs, has not held any job for longer than 12 months. She indicated that she suffers from depression.

Saundra referred to being raped at the age of 12. Her family knew about the rape, and the offender was convicted and sentenced to prison. However, after the offender went to prison, the case was never again discussed. Her family ignored all related discussions and instructed her to never mention it again.

She lost both parents at an early age. Her father died when she was 13; her mother when she was 27. She admitted to feeling intense pain at the thought of being "left alone." She indicated that she has never dealt with that pain (until the Gateway Program).

Saundra's drug of choice is heroin. She has been using for 19 years. She has never received any drug treatment. She has been in the Gateway Program since July 20, 1999. She is presently in the aftercare phase, and expects to be released on October 9, 2000.

Interviewer: What did you find most helpful about the program?
Saundra: The staff - all of them. The program helped me to find myself and to build on my self-esteem. I am also more open-minded now.

Interviewer: What made you decide to seek treatment at this point?
Saundra: I had tried stopping before. I went cold turkey, but always returned. When I heard about this program, I said I was interested. I wanted to change. And, I didn't want to return to the institution. I guess I just got tired of using. I never knew how to get drug treatment. I never had access to it until Gateway.

Interviewer: How has the program helped you adjust to prison life?
Saundra: I am more calm. I can deal with people better. I learned patience - that was hard. I always wanted to fight. In the groups, I learn to gain patience and I learned acceptance. It also opened my eyes to spirituality.

Interviewer: Has the program helped you with family issues?
Saundra: It was very helpful. I was so depressed because I had lost family members and feared losing others. I didn't know how to deal with it, so I medicated myself. I never talked about the issues to anyone. I thought I had to be the strongest in the family because I am the second oldest. I now can talk openly about my fear and about the issues.

Interviewer: How has the program helped you with your attitude toward others?
Saundra: I learned a lot about anger and acceptance. I try to help others now. I never did this before.

Interviewer: Has the program helped in how you feel about yourself?
Saundra: Yes. I love myself now. I love being clean. I want to continue to grow. I had stopped growing for a long time. I know how to go after things I want now. I didn't know how to do that before. I learned how to read and I like it. I am going to try to get into school.

Interviewer: Are your satisfied with the program?
Saundra: I am very satisfied.

Interviewer: What are your plans after release?
Saundra: I want to be with my children. I will enter into outpatient treatment.

Interviewer: Are there any recommendations you can make to the program?
Saundra: It is all good. Well, it is good for those who want it. Those who don't want the program, shouldn't be here.

003 - "Mary"

Mary is a 29-year old African American woman. She is divorced and has three children. She has 11 years of formal education and held her job for six years prior to her current incarceration. She denies having any mental health issues.

Mary's drug of choice is cocaine. She has been using for nine years. She has attended one prior inpatient treatment, which was unsuccessful. She indicated that she wasn't ready for treatment at the time.

She has been in the Gateway program since June, 1999. She is presently in the aftercare phase, and expects to be released on November 2, 2001.

Interviewer: What did you find most helpful about the program?
Mary: The staff - they were all really cool. They let us know that we can be honest with them. They were always there for each of us. The groups also helped a lot. We were able to talk about our problems and be honest about how we feel about things we are going through.

Interviewer: What made you ready for treatment now?
Mary: I was ready. I just got tired of using. I figured out that I couldn't use successfully. I just needed to stop.

Interviewer: How has the program helped you adjust to prison life?
Mary: I wasn't able to cope in the general population. The Dwight program helped me to cope and gave me the structure I needed. It helped me come out of my negative behavior. I was angry with everyone. I did a complete turnaround in the program. I learned to communicate.

Interviewer: How has the program helped with your family relations?
Mary: My family and I never got along. I am now much closer to my sister - we talk more now. I am also a better mother. Prior to being locked up, I was not a mother to my children. I am now speaking with them. Groups helped me to be a mother again.

Interviewer: Has the program helped in your ability to maintain healthy relationships?
Mary: Yes. I know now what it takes. I know now to take things slow. I also know not to get involved with anyone for at least a year after my recovery.

Interviewer: How has the program helped with your attitude toward others?
Mary: I learned to cope. Through "encounters" sessions, I learned to deal with my feelings - good or bad - with others in an open setting.

Interviewer: How has the program helped in your attitude toward yourself?
Mary: I love myself. I have learned that I am #1. And, I learned that I deserve to be loved. I also learned that I cannot be loved by others or love others, until I learned to love myself. The program helped to build my self-esteem.

Interviewer: Are you satisfied with the program?
Mary: Yes.

Interviewer: What are your plans upon release?
Mary: I want to enroll in an inpatient treatment facility. And I need to get a job. I am not quite ready to return to my family - I need a foundation first.

Interviewer: Any recommendations for the program?
Mary: No, it is a good program.

004 - "Brenda"

Brenda is a 29-year old Caucasian woman. She has been married since 1989 and has five children. Her children are currently in the custody of her mother. She has 11 years of formal education and refers to having held many different jobs, none for any significant length of time. She has received prior mental health counseling and has been diagnosed borderline schizophrenic and manic depressive.

Brenda's drugs of choice are many: alcohol, marijuana, crack, LSD, and pills..."almost anything," she stated. She has been using since the age of 12, beginning with marijuana, and escalating to more serious usage at the age of 13. She has received numerous prior treatments, more than 15, both inpatient and outpatient. None have been successful.

Brenda has been in the Gateway program since September 1, 1999. She is presently in the aftercare phase.

Interviewer: What did you find most helpful about the program?
Brenda: The staff were great. They take time with each client. I also learned about changing my behavior. That is why the other treatments didn't work - I never learned to change my behavior. I had been in treatment more than 15 times, so I knew about drugs - but I didn't know about behavior change. This program helped me learn about this.

Interviewer: Why were you again ready to try treatment?
Brenda: I was tired of using.

Interviewer: How has the program helped you adjust to prison life?
Brenda: It helped me tremendously. When I first came here, if I was part of the general population, I would've ended up with the wrong crowd and would've messed up. Dwight saved me.

Interviewer: Has the program helped you with your mental health issues?
Brenda: When I first came here, I was immediately sent to the Psych doctor [psychiatrist]. I was put on medication. I don't use the medication anymore - I am just fine.. Through Gateway, I learned that a lot of my mental health issues were related to my drug usage.

Interviewer: How has the program helped you with family issues?
Brenda: It has helped a lot. I am more open and honest with my family.

Interviewer: Has the program helped you to maintain healthy relationships?
Brenda: Yes, before I came here I was in an abusive relationship. I am now free of that.

Interviewer: Regarding your attitude toward others, has the program helped you there?
Brenda: Yes, I am much better - a 90 percent change.

Interviewer: Has the program changed your attitude toward yourself?
Brenda: Yes, I feel much better about myself. I feel worthy and actually like myself.

Interviewer: Are you satisfied with the program?
Brenda: Yes. It is the best program I have ever been through.

Interviewer: What are your plan after release?
Brenda: I want to enter into residential treatment. Then, I want to start being a mom to my kids.

Interviewer: Do you have any recommendations for the program?
Brenda: No.

There were several themes which emerged from all of the interviews:

1. The Drug Treatment Program has helped the women address their addictions. It has assisted them in learning about drugs and addictions, about recognizing risk factors, and about identifying the steps they need to complete in order to become and remain drug-free.

2. The Drug Treatment Program has assisted the women with issues aside from their addiction. Each of the women interviewed indicated that the program has helped improve their lives in areas such as self-esteem, relationships, and parenting skills.

3. The Drug Treatment Program has helped the women cope with prison life. All of the women referred to respecting the staff and getting the structure they needed. They also indicated that they learned about discipline and how to appreciate and get along with others.

4. The Drug Treatment Program helped to prepare the women for their reintegration into the community. The women spoke of issues such as: not being involved in a romantic relationship for one year after release, of not having a male mentor, and of the importance of continuing treatment upon release.

VII. CONCLUSIONS

In order to properly and effectively address the issues of the female substance abusing offender, we need to first begin to ask the right questions: Who are these women? What factors differentiate those who volunteer for the program from those who decline services? How has the program benefitted them? What services do they need? This evaluation is an attempt to address some of these questions. In this section, the key findings of the evaluation are discussed.

Who are these women?

The typical female client at the Gateway program in the Dwight Correctional Facility is generally charged with a nonviolent, drug-related offense and has had a nonviolent criminal history. She is often around the age of 35, and from a racial or ethnic minority. She is generally from a dysfunctional family, where her parents had used alcohol and/or drugs. She is divorced, albeit a single mother, and the sole supporter of her children. She has more than one child. She is unemployed and undereducated. While not abused as a child, she has witnessed or experienced abuse as an adult. She has substance abuse problems, with her primary drug of choice being cocaine. Although she refers to her addictions as being severe and she spends most of her time involved in drug use, she had not always sought treatment. She has few close friends, and does not always receive the support of her spouse or significant other regarding her abstinence.

The profile above mirrors that found in the literature in almost all areas. However, there are some differences. First, according to the literature, most women involved in the criminal justice system have extensive histories of physical and sexual abuse. The women in the treatment group admitted to experiencing or witnessing abuse in their household as an adult, but denied being victims of abuse as a child. As stated in the report, these low percentages may be more reflective of when the information was collected during the program. Most intake and initial assessment interviews are conducted during the early stages of program participation, a time when the clients are not yet comfortable enough to discuss issues of such a sensitive nature.

The other glaring difference was in terms of mental health. The data collected for the present study suggested that the women did not suffer from severe mental health histories. According to the literature, largely as a result of the trauma of early sexual and physical abuse, female offenders often enter the system with a host of psychological issues.

What factors differentiate those who volunteer for the program from those who decline services?

The two groups were compared and contrasted using a number of variables. The following chart summarizes the similarities and differences of the two groups.

Present Charge (PCS)	Prior Convictions (control group more likely to have more convictions)
Escape Risk (low)	Prior Incarcerations (control group more likely to have more incarcerations)
Present Age (34 - 35)	
Race (African American)	
Marital Status (unmarried)	
Educational Level (10th)	
Employed Prior to Incarceration (no)	
Mental Health History (no)	
Drug of Choice (heroine and cocaine)	
Prior Substance Abuse Treatment (no)	

The variables were further analyzed statistically to determine the strength of the relationships between variables within each separate group and to assess which of those variables impacted both groups together. While all of the findings will not be summarized here, some of the key points include:

With the treatment group:

- prior drug history is positively related to prior convictions: the more of a drug history one has, the more likely they are to have prior convictions

- prior drug history is negatively related to previous treatment: the more of a drug problem one has, the less likely they are to have received treatment

With the control group:

- prior incarceration is negatively related to number of prior convictions: as incarcerations increase, the number of convictions decreases

- mental health history and abuse experience are positively related: as abuse experience increases, so does mental health history

- drug history and previous treatment are positively related: the more of a drug history, the likelihood of previous treatment increases. This relationship is the opposite of that found with the treatment group.

The Paired samples t-test determined that: marital status, previous substance abuse treatment, and drug of choice are significant for both groups in terms of the likelihood of being incarcerated for the charge of Possession of a Controlled Substance.

What services do they need?

From the data collected from the files and based on the interviews, the women need assistance in the following areas:

employment/marketable skills (most noted were clerical skills, computer skills)
financial management
assistance with DCFS
parenting skills
education
groups to deal with isolation
groups to deal with domestic violence

(Note that we recognize that the program already offers services in a number of these areas, this is simply a list of what some of the women referred to as needed services).

How has the program benefitted them?

From the interviews, we determined that the program benefitted the women in several areas. The women indicated that the drug treatment program assisted them not only with their addiction, but also in areas including:

- adjusting to prison life
- mental health well-being
- ability to having healthy relationships
- ability to get along with others
- increased self-esteem
- preparing for their release

VIII. RECOMMENDATIONS FOR FUTURE RESEARCH

As the number of female substance abusers under the control of the criminal justice system continues to increase, it becomes even more critical that efforts toward providing this population with the most effective supervision and services keep pace. Moreover, research and evaluative data pertaining to this specific population of offenders needs to not only continue, but to expand. This section offers recommendations for consideration of future research.

Future evaluative research efforts at the substance abuse treatment program at the Dwight Correctional Facility need to focus in a number of specific directions.

First, studies need to focus on the impact of the program on discipline issues within the institution. Previous evaluations of correctional-based drug treatment programs have shown that clients involved in a treatment program have less grievances and are more satisfied than a matched-group of inmates who are not participating in the program. We were unable to access any discipline reports for this evaluation, however, such data becomes important information for long-term planning efforts.

More interviews should also be conducted with the clients of the program, meaning more in terms of numbers and intensity. We were able to interview only four inmates, which poses some validity questions (such as- were these only the "content inmates). Nonetheless, the information extracted from the interviews was valuable. Personal interviews allows for the gathering of information not often captured within the files.

Future studies should provide for further follow-up of the control and treatment women, meaning post-release. These two groups should be compared in terms of: re-arrest, re-conviction, re-incarceration, drug usage, adjustment to the community, just to name a few variables.

Finally, questions need to be addressed regarding needed services both inside and outside the institution. While the study found that the present program does an effective job at addressing a host of confronting problems, issues such as isolation needs to be further analyzed.

IX. REFERENCES

Austin, James (1996). Correctional Options: An Overview. American Correctional Association.

Austin, J., Bloom B., & Donahue, T. (1992, April). Female Offenders in the Community: An Analysis of Innovative Strategies and Programs. San Francisco, CA: National Council on Crime and Delinquency.

Bloom, B. (1993, June). Why Punish the Children? A Reappraisal of the Children of Incarcerated Mothers in America. The IARCA Journal on Community Corrections. 5 (6),14-17.

Bloom, B., Brown, M., & Chesney-Lind, M. (1996). Women on Probation and Parole. In Lurigio, A. (Ed.), Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and CoDisorders. Prepared for the National Coalition for Mental and Substance Abuse Health Care in the Justice System through a grant by the Center for Substance Abuse Treatment (CSAT).

Bureau of Justice Statistics. (1990). Drugs and Crime Facts. Washington, D.C. Government Printing Office.

Callahan, C. (1986, June). Women in Prison: Does the Justice System Do Them Justice? Report on a Leadership Seminar Sponsored by the Alaska Women's Commission.

Centers for Disease Control. (1993). Morbidity and Mortality. Weekly Report. November 19, 1993.

Center for Substance Abuse Treatment. (1994). Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs. Rockville, MD: Department of Health and Human Services, Public Health Service.

Chesney-Lind, M. (1986, Autumn). Women and Crime: The Female Offender. Journal of Women in Culture and Society, 12(1),78-96.

Chesney-Lind, M. (1987). Female Offenders: Paternalism Reexamined in Women, the Courts and Equality. Newberry Park: Sage Publications.

Chesney-Lind, M. (1989). Girl's Crime and Woman's Place: Toward a Feminist Model of Female Delinquency. Crime and Delinquency, 35(1),5-29.

Chesney-Lind, M. (1993). Sentencing Women to Prison: Equality Without Justice. Paper presented at the Seventh National Roundtable on Women in Prison. American University.

Chesney-Lind, M. (1997). The Female Offender. Thousand Oaks, CA: Sage Publications.

Chesney-Lind, M. & Immarigeon, R. (1990). Beyond Building Prisons for Women: A Strategy to De-Incarcerate Female Inmates in the United States. Paper presented at the American Society of Criminology Meeting, Baltimore, Maryland.

Denno, D.W. (1994). Gender, Crime, and the Criminal Law Defenses. The Journal of Criminal Law and Criminology, 85(1), 80-177.

El-Guebaly, N. (1995). Alcohol and Poly-substance Abuse Among Women. Canadian Journal of Psychiatry, 40(2), 73-79,.

Erez, E. (1988). The Myth of the New Female Offender: Some Evidence From Attitudes Toward Law and Justice. Journal of Criminal Justice, 16, 499-509.

Erez, E. (1989). Gender, Rehabilitation, and Probation Decisions. Criminology, 27(2), 307-327.

Fisher, R.L. (1987, March). Sample of 1986 Female New Commitments for Controlled Substance Convictions Involving "Crack." Report prepared for the State of New York: Department of Correctional Services.

Fritsch And Burkhead. (1981). "Behavioral Reactions of Children to Parental Absence due to Imprisonment." Family Reaction. Volume 30. Pgs. 83-88.

Gransky, Laura A. and Jones, Robert. (1995). Evaluation of the Post-Release Status of Substance Abuse Program Participants. Illinois Criminal Justice Information Authority. September, 1995.

Greenfeld, L.A. (1985). Examining Recidivism. Bureau of Justice Statistics Special Report. U.S. Department of Justice.

Greenfeld, L.A.. & Minor-Harper, S. (1991, March). Women in Prison. Bureau of Justice Statistics: Special Report. U.S. Department of Justice.

Howell, Nic. (September, 1992). "Special Problems of Female Offenders." Corrections Compendium. Volume XVII. No. 9.

Iglehart, Alfreda and Stein, Martha. (1985). "The Female Offender: A Forgotten Client?" Social Casework: The Journal of Contemporary Social Work: Family Service America.

Illinois Department of Corrections. (1995a). 1995 Five Year Plan for Female Inmates. Prepared by Planning and Research Unit.

Illinois Department of Corrections. (1995b). Human Services Plan- Fiscal Years 1995-1997.

Immarigeon, R. (1987, Spring). The Extent of Women's Imprisonment. The JOURNAL of the National Prison Project, pp. 2-5.

Inciardi, James A. (1996). A Corrections-Based Continuum of Effective Drug Abuse Treatment Alternatives to Incarceration. July/Aug., 1996.

Jones-Brown, Paulette. (August, 1992). "Survey: Most Female Offenders Incarcerated for Non-Violent. Drug and Alcohol Related Offenses." Corrections Compendium. Vol. XV11. No. 8.

Kendall, Kathleen. (January, 1994). "Creating Real Choices: A Program Evaluation of Therapeutic Services at the Prison for Women." FORUM on Corrections Research. Vol. 6, Number 1.

Kinsey, K. (1993, June). The Female Offender. The IARCA JOURNAL of Community Corrections. 5(6),6-8.

Klosak, Jacqueline M. (1999). "The Course of Their Lives: Female Offenders on Probation." (Dissertation)

Kolman, K. (1983). "Parents in Prison: A Comparative Analysis of the Incarceration on the Families of Men and Women." Research in Law, Deviance and Social Control.

Krajick, Kevin. (1995). Correctional Options: Institutional Programs. Corrections Today. American Correctional Association.

Lipton, Douglas S. (1996). Prison-Based Therapeutic Communities: Their Success with Drug-Abusing Offenders. National Institute of Justice Journal - Research in Action. February, 1996.

LIS, Inc. (January, 1994). Profiles of Correctional Substance Abuse Treatment Programs: Women and Violent Youthful Offenders. Prepared for the National Institute of Corrections Academy.

Loucks, A. & Zamble, E. (1994, January). Some Comparisons of Female and Male Serious Offenders. FORUM on Corrections Research, 6(1),22-25.

Lurigio, A. & Rotenberg, S. (1996). The Mentally Ill on Probation and Parole: Overlooked, Understudied, and Underserved. In Lurigio, A. (Ed.), Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and CoDisorders. Prepared for the National Coalition for Mental and Substance Abuse Health Care in the Justice System through a grant by the Center for Substance Abuse Treatment (CSAT).

McDiarmid, A. (1993, June). NIC Update on Female Offenders. The IARCA JOURNAL of Community Corrections. 5(6),21-22.

Morash, M., Bynum, T., & Koons, B. (1998, August). Women Offenders: Promising Needs and Promising Approaches. National Institute of Justice. Research in Brief.

National Council on Crime and Delinquency. (1994, July 15). Criminal Justice Newsletter, 25(14).

National Institute of Corrections. U.S. Bureau of Prisons. (1989). Report on NIC Special Topic Session: Women Offenders Under Community Supervision.

Nelson-Zlupko, L., Kauffman, E. & Dore, MM. (1995). Gender Differences in Drug Addiction and Treatment: Implication for Social Work Intervention with Substance Abusing Women. Social Work, 40(1), 45-54.

Nicklas, M. (1997). Private Communication. Illinois Department of Alcohol and Substance Abuse.

Office of National Drug Control Policy. 1995 Drug Control Strategy.

Office of Justice Programs. United States Department of Justice. (1990, September). Survey of Intermediate Sanctions.

Office of Justice Programs. United States Department of Justice. (1997, June). Correctional Populations in the United States, 1995.

Pollack, Shoshana. (1994, January). "Opening the Window on a Very Dark Day: A Program Evaluation of the Peer Support Team at the Kingston Prison for Women." FORUM on Corrections Research. Volume 6, Number 1.

Quinlan, Deidre A. (1993, June). "Gender Specific Programming for Adolescent Females." The IARCA JOURNAL on Community Corrections.

"Report on NIC Special Topic Session: Women Offenders Under Community Supervision." (1989). U.S. Department of Corrections. National Institute of Corrections.

Ryan, T.A. (1985, June). Special Needs of Female Offenders: Implications for Correctional Education Administrators and Supervisors. Unpublished.

Scheckel, Lisa W. (1993). Forging Links to Treat the Substance Abusing Offenders: Challenges and Directions for the 1990s. The Communique. Center for Substance Abuse Treatment. Spring, 1993.

Simourd, Linda, and Andrews, D.A. (1994, January). "Correlates of Delinquency: A Look at Gender Differences." FORUM on Corrections Research.

Snell, T.L. (1992, March). Women in Jail 1989. Bureau of Justice Statistics: Special Report. U.S. Department of Justice. Office of Justice Programs.

Snell, T.L. & Morton, D. (1994, March). Women in Prison. Bureau of Justice Statistics: Special Report. U.S. Department of Justice. Office of Justice Programs.

Teplin, L.A., Abram, K.M. & McClelland, G.M. (1996). Prevalence of Psychiatric Disorders Among Incarcerated Women. Archives of General Psychiatry, 53(6): 05-512.

Tunis, Sandra. (1995, September). Outcome Evaluation of Jail-Based Drug Treatment: Effects on Recidivism. FOCUS. National Council on Crime and Delinquency.

Turnbaugh, Kristi. (1995). Dwight Gateway Substance Abuse Treatment Program. The Compiler. Illinois Criminal Justice Information Authority. Summer, 1995.

U.S. General Accounting Office. (1991). Drug Treatment: State Prisons Face Challenges in Providing Services. Report to the Committee on Government Operation. House of Representatives. September, 1991.

Vachon, Marla Marino. (1994, January). "It's About Time: The Legal Context of Policy Changes for Female Offenders.: FORUM on Corrections Research. Volume 6, No. 1.

Warren, M.Q. & Rosenbaum, J.L. (1987). Criminal Careers of Female Offenders. Criminal Justice and Behavior, 13 (4),393-418.

Wexler, H. K. (1995). The success of therapeutic communities for substance abusers in American prisons. Journal of Psychoactive Drugs, 27 (1), 57-66.

Wellisch, J., Prendergast, M.L., & Anglin, M.D. (1994, October). Drug-Abusing Women Offenders: Results of a National Survey. National Institute of Justice - Research in Brief. U.S. Department of Justice.

Wilsnack, R.W., Wilsnack, S.C. and Klassen, A.D. (1984). Women's Drinking and Drinking Problems. Patterns from a 1981 Survey. American Journal of Public Health.