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PROCESS EVALUATION ASSESSING THE GENDER APPROPRIATENESS OF THE KEY / CREST PROGRAM
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Introduction

The Delaware Criminal Justice Council received a grant from the National Institute of Justice to conduct a process evaluation[1] to assess the gender appropriateness of a Therapeutic Community (TC) model used at the Baylor Women's Correctional Institute (Baylor) and the CREST North and South TC treatment programs. Baylor is a level V women's prison, CREST North is a TC treatment work release program and CREST South is a TC work release program housed on the campus of the Sussex Correctional Institution (a level V prison). A Level V prison is one in which the facility is secured and prisoners do not have the capacity to leave. Level V prisons hold people who are sentenced to more than one-year incarceration for the commission of misdemeanors or felonies.

The evaluation included the use of data analysis on the 1999 KEY program at Baylor, individual interviews with the women currently participating in the Baylor KEY program, curriculum analysis and focus groups with the participants in the Baylor, CREST North and CREST South treatment programs. The goals of the research and interviews were:

1. To assess what the participants thought about the program; and
2. To determine if the women thought the program met their needs specifically based on gender.

Background

Drug use leads to many antisocial behaviors including dysfunctional families and criminality. One of the treatment programs that has gained in prominence in treating drug addicts, while in prison, is the Therapeutic Community Model. Therapeutic communities, in prison environments, are based on the concept that the addict must be removed from the general

1 By process evaluation the author means an evaluation in which the goal is to review the theory and operations of the program to determine if the program, as implemented and received by the clients of the program, is reaching the desired goals.

population and placed in a separate area in which the negative influences of prison are removed in order to create an environment that allows for positive behavior change. In a Therapeutic Community Model drug treatment program, drug addiction is viewed as a symptom of the dysfunctional behavior in the addicts' life and not the cause of the dysfunction in the life of the addict. The addict is considered to be in need of habilitation to positive social behaviors rather than rehabilitation.

The State of Delaware instituted a Therapeutic Community (KEY) in the Multi-Purpose Criminal Justice Facility located in Wilmington Delaware in 1988 to treat drug addicts in the facility. In 1994 a similar program was established at the Baylor Women's Correctional Institution. Research has shown that the Therapeutic Community model is successful for women but requires modifications from the application of the program to men. Research has also shown that success of women in Therapeutic Community programs are influenced by various factors including length of stay, the number of participants in the program, history of sexual abuse and the presence of female counselors and program directors.

During the implementation of the KEY program, it was observed that after care was needed to continue and maintain the positive changes in a Therapeutic Community KEY graduate. One of the methods used to meet this need was to establish a work release program based on the Therapeutic Community Model. In 1990 Delaware received funding from the National Institute on Drug Abuse to establish the first work release Therapeutic Community (CREST). Research since the implementation of KEY and CREST has found that addicts who attend KEY and CREST have lower recidivism rates than those without KEY or CREST program experience.

In 1999, the Delaware Criminal Justice Council received a grant from the National Institute of Justice (NIJ) to conduct a process evaluation on the Therapeutic Community program at the Baylor Correctional Institute and the CREST work release program to assess whether the treatment continuum is gender appropriate and to make recommendations to the programs regarding necessary improvements. This report is the final draft a report to NIJ assessing the gender appropriateness of the KEY / CREST programs.

Methodology

The evaluation was divided into four parts:

Part One: Assess recent graduates of Baylor as a basis to create a profile of program participants and secure background data for survey / interview questions.

Part Two: Curriculum review.

Part Three: Assess client satisfaction.

Part Four: Focus group analysis.

The goal of part one was to determine drop out points along the continuum of the treatment model. The goal of part two was to assess if the program as designed and implemented is gender specific and gender appropriate. The goal of part three was to assess what participants thought about the program and the treatment model. The goal of part four was to provide an opportunity for open discussion on the gender appropriateness of the program and to discuss the concepts behind the models as well as gain insight into concerns of program participants.

Summary of findings

The analysis of the women who were discharged from Baylor in 1999 provided a profile and template for survey and interview questions that were developed for the women who are currently in Baylor. The profile of the typical participant in the TC program is a woman who is Caucasian or African American, with less than a high school education, between the age of 31 and 50 years old. She has children and has suffered some level of abuse in her past. Although she does not have a formal psychiatric treatment history or diagnosis, she has suffered depression, anxiety and/or an inability to concentrate. She may have entertained thoughts of suicide or has attempted suicide. She participated in drug treatment prior to Baylor and her drug history began during her adolescence. She is a multiple drug user with the most common drugs used being cocaine and heroin. Of the various demographic and social factors that accompany her into treatment at Baylor, four factors will have the most impact on whether she will succeed. She is at

higher risk of failure if she has any of these four factors:

(1) A *psychiatric history* (formal diagnosis and/or emotional/psychological difficulties),

(2) If she has *contemplated suicide*,

(3) If she has *attempted suicide*, or

(4) If she has *difficulty in controlling her temper or her behavior is hostile / violent.*

The first five weeks are the critical weeks for new participant at Baylor. If she fails, it is likely she will do it during the orientation of the treatment. If she, however, remains in the program through the 49th week (the mid point of the treatment cycle), she is most likely going to remain in the program and be successfully discharged from KEY.

Dr. Bonniwell Haslett was contracted by the Delaware Criminal Justice Council to conduct an analysis of the curriculum used at Baylor and CREST and to assess the environment of both programs to determine gender appropriateness of the program. Dr. Haslett concluded that the program was gender appropriate but made two main recommendations. First that the CREST program be made single sex and second that Baylor and CREST reassess the hierarchy structure of the program to be more therapeutic in nature. Other observations included the need to reduce the level of hostility in encounter groups, increase direct access of clients to counselors and updating the curriculum.

Overall, program clients ("family members") considered the program gender appropriate and the women did not feel unsafe or threatened by the presence of males in the program. Clients did voice various concerns including the need to reduce the level of hostility in encounter groups, more focus on the nature of addiction and the various types of addiction rather than behavior modification and more direct access to counselors. Family members were supportive of the program design in which family members are in positions of authority to enforce family rules. Overall, they found the rules fair, although some complaints were made in regard to favoritism in enforcement of those rules. Some of the women noted that the program needed more female only encounter groups and that the program needed more programming designed to help addicts make peace with their families outside and to maintain contact with their children. Although the program clients were not without complaints, they agreed that the program can offer an addict a

way to "straighten up" and that in the end "the addict has to want to change" and if the addict does not want to change it does not matter what program she is in.

Recommendations

1. **A review should be conducted on how people are placed in CREST North and South.**
   Currently a person can be placed in CREST North or South by court order, as a condition for release from Baylor or Gander Hill or by request by an inmate without being required to go through the KEY program. The program needs to have a reduced number in order to end the "crowded" aspect of the program and include inmates who "want" to make a change in their lives. Inmates who are placed in CREST North or South under order and who don't want to be there take away from the therapeutic nature of the program.

2. **Both Dr. Haslett and the program directors agreed that the more outside training for the staff is needed. The curriculum should also be reviewed to make sure that it is current and that it is relevant to drug treatment programming and gender appropriate.**

3. **An assessment is needed to determine what actually needs to change to improve the environment and therapeutic value of program operations and what views from the "family" members are based on the negative behaviors of addicts and people who are incarcerated.** The meetings with family members and program staff made clear that there are various differences of opinion as to the quality and nature of what is treatment and whether the program offers "family" members an environment for positive change. It is not proposed that the program does not provide such an environment but that the "family" members perceive it as not being a positive environment. Although the program was found to be gender appropriate, there appears to be differences in what the program directors and counselors define as treatment as compared to what the "family" members define as treatment. *This is significant because research has shown that people in treatment are more successful when they view program modality as treatment*

Statistics show that more than 74 million Americans have tried illicit drugs at least once in their lifetimes.[1] Drug use leads to many antisocial behaviors including dysfunctional families and criminality. As a result of drug addition and criminal activity that occurs due to drug use, prisons in the United States have suffered large increases in population.[2] One of the treatment programs that have gained in prominence in treating drug addicts while in prison is the Therapeutic Community (TC) model.[3] DeLong explains that therapeutic communities "are guided by a perspective consisting of four interrelated views of the substance disorder, the person, recovery and right living."[4]

> View of the Disorder:
> Physical dependency must be seen in the context of the individual psychological status and lifestyle. The problem is *the person*, not *the drug*.
> View of the Person:
> Individuals are distinguished along dimensions of psychological dysfunction and social deficits rather than drug use patterns.
> View of Recovery:
> The goals of treatment are global changes in lifestyle and identity.
> View of Right Living:
> Certain precepts, beliefs, and values are essential to self-help recovery, social learning, personal growth, and healthy living.[5]

According to DeLong the essential elements and concepts of the TC modality is that substance abuse

> is a disorder of the whole person. Recovery is a self-help process of incremental learning toward a stable change in behavior, attitudes and values of right living that are associated with maintaining abstinence.[6]

"What distinguishes the TC from other treatment approaches . . . is the *purposive use of the peer community to facilitate social and psychological change in individuals*."[7] Because of the view

that it is through community interaction, the behavior of the addict is changed, the "quintessential element of the TC approach may be termed *community as method.*"[8]

Therapeutic Communities in prison settings function under the concept that the addict must be removed from the general population and placed in a separate area in which the negative influences of prison are removed in order to create an environment that allows for positive behavior change.[9] TC's view drug addiction as a symptom of disorder in the addicts' life and not the cause of the disorder in the addict's life.[10] As explained by Hooper, Lockwood and Inciardi:

> The treatment perspective of the TC is that drug abuse is a disorder of the whole person - that the problem is the person and not the drug, that addiction is a symptom and not the essence of the disorder. In the TC's view of recovery, the primary goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use.[11]

TC's are based on the premise that feelings and thoughts result in behaviors and that "people choose how they will behave [and] have free choice and are responsible for their own actions."[12] As explained by Inciardi, TC concept of drug addiction views

> drug abuse as <u>overdetermined behavior</u>. That is, physical dependence is secondary to the wide range of influences that instigate and regulate drug-taking and drug seeking behaviors. In the vast majority of drug offenders, there are cognitive problems; psychological dysfunction is common; thinking may be unrealistic or disorganized; values are misshapen, and frequently, there are deficits in education and employment skills. [D]rug use is a response to a series of social and psychological disturbances.[13]

TC's "seek to improve interpersonal skills and coping strategies so that clients may better handle the problematic situations they encounter in their everyday lives."[14] TC's view the client as a person in need of habilitation rather than rehabilitation.[15] "Whereas <u>rehabilitation</u> emphasizes the return to a way of life previously known and perhaps forgotten or rejected, <u>habilitation</u> involves the clients initial socialization into a productive and responsible way of life."[16]

The TC model in correctional institutions has three stages of treatment:

(1) An *intake or primary stage* in which the client is introduced to the rules of the TC and the main goal is to make adjustments in the behavior of the client;

(2) A *transition or secondary stage* in which the client has been released from prison, is participating in a work release program and is beginning to function in the community; and

(3) An *tertiary or third stage* in which the client has graduated from the TC and is living in the community under probation supervision.[17]

TC's have been developed to function using a holistic approach to the treatment needs of the client.[18] The holistic approach includes behavioral, cognitive and emotional therapy.[19] *Behavioral theory*, which occurs during the primary stage, is geared to foster a positive demeanor and pro social conduct in the client upon entry into the TC.[20] The "focus is on his behavior as opposed to thoughts and feelings."[21] Focus is on behavior because behavior is the most evident aspect of the program. By "focusing first on behaviors, clients are more likely to become engaged in treatment because they can readily understand and assimilate the treatment plan to change behaviors."[22] *Cognitive therapy* is designed to help the client recognize flaws in thinking.[23] The focus is to help the client understand how his thinking patterns have developed over time and how to form new thinking patterns that are positive. The cognitive therapy occurs during group and individual sessions.[24] *Emotional therapy* helps the client deal with unresolved conflicts that have resulted in feelings and behaviors that have in turn lead to drug use and other antisocial behaviors.[25] The goal is to provide the client with a "better understanding of how they think and feel about themselves and others."[26]

TC's have been divided into two general models: democratic TC's and hierarchical or concept based TC's.[27] TC's in the United States tend to use the hierarchical model while the TC's in Europe and in the Nordic countries tend to use the democratic model.[28] In the hierarchical TC design, the clients themselves govern the program under the supervision of staff.[29] Each client moves up the hierarchy based on improvement in attitude and participation in the program. Clients, who have been in the program for longer periods of time, are given supervisory

authority over clients who have been in the program for shorter periods of time. Clients who have been in the program for longer periods of time are expected to be positive role models for younger clients and are expected to assist in the therapy of younger clients as they move through the TC process. Promotions and other privileges are used as positive reinforcement of positive behavior and TC rules and regulations are all geared to provide a therapeutic guide for positive behavior of the clients.[30] The environment of positive confrontation in group sessions addresses inappropriate behavior of clients[31] thus creating a "24 - hour - per - day learning experience in which a drug user's transformation in conduct, attitudes, values, and emotions are introduced, monitored, and mutually reinforced as part of the daily regime."[32]

The State of Delaware instituted a TC in the Multi-Purpose Criminal Justice Facility (known as "Gander Hill") on July 21, 1988 based on the principles and concepts of TC's.[33] Gander Hill is an all male correctional facility located in Wilmington, Delaware. The KEY program was designed for application to male drug addicts. In January 1994 a TC was opened at the Baylor Women's Correctional Institution to provide drug treatment based on TC model for women. Since the implementation of TC at Baylor, research has shown that the TC model is effective for women but only with modifications, chief of which is the reduction of the use of confrontation between clients.[34]

Although research on TC's that specialize in women is limited[35] in regard to published studies, research shows that certain factors lead to increased success. These include:

(1) Higher lengths of stay in the program (12 to 18 months)

(2) Small program size (5 to 20 women), female sensitive programming including child care, parenting skills, and personal mental and physical health

(3) Programming that includes addressing past sexual and physical abuse

(4) Training in improving interpersonal skills with both men and other women - including the ability to learn how to trust.[36]

Research has noted that various factors influence the length of stay in a TC program, some of which originate in the program and some originate in the client.[37] The factors that influence

length of stay inherent to the TC program itself include:

(1) Low turnover of program staff

(2) Decreased use of confrontation

(3) A nurturing and affirmative environment

(4) Participation by the clients

(5) The presence of positive role models

(6) Activities that foster bonding among "family" members.[38]

The factors that influence length of stay inherent to the client include:

(1) Increased age (25 and older),

(2) Higher education (high school or above),

(3) Less children (2 or less),

(4) Less likely to harbor suicide thoughts[39]

(5) Flexible views and constructions of what is and is not treatment.[40]

The issue of gender appropriateness is important for two reasons: First, TC's, like other substance abuse treatment programs, were originally designed for men and were not designed to deal with the issues that are specific to women.[41] Secondly, "women appear to benefit from different treatment modalities than men (e.g. less confrontational), and their sexual history" makes trusting difficult.[42] Additionally, women bring various sexual relationships, family relationships, children, criminal histories, drug and alcohol abuse histories, and other personal issues in conjunction with drug addictions that are not usually found with male drug addicts. In reviewing the literature Bouffard and Taxman note that

> . . . male addicts . . . were more likely to have initiated drug use in response to peer influences and as a means of obtaining pleasure. On the other hand . . . female drug users were more likely to have initiated drug use as a result of the influence of their male sexual partners and also as a means of self-medication.[43]

The Delaware Health and Social Services, Division of Alcoholism, Drug Abuse and Mental Health came to similar conclusions in a report on women-focused drug treatment noting

> Research on drug-dependent women has shown that women's treatment needs are different from those of men. Women entering treatment tend to have low self esteem/self worth, child care responsibilities, relationship issues and role conflict, lack of trust, particularly of other women, identity issues, histories of sexual and/or physical abuse, extensive medical needs and mental health issues, particularly depression. Effective treatment for drug-dependent women must address these and other issues specific to women.[44]

In response to these factors, a TC for women must provide an environment that can deal with these gender specific issues in order for the clients to be successful in dealing with the various issues and attitudes that support their antisocial behavior that resulted in drug addiction and incarceration.

Research has also shown that there are several programmatic operations that have been found to be essential for a TC to be gender appropriate for women.[45] These programmatic operations include:

(1) Staff expertise in women's health care and health needs

(2) Staff knowledge and expertise in working with the various emotional, physical and psychological abuse incarcerated women tend to suffer from

(3) Staff ability to "reach" the women and understand the "streets" from which they come

(4) Providing a "safe" environment in which the use of rewards and punishment is done fairly

(5) A sense of "family" in order to help clients develop abilities of trust and bonding to others

(6) Addressing histories of abuse and the results of negative relationships with men - with a focus on teaching how to build and maintain positive relationships

(7) Program coordination with social welfare agencies to meet the needs of clients who are mothers and have children to care for.[46]

The issue of gender appropriateness is more than simply making sure that the TC is less masculine in implementation. Both the design of the facility and the atmosphere of the facility and

the operation of the drug treatment program must contribute to the creating of a safe environment for women dealing with the social stigma of being an addict and their embarrassment and shame in being drug-dependent.[47] Research has demonstrated that women who have drug addictions are different emotionally, socially and psychologically than male addicts.[48] DeLeon and Jainchill point out that

> female addicts are generally younger than males when they enter treatment. They are less involved in serious crime, more often come from deviant families in terms of drug / alcohol use, criminality, and psychopathology; and more women have attempted suicide.[49]

Blume points out that there are basic

> differences between male and female physiology [that] influence the results of alcohol and other drug ingestion. One such difference is the relative content of body water and body fat. Women have less body water per pound than men. Since ingested ethanol is distributed in total body water, women will attain a higher blood alcohol level from an equivalent dose of ethanol per unit of body water.[50]

Wilsnack, et, al, points out that because women "reach higher blood alcohol concentrations than men from the same weight-adjusted levels of consumption [women] may develop liver disorders after lower levels of regular alcohol consumption and earlier in their drinking careers than men."[51] Farrell explains that women who are drug users are "less likely to become involved in systematic or compulsive violence as a result of drug use [and they] have been found to have high levels of community, family and social dysfunctions from which drugs offer an escape."[52] Reed points out that

> Women have historically been more likely than men to use socially acceptable drugs and to perceive their use of psychoactive substances as a form of coping. Men are more likely to engage in rule-breaking behavior and illicit drug use, and to perceive their use as serving social and recreational purposes. Although alcohol [use and] drunkenness is more permissible for men [there is]

> strong societal disapproval of such behaviors in women has led to more shame and secrecy for women, and less recognition of women's alcoholism.[53]

Women generally have issues of maternity and childcare pressures that can both motivate and prevent them from seeking and remaining in long term treatment in a TC.[54] Research has also found that some women who are incarcerated have mental health disorders[55] and they "seem more psychologically disturbed than men [and] are characteristically worse, particularly on measures of depression, anxiety, and self esteem."[56] As Reed points out

> While men often become profoundly depressed as their denial begins to ebb, the depression and low self-esteem in many drug dependent women are very severe even before they enter treatment and may be a major impediment in their ability to seek help for themselves.[57]

The reasons for the depression in women come both from the self deprecation of being an addict as well as societal reactions to women who have addictions that are more harsh than those to men.[58] Research on the differences in results of men and women who participate in TC programs include the following:

(1) Women drop out of programs in the earliest stages of the program more frequently than men

(2) Retention rates over a one year period are about the same for men and women

(3) The level of behavior improvement (no criminal activity or drug use) for both men and women are both related to longer lengths of stay in the program

(4) Psychological improvement is also related to length of stay but gains are significantly better for women.[59]

In regard to the "significantly better" psychological improvement in women over men, DeLeon and Jainchill suggest that the difference is based on the concept of the TC:

> Treatment focuses upon changes in conditioned social roles as an integral element in its approach to recovery. Although both sexes improve psychologically, the positive change for women is larger because much of the self-stigma of their

> disorder is removed. For men, drug abuse does not convey the same negative social stereotype. Socially conditioned self-stigma is less relevant and hence its elimination does not improve the men's psychological status to the extent that it does with women.[60]

The "different patterns of behavior and psychosocial coping in women [is not without therapeutic value because] depression, anxiety and low self-esteem – common patterns in women – can be very useful motivators within treatment if a therapist knows how to work with them."[61]

Thus, for a TC to be gender appropriate it must not only offer the basic model for TC treatment it must be sensitive to the special needs and issues that women have. The program must integrate into its operation an understanding of the difference between men and women generally, but also the differences between male and female drug addicts. *The TC must have an environment that is perceived by the women to be just, friendly and safe.* They need to feel safe and able to secure help without undue confrontation that is similar to the emotional abuse they may have previously suffered. As observed by the Delaware Health and Social Services report

> Women-specific treatment ensures that the means used to confront clients does not undermine the treatment process, does not mirror abusive authority figures that many of the women have encountered and is not administered without appropriate support. ... A dual approach where rules are enforced in combination with support and encouragement is most compatible with a women-specific treatment approach. Effective treatment for women focuses on positive reinforcement rather than punitive responses.[62]

The presence of child care education, positive social skills training, mental and physical hygiene courses, positive emotional bonding, assertiveness training, and teaching women how to find positive friends and relationships are all part of making a TC program gender appropriate. Specifically, the goal of a TC program for women is to change both behavior and self-perception of the clients. For an interesting article on how a drug treatment program was restructured to accommodate women, see Gloria Zankowski.[63]

Therapeutic Community research has observed that after care is needed to continue and maintain the positive change in a TC graduate.[64] One of the methods used to meet this need is to establish a work release program based on the TC model. In 1990, the Center for Drug and Alcohol Studies at the University of Delaware received a five million dollar grant from the National Institute on Drug Abuse (NIDA) to implement the nation's first work release therapeutic community.[65] The implementation of the TC model to a work release program did not happen without some interesting and challenging difficulties, including the clinical director being arrested for possession of drug paraphernalia (after being removed from the program due to allegations of sexual harassment of female clients), local "wanna be" politicians attempting to "shake down" the program for money, community "not in my back yard" reactions, institutional road blocks from the University of Delaware, program administration changes, and philosophical differences with Department of Correction staff and misunderstandings between researchers and treatment staff.[66] In spite of these challenges, the CREST program began operations, resolved critical issues and has continued since 1990.

The CREST program operates on a similar design as the KEY TC program. The clients enter the program and progress through the program in phases.[67] "The treatment philosophy at CREST Outreach Center is similar to that of most [therapeutic communities] in that it is based on the notion that substance abuse and addiction are symptoms of a wider behavioral disorder and that, in order to discontinue drug use, all aspects of an addict's life must be reevaluated and changed where appropriate."[68] CREST contains the typical hierarchical system with a clearly defined chain of command with established rules, consequences and rewards.[69] CREST is a co-ed program in which clients arrive by court order and/or through graduation of the prison based KEY program at Baylor or Gander Hill.[2]

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2 A client can be placed into the CREST program by either by judicial order or by classification by the Department of Corrections. The Court can place a person in CREST by ordering the person to be held on a level III (placed on probation), held at Level V (incarceration) then placed in CREST, directly sentenced to CREST from the community, or

While the TC program at Baylor operates on a three-phase schedule, in which women have between six and eighteen months remaining on their sentence,[70] the CREST program is a five-phase model that operates for six months.[71] The five phases include the following:

(1) In *phase one,* the new client is given orientation to the program including written materials about CREST, program rules and regulations and an explanation of the rank structure. *Phase one* lasts about two weeks.

(2) *Phase two* emphasizes participation in the meetings, jobs within the facility and general involvement in the daily operations of the community. In this phase the client is expected to learn through experience how to function within a community and meet one's obligations and receive constructive criticism when obligations are not met. Phase two lasts about eight weeks.

(3) In *Phase three* the client is expected to continue to participate in the community by acting as positive role models for newer clients and begin to accept authority over clients with less time. Phase three last for about five weeks.

(4) In *Phase four* the clients' begin transition out of the program through the process of finding employment outside of the facility. Job interview training and how to make positive impressions on employers is part of the main focus. Phase four is about two weeks.

(5) *Phase five* involves clients obtaining and maintaining gainful employment outside of CREST. Clients still live in CREST but begin to search for housing. Phase five lasts for about seven weeks. "At the end of approximately seven weeks, which represents a total of twenty-four to twenty-six weeks at CREST, residents have completed their work release commitment and are free to live and work in the community as program graduates."[72]

Since the opening of CREST, various process and outcome evaluations have been conducted on the implementation, operation and results of the program.[73] Neilsen, Scarpitti, and

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placed in CREST as a condition for sentence. The Department of Corrections can place any inmate into CREST

Inciardi[74] compared inmates who were released from prison and slotted to enter work release. The two groups compared were comprised of inmates randomly selected to enter CREST (CREST group) and those who participated in Delaware's conventional work release program (comparison group). Interviews were conducted on a total of 689 respondents (248 - CREST group and 441 - Comparison group) to create a baseline data. Of the 248 CREST group participants 191 were interviewed 6 months after prison release and 145 CREST participants were interviewed 18 months after prison release. Of the 441 Comparison group participants, 320 participants were interviewed 6 months after prison release and 162 participants were interviewed 18 months after release from prison. The study assessed drug use during the 6 and 18-month periods (relapse) and whether participants had been arrested and charged with a crime (recidivism). Based on self-report interviews, "the relapse and recidivism rates for CREST clients are significantly lower than those of the Comparison group. At the 6-month follow-up, only 16.2% of the CREST group had relapsed, relative to 62.2% of the Comparison group. Similarly, only 14.7% of CREST clients had been arrested by the first follow-up, as opposed to 35.4% of the Comparison group."[75] At the 18-month point, 51.7% of the CREST clients had relapsed compared to 79% of the Comparison group and the recidivism rate for the CREST group was 38.2% compared to the 63% rate of the Comparison group.[76] Although the recidivism and relapse rates for the CREST group increased between the 6 and 18 month periods, the CREST group had "significantly lower rates than the Comparison group, a finding that speaks to the effectiveness of the combined TC and work release approach relative to conventional work release for a comparable group of offenders."[77] When the relapse and recidivism data for the CREST program was assessed no significant differences were found between the genders.[78]

Lockwood, Inciardi, Butzin and Hooper, conducted a companion study comparing clients who received treatment through the KEY program only and did not enter CREST (KEY group), clients who entered CREST directly from general population prison (CREST group), and clients who received treatment in KEY and then entered CREST (KEY – CREST group).[79] Participants

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program at its discretion or a person can transfer from one CREST to another.

were interviewed upon leaving prison, six months after completing work release and 18 months after leaving prison. At the six month interview[80] 54.5% of those in the KEY group were drug free as opposed to 94.1% of the KEY / CREST group and 84.5% of the CREST group. While the 75% of the KEY group were arrest free six months after leaving prison, 86.5% of the CREST group was arrest free and 97.1% of the KEY/CREST group was arrest free. The low recidivism and relapse rate for the KEY/CREST group can be expected since the first interview occurred about the same time as completion of CREST. Any violation of CREST rules, which would include being arrested or using drugs, results in a return to prison.[81]

Lockwood, Inciardi and Surratt, compared a KEY/CREST group, a CREST group and group of released inmates who did not participate in KEY or CREST (Comparison group).[82] The same procedure of interviews at the 6 and 18 months after release from prison was used as previously noted research. The results were similar to previous studies. At the six-month point 96% of the KEY/CREST and 83% of the CREST group were arrest free while only 71% of the Comparison group was arrest free.[83] When respondents were asked if they had committed any crimes since their base line interview, 85% of the CREST and 97% of the KEY/CREST groups were crime free opposed to the 51% of the Comparison group that was crime free.[84] Drug use produced similar results, in that 20% of CREST and 6% of KEY/CREST group reported relapse opposed to 45% of the Comparison group. "The respondents in the CREST group who relapsed reported use of alcohol or marijuana [while] the Comparison group [reported relapse use] of alcohol, marijuana, crack and cocaine."[85]

All three studies concluded that participation in CREST after KEY produces the highest rate of drug and crime free behavior measured at 6 and 18 month intervals. All three studies are preliminary in that the majority of measurements were at the 6 month period, meaning that the KEY and KEY/CREST groups have not had an extended period of time out of the confining environment of treatment (CREST). As the Neilsen, Scarpitti, and Inciardi study found, there was an increase in relapse and recidivism of the CREST group between the 6 month and 18 month follow up interviews; 16.2% relapse rate at 6 months and 51.7% at the 18 months.[86] Similarly, the CREST group had a 14.7% recidivism rate at 6 months and 38.2% at 18 months.[87]

On the other hand, "both KEY-CREST and CREST clients reported better maintenance of drug-free and crime-free behaviors than did the comparison group clients. From this preliminary analysis, it appears that CREST, a work-release TC, is effective in reducing both criminal activity and drug use."[88]

Farrell conducted a study using the data from the studies previously noted, specifically looking at the women who participated in CREST to determine the effectiveness of the CREST therapeutic community in meeting the specific needs of women to form and maintain social bonds in the community after release.[89] Farrell took data from interviews at the 18-month period and compared women who were in CREST to those that were not (CREST vs. Comparison). At the 18-month interview, the comparison group had a relapse rate of 50% compared to a 39% rate for CREST.[90] Farrell noted that the CREST program had better relapse rates for alcohol and marijuana use than the Comparison group, 26.8% - 65.8% and 26.8% - 34.2% respectively.[91] These results are in line with the results reported by Lockwood, Inciardi and Surratt.[92] Farrell reported that "women participating in the CREST program are equally likely as the women participating in the [comparison group] to be arrested or self report involvement in a crime at the eighteen month interview."[93] Farrell reported that when comparing CREST to the comparison group in regard to the ability of women to secure social support and community connection at the 18-month point, in certain support systems "the women participating in the CREST program were significantly more successful."[94] The CREST group was shown to have higher rates for continued treatment, treatment attendance and connection with friends and/or relatives.[95] After examination of isolation and identification indexes, Farrell concluded that there was no significant difference between the CREST and comparison groups in regard to connection with the community.[96] Farrell reported that involvement with CREST did not significantly predict recidivism or drug use relapse and concluded "that participation in the treatment program alone was insufficient in explaining why clients relapsed or returned to crime."[97] These conclusions are contrary to the results of the three studies previously noted.

In January 1994 a forty-two-bed TC program was instituted at Baylor through a grant from the Center for Substance Abuse Treatment (CSAT).[98] The University of Delaware Center for Drug & Alcohol Studies was awarded a grant from the Center for Substance Abuse Treatment to conduct a three-year process evaluation of the program.[99] The researchers at the Delaware Center for Drug & Alcohol Studies have published numerous articles and presentations based on their evaluation of the TC programs at Baylor and Gander Hill.[100] In July 1999 the Delaware Criminal Justice Council received a grant from the National Institute of Justice to conduct a process evaluation on the TC program in Baylor and the CREST work release programs to assess whether the treatment continuum is gender appropriate and to make recommendations to the programs regarding necessary improvements.

A four-step process was designed to assess the gender appropriateness of the therapeutic community treatment program at Baylor and the CREST work release programs. The process is outlined as follows:

Part One: Assess recent graduates of Baylor as a basis to create a profile of program participants and secure background data for survey / interview questions.

Gather information on those who were discharged from the program during calendar year 1999. Gather demographic, drug history, prior criminal history, etc.

Goal: To determine drop out points along the continuum of the treatment model. To review the case files to discover any patterns in the client participation and review demographic data in the KEY / CREST programs. This data served as a guide for the design of interview questions for women currently participating in Baylor.

Part Two: Curriculum review.

Review policies, procedures, program design, and program process to assess gender sensitivity.

Goal: To assess if the program as designed and implemented is gender specific and gender

appropriate. Focus was on the written policies, physical layout of the facility, staff training, staff attitudes, and intangible factors that influence the perception of a program to a woman as threatening or non threatening (safe or unsafe). The curriculum review was conducted by Dr. Beth Bonniwell Haslett, Professor of Communication, University of Delaware.

Part Three: Assess client satisfaction.

Interview current participants in the TC program at Baylor.

Goal: To assess what current participants think about the program and treatment model. A database was constructed to search for any consistencies or variables that would address the issue of gender appropriateness or lack of such in the operation of the program from the participants' point of view. Data from the interviews was further analyzed to help prepare additional questions for focus group interviews with Baylor and CREST participants.

Part Four: Focus group analysis.

Conduct focus groups to discuss the operation and implementation of the Baylor and CREST programs with program participants and staff to assess gender appropriateness. Ten focus groups were implemented. The focus groups were implemented in two rounds.

Round One: Nine focus groups were conducted. Three focus groups were conducted for each point in the treatment model: Baylor (TC only), CREST North (TC and work release) and CREST South (work release only) had three focus groups each. Because TC's are organized by a strict hierarchical system, the participants in each focus group were about equal in rank to reduce the possibility of participants being intimidated by making honest comments about the program and its operation in the presence of superiors.

Goal: To provide an opportunity for open discussion on the gender appropriateness of the program and to discuss the theories behind the model as well as gain insight into concerns of program participants.

Round Two: Post preliminary report focus groups. This focus group was composed of program directors and representatives of the counseling staff. This focus group reviewed the research report developed from information and data from parts one, two, three and the nine focus groups.[3]

Goal: To provide an opportunity to discuss the results and observations of the research team and receive comments from program administrators and participants.

Final product: A TC program evaluation encompassing the information and data secured in parts one through four and will provide the following:

(1) A review of the current status of programs available for female state prisoners in Delaware;

(2) Assessment of the level of gender appropriateness of the TC program components and any recommendations for improvement;

(3) Assess how the co-educational work release environment fits into gender appropriate drug treatment continuum; and

(4) Provide constructive recommendations to the Baylor and CREST program staff.

The above described evaluation model was approved by the National Institute of Justice and the Delaware Criminal Justice Council Institutional Review Board in compliance with federal regulations to protect program evaluation subjects.

[3] The original design included an eleventh focus group with program clients reviewing the preliminary report. This focus group did not occur due to concerns raised by two of the three program directors. The program directors believed that the preliminary report was negative in regard to its conclusions about the operation of their programs and that such views would validate negative behaviors of the clients – that the program does not work thus they did not have to cooperate with it. The concern was that since addicts are looking for a way to say the program does not offer anything, a report that could be viewed as verifying that view would become detrimental to treatment. The researchers decided, as a matter of reality and in deference to the views of treatment professionals, that seeking the eleventh focus group would not be advantageous.

Part One: Assess recent graduates of Baylor as a basis to create a profile of program participants and secure background for survey / interview questions.

Data was secured from case files of women who had been discharged from the Therapeutic Community (KEY Village) program in Baylor Women's Correctional Institute in 1999 to prepare the survey instrument used for the interviews given to the women in Baylor during the Fall of 2000.[101] Demographic data, criminal history information, medical, prior drug treatment histories, and program success or failure was secured from 105 case files. The data also provided a profile of the women who participated in the Baylor program. This profile was considered to be reflective of the current population of women in the KEY village program for purposes of designing survey questions. Discussed in this section will be the results of analysis of these 105 cases.

Of the women in the 105 case files, the majority of them were Caucasian (52.3%). The remaining racial distribution was African American (42.9%), Hispanic (3.8%) and Asia / Pacific Islander (1%). The majority of the women were single (60.6%) or divorced (20.2%). "The combined percentages of unmarried women (88.5%) are substantial enough to consider an interview question based upon the support network of significant others as being integral in successfully completing the KEY Village treatment program."[102] The women tended to be *less educated* with 57.1% of the women having less than a 12th grade education.[103] Only a small minority (2.9%) had a college degree and only fifteen (15.3%) percent of the women had an education level of 12th grade or higher. The majority of women (63.5%) had a *poor working history* in that they were not able to hold a job for longer than one year. Less than thirty (29.8%) percent had work histories in which a job was held for three years or less. Almost the majority (49.5%) of women were *middle age adults* between the age of 31 and 50 years old. The single highest age grouping (25.7%) of the women was 26 to 30 years old. The *majority of women* (59%) *had children*, and the majority of women with children (62.3%) had three or fewer children. While the number of children or the presence of children did not prove significant to

discharge status, those women with children were more successful than those without children.[104] Research on women in the criminal justice system has noted that a majority of them have histories of abuse.[105] Review of the data from the 105 case files reveal that of those files with abuse information (74.3%), *the majority of the women (92.3%) had histories of emotional, physical and or sexual abuse.*[106] A majority of case files (74.3%) provided information on the type of abuse occurred. More than thirty (35.9%) percent of the women had histories of combined emotional, physical and sexual abuse.[107] The majority of women (56.4%) suffered abuse that included sexual abuse.

Research also noted that women in the criminal justice system have histories of psychiatric disorders.[108] Review of the data from the 105 case files reveal that of those files with psychiatric history information (98.1%), *the majority of women (63.2%) had no prior psychiatric histories* (formal psychiatric diagnosis). Of the 105 cases in which data are available, a majority of women (72.2%) had experienced depression (N total cases = 79), a majority of women (70.1%) had experienced anxiety/tension/nervousness (N total cases = 77), a majority of women (63.6%) had experienced trouble comprehending, concentrating or remembering (N total cases = 77),[109] and a majority of women (61%) did not receive treatment for psychological problems (N total cases = 77).

Psychiatric History Compared to Discharge from the KEY Treatment Program			
	Discharge Status		
Psychiatric History	Successful	Unsuccessful	Total
Yes	10	20	30
No	36	26	62
Total	46	46	92

Research has shown that women in the criminal justice system that have histories of suicide and/or attempted suicide and that attempted or contemplated suicide can affect the success in treatment programs.[110] Although a minority of women had *contemplated suicide* (32.4%) or *attempted suicide* (31%), both *were found to be significantly related to discharge* (successful or unsuccessful) *as was the general variable of having a psychiatric history*. Contemplated suicide had a chi square significance of .060, attempted suicide had a chi square significance of .036, and the presence of a psychiatric history had a chi square significance of .026 to successful or unsuccessful discharge.

Attempted Suicide Compared to Discharge from the KEY Treatment Program			
	Discharge Status		
Attempted Suicide	Successful	Unsuccessful	Total
Yes	10	12	22
No	35	14	49
Total	45	26	71

Contemplated Suicide Compared to Discharge from the KEY Treatment Program			
	Discharge Status		
Contemplated Suicide	Successful	Unsuccessful	Total
Yes	11	12	23
No	34	14	48
Total	45	26	71

Review of the data from the 105 case files reveal that of those files with prior drug treatment information (97.1%), *the majority of women (77.5%) had been involved in prior drug*

treatment before Baylor.[111] Prior treatment was a broad variable and covered programs ranging from detoxification to long-term inpatient and/or outpatient treatment programs.[112] The majority of women (55%) had one to five prior drug and / or alcohol treatments upon entering Baylor.[113] Of the 105 cases in which the outcome of prior drug / alcohol treatment is available (76.2%), the majority of women (56.3%) were successful in completing a prior drug treatment program.[114]

Of the 105 cases in which age at onset of drug use in known (98.1%), *the majority of women (63.8%) began to use drugs between 13 and 20 years old.* As shown below, drug use peaks during the teen years and then declines in the young and older adult years.

Age of First Drug Use		
Age Group	**Number**	**Percentage**
12 and under	15	14.6
13 to 15 years old	41	39.8
16 to 20 years old	26	25.2
21 to 29 years old	14	13.6
30 to 39 years old	6	5.8
40 years old and older	1	1.0
Total	**103**	**100.00**

Of the 105 cases in which type of drug use and favored drug used is available (98.1%), the *majority of women (79.6%) preferred using a combination of drugs.*[115] The most common drug combination was cocaine and/or heroin with methadone or a hallucinogen. Cocaine and/or heroin were also combined with cannabis.[116]

Of the 105 cases, forty-five (45.2%) of the women were discharged successfully from the KEY treatment program.[117] *Only four variables were found to be significantly related to discharge*: presence of psychiatric history (Chi Square = 0.26), attempted suicide (Chi Square =

.036), contemplated suicide (Chi Square = .060) and trouble in controlling violent or hostile behavior (Chi Square = .019). As shown below, those who had the ability to control their behavior were much more likely to be successfully discharged from Baylor than those women who could not.

Trouble in controlling violent or hostile behavior Compared to Discharge from the KEY Treatment Program Status			
	Discharge Status		
Trouble in controlling violent or hostile behavior	Successful	Unsuccessful	Total
Yes	14	15	29
No	31	10	41
Total	45	25	70

When looking at discharge patterns, *the period including the first five weeks is the single highest discharge point.*[118] Of the total unsuccessful discharges from Baylor (N = 47), half (53.2%) are accounted for within the first five weeks (the orientation phase). The remaining women, who were discharged from the program, were discharged between week 6 and 49.[119] None of the women were unsuccessfully discharged were in the program past week 50.

In conclusion, the analysis of the women who were discharged from Baylor in 1999 provided a profile and template for survey and interview questions that were developed for the women who are currently in Baylor and in CREST. The profile of the typical participant in the TC program is a woman who is Caucasian or African American, with less than a high school education, between the age of 31 and 50 years old. She has children and has suffered some level of abuse in her past. Although she does not have a formal psychiatric treatment history or diagnosis, she has suffered depression, anxiety and/or an inability to concentrate. She may have entertained thoughts of suicide or has attempted suicide. She participated in drug treatment prior to Baylor and her drug history began during her adolescence. She is a multiple drug user with the

base drugs used being cocaine and heroin. Of the various demographic and social factors that accompany her into treatment at Baylor, four factors will have the most impact on whether she will succeed. She is at higher risk of failure if she has a any of these four factors: a psychiatric history (formal diagnosis and/or emotional/psychological difficulties), if she has contemplated suicide, if she has attempted suicide, or if she has difficulty in controlling her temper or her behavior is hostile / violent. The first five weeks are the critical weeks for a new participant at Baylor. If she fails, it is likely she will do it during the orientation phase of the treatment. If she however remains in the program through the 49th week (the mid point of the treatment cycle), she is most likely going to remain in the program and be successfully discharged from KEY.

Part Two: Curriculum review.

As part of the process of determining the gender appropriateness of the TC at Baylor, Dr. Bonniwell Haslett conducted an analysis of the curriculum[120] used at Baylor and CREST as well as assessed the tangible and intangible environment within the TC in regard to how the facilities, staff, policies and procedures impact the operation of the program. The goal was to assess the presence or absence of factors that limit the gender appropriateness of the TC model in Baylor and CREST. There are various factors that can influence the gender appropriateness of a TC program in a women's facility. These include differing philosophies between TC's and correctional facilities and the quality of communication between staff members and between staff members and program clients. The report by Dr. Haslett was used to provide guidance for both interview focus group question formation and context for survey results. KEY observations are reflected and summarized in this report; for a full review of Dr. Haslett's assessments of the program, a copy of her report is included in appendix tab 2.

One of the factors of implementation of a TC in a correctional facility is dealing with the philosophical differences that are inherent between the TC model and corrections.[121] Since the implementation of the TC program in Baylor and the institutionalization of the CREST program, many of these difficulties and outright biases between the two staffs have been ironed out.[122] Haslett reported that additional and continued communication "to discuss pressure points and

difficulties, in non-crisis circumstances would be helpful."[123] Haslett noted that there are three "pressure points affecting the overall program."

First. The TC continuum flows from the TC program in Balylor to the CREST programs. Because clients can enter the continuum at different stages, "it is extraordinarily difficult to establish and maintain a consistent therapeutic climate."[124] Because clients can be directly sentenced to the CREST programs, TC encounter groups can have TC veterans (from Baylor or Gander Hill) with newer clients who have a much lower understanding of the TC model and possibly slow down the efficacy of the group.[125] Thus "counselors are in a very difficult position of dealing with individuals who are widely divergent in terms of where they are along the path to recovery."[126] Haslett noted the following:

> My observations suggest that this blended population makes habilitation and recovery for clients even more difficult. Given the variation in sentencing, and degrees of substance abuse and criminality among clients, I do not know if this blend can be altered or restructured. But . . . it would be helpful to have conversations among the TC directors and judges to discuss sentencing, who might benefit from TC programs and who might not, and other related issues in order to strengthen the TC program.[127]

Second. Client selection is another pressure point because the program staff believes that "as many as 20 - 25% of clients have significant mental health issues, above and beyond depression [and at] present the TC programs are not equipped to handle such clients."[128] As noted by the research on women who were discharged from Baylor in 1999, the staff is correct with more than 30% of the women either having considered or attempted suicide and more than 90% having histories of abuse. Although the TC model is designed to deal with some of the emotional and/or psychological factors behind drug use, the prison based TC model is not designed to handle clients with serious and/or chronic mental health difficulties. The issue of having mentally ill clients in Baylor is reflective of the larger questions of "whether the DOC should handle mentally ill individuals who have criminal records, or whether or not its more appropriate to treat such individuals elsewhere."[129] Dr. Haslett recommended that the program directors should have "the final authority as to whether or not clients are accepted into the TC

programs [because they are] the best judges of who would benefit from the TC treatment."[130] In the focus group with the program directors and counselors, the directors agreed with Dr. Haslett and explained they have the authority to accept or reject anyone who does not meet the requirements of TC drug treatment. They agreed that the current program at CREST has been altered by the addition of sources into the program (clients entering other than as KEY graduates and the CREST program was designed for KEY graduates – thus the net of people in CREST has grown) they are not without authority to control who comes into the program.

Finally. The structure of the TC program at Baylor and CREST is the rational hierarchal structure in which the rules are clearly defined and supervision of clients is conducted by clients as well as professional staff. Haslett made the following observation on the general concept and operation of the TC program at Baylor and CREST:

> The treatment components in the TC program include, behavioral, cognitive and emotional aspects. Of these three elements, the behavioral aspects appears to be the most heavily emphasized. Although a behavioral emphasis is needed at the beginning of the program, as incoming clients 'learn' the system, it should become less important over the duration of the program. ***The cognitive and emotional aspects need to become more prominent because it is these two components that will allow the client to remain free of crime and substance abuse.***[131]

Research has noted that the structure of a TC, to be gender appropriate, must be such that the women feel "safe" both emotionally and physically. As noted by DeLong, the purpose of TC house rules should be to serve a therapeutic purpose rather than a managerial purpose:

> In the TC *all* activities are designed to produce therapeutic and/or educational effects. These activities, singly and in various combinations, constitute interventions that directly and indirectly affect the individual in the change process. Indeed, it is this element of using every activity for teaching or healing that illustrates the meaning of community as method.[132]

The Delaware Health and Human Services report noted the concern about the purpose for rules within a women-based treatment program, when it observed

> Many alcohol and drug treatment programs establish strict rules with significant consequences in an effort to provide structure for clients and, in turn, to affect behavior change. Frequently, the rules and the consequences for non-compliant behavior undermine the treatment process, particularly treatment engaged, for women. Programs providing women-specific treatment ensure that rules support and encourage women in treatment. Similarly, consequences for non-compliant behavior are relevant to women and, again, aimed at promoting treatment retention and progress.[133]

Currently, clients must go through the hierarchy to gain access to a staff counselor. This practice is designed to control the access of clients to professional staff as well as to utilize senior clients whose job is to be an advocate for and listen to less senior clients and to help them deal with issues and concerns. Although this practice has its purposes, both therapeutic and managerial, Haslett "strongly" encouraged a modification to this practice, noting clients "whose job function is to act as an advocate or active listener may not always understand, or adequately report, a potential serious issue."[134] The program directors took some issue with this observation, explaining that the point of having clients report to other clients is that in the world they are going to be released to, they wont have a counselor to run to every day. The clients must learn how to deal with peers without the need to run to counselors. One of the directors explained addicts need to learn how to deal with people without resorting to an emotional crutch, either a counselor or drugs. The point behind the "family" is to instill basic behavior skills, one of which is learning how to deal with people and deal with people who are not doing right without running to something to get comfort or validation.

As noted in the literature, one of the chief issues in gender appropriateness of a TC program is women feeling "safe" in the program; safe to express their needs, emotions, past histories of abuse and past behavior without fear of rejection or confrontation. Women, unlike men, "bond" through conversation and confrontation is not a tool that positively makes changes in

behavior.[135] Men and women function differently in groups, as Haslett points out, "women seek connections through talk, while men seek connections through activities . . . Women tend to build on one another's remarks whereas, men frequently ignore or challenge others' remarks."[136] Men tend to use confrontation in a hostile manner while women use confrontation in a supportive manner "(e.g. 'You need to tighten up and get your act together because you need to get home and take care of your babies.')."[137] Women tend to be motivated by the presence of children while men are less motivated by children to succeed in treatment.[138] These differences are significant when assessing the gender appropriateness of the CREST programs, which are co-ed. Haslett assessed the presence of co-ed treatment as follows:

> When interrupted or challenged by men, women tend to remain silent.[139] I believe [the TC program and staff] have overlooked the degree to which encounter groups and the TC hierarchy may inadvertently create an environment of male dominance associated with earlier patterns of abuse [suffered by the female clients]. The confrontational strategies used in the programs, often verbally aggressive and hostile, as well as the overwhelming number of males in the Crest program (better than a 7 - 1 ratio of men to women) and their predominance in the TC hierarchy, combine to form a psychologically threatening environment for women.[140]

Dr. Haslett concluded that because of the difference between men and women and the histories of women within the criminal justice system (having histories of negative male dominance and abuse), "***the Crest program should be a same sex program as is the KEY program. Some educational programming could be coed, but the basic functioning of the TC houses and groups should be same sex grouping.***"[141] Both the program participants and program staff advocated a different view. As discussed below, the program clients asserted that it was a positive experience to have co-ed treatment at CREST. The program directors also believed that co-ed treatment did not have negative affects on clients. The program directors noted that controlling the interaction is a "challenge" but that male and female interaction per se is positive. One director did agree that there are some women who need to be in a single sex program and many of the women need to participate in single sex sessions because they need to learn how to have positive relationships with women.

Dr. Haslett noted various observations and recommendations to maximize the gender appropriateness of the TC programs at Baylor and CREST. The chief recommendation was the segregation of males and females in treatment group sessions and living arrangements. She noted that the presence of men could, without intention, create a male dominated environment that is antithetical to the TC concept model for women which is to create a "safe" environment for continuing the habilitation of the women. Dr. Haslett made other observations specific to Baylor, chief of which was that the "general chain of command should be modified so there is a recognized procedure for clients to have direct access to staff. Clients in 'gate keeping' positions may not always exercise good judgment in limiting access or in identifying problems."[142] Haslett observed that although the current job descriptions and hierarchy are useful in meeting the teaching and behavior control needs of the program, "each job function should be reviewed for its therapeutic as well as 'house management' usefulness."[143]

Dr. Haslett noted the program appears to meet behavioral needs but needs to reassess operations to meet more of the cognitive and emotional aspects of the TC model and needs of the clients. One reason for this is the need for an update in TC curriculum. Haslett observed the following:

> Each TC site has several volumes of curricular materials (e.g., curriculum outlines for various life skills, addiction, the disease concept, ect.). However, these materials usually had to be borrowed and the materials I looked at were dated (most references from the 1970's, 1980's or early 1990's). I believe ***the resource materials available to counselors needs to be updated and strengthened.***[144]

On this observation, the program directors agreed totally. They noted that the need for staff training is serious concern. In addition to a basic upgrade of the curriculum available to staff, ***there needs to be an integration of the TC curriculum and basic information on psychology.*** "For women, there should be materials covered in an introductory psychology of women course (e.g., self-esteem issues, sexual abuse, systemic discrimination, patriarchy, ect.). Such material . . . would provide an overall framework for integrating all the program information (i.e., information about patterns of criminality, job training, life skills, and so forth.)"[145] Haslett

recommended that the curriculum cover areas including women's health issues, sex specific anger management (taking into account that men externalize anger while women internalize anger and how the differences matter) and how development of healthy relationships. Lastly, there needs to be an overall integration of the curriculum so that each topic builds upon what was learned in the previous lesson rather than appearing to be a group of unrelated topics.[146] On this observation, the program clients were in agreement. Many of the clients noted that there is a disconnect between various group sessions and the materials in each one. Some noted that the material in different sessions is the same thus "they have heard all this before." The program directors noted the issue is not whether they have "heard" it before but whether they have "learned" it before. The distinction of course is between hearing and not integrating the material into one's behavior and hearing the material and integrating it into behavior.

One of the KEY aspects of the TC model is the use of encounter groups in which clients are confronted in regard to negative behavior. Haslett made several recommendations for improving interaction in the encounter groups. In particular, she recommended that

> encounter groups have no more than twenty clients in each group and that using hostility [venting] in the womens' encounter groups be eliminated. Finally, the practice of not allowing clients to respond to criticism should be reconsidered, at least in some confrontational settings. Clients should have the opportunity to respond to criticism and learn how to do so in a constructive manner.[147]

The program directors stated that although clients in some encounter groups can't immediately answer criticism in the encounter groups, they have avenues to respond. They can respond to individual clients later in a session or they can respond in another session. The point of preventing immediate response is to teach the clients how to take criticism and reflect on it before responding. The directors explained that addicts are accustomed to responding emotionally and immediately without consideration of the nature of their response or the ramifications of the response or even assessing if a criticism is worthy of a response. By controlling the impulse to respond without timely reasoned thought, the addicts learn to consider a criticism and then decide how to respond if at all.

Overall, Haslett did find that the Baylor / CREST programs in theory and program implementation were gender appropriate for women. Her review found the programs to have facilities that were appropriate for women in the color of the walls and the ability of the women to personalize their living areas. She noted that more space was needed at the CREST facilities. The program had the support of program staff and DOC staff and the program was in line with the general concepts of TC programs. She also noted that the curriculum should be updated and integrated into one seamless continuous program. The encounter groups need to further minimize the use of hostility (venting) as a mode of operation and allow clients to interact more when criticism is made. The two chief recommendations were:

(1) The co-sex structure in CREST does not assist women in habilitation and can be a detriment to the gender appropriateness of the TC program

(2) The program at Baylor should

(a) Reevaluate the hierarchy structure to focus on the emotional and psychological needs of the clients and the TC model rather than on the behavioral control aspects

(b) Reevaluate the hierarchy structure to allow clients more direct access to program counselors

Part Three: Assess client satisfaction

The current residents of the Baylor KEY program were interviewed in order to assess what the "family"[148] members thought of the program. There have been various changes to the program between the time of 1999 graduates and the current "family" members. One of the main changes has been the location of the program. The KEY program was moved to a new unit divided into four pods within the Women's Correctional Institute. This change was significant to the program design because the program was divided into four independent pods rather than one inclusive community. Previously, the program was a 42-member pod in which all of the women were part of one community. The change in location allowed for the creation of four independent pods in which each pod had 24 "family" members. Each pod is self-contained with an

independent authority structure. Our interviews occurred after the changes had occurred.

During the Fall 2000 and Spring 2001, a survey was developed to assess how the current "family" members viewed the KEY program. The questions were intended to gather information to assess the gender appropriateness of the program. During the interview period there were a total of eighty-eight women in the KEY Program. Of the eighty-eight women, seventy-six women agreed to participate in the survey. See tab three for a copy of the survey and IRB protections.

Of the seventy-six women who agreed to participate in the survey, almost 66% were between the age of 18 and 35 years old. African American women accounted for 57% of the total population and Caucasian women accounted for 41%. The majority of women (63%) had previous drug / alcohol treatment of which 73% had been in treatment between 1 and 3 times prior to being placed in the KEY Program. The majority of "family" members (83%) had no prior experience at the KEY program. Of the 17% of "family" members who had prior KEY experiences, the majority of them (69%) only had one prior experience with the KEY Program.

The confrontational aspect of the program allows for general confrontation (in which behavior that is contrary to orderly operations of the pod are handled through sanction application by superior "family" members) and peer sessions in which a "family" member is told about behavior that is contrary to acceptable behavior or improvement in drug treatment. The majority of the "family" members (53%) approved of the confrontation aspect of the program. A minority of "family" members did not approve of the confrontational aspects of the program (32%) and 15% of the "family" members had mixed opinions of the confrontation aspects of the program. The difference in approval did not change when assessed by age, with the exception of "family" members between the ages of 36 and 40 years old. More women in this age group (36 to 40) disapproved of the confrontation aspects of the program than those who supported it; interviews reflected that these women felt disrespected by the younger women's criticism. The majority of women (59%) thought the confrontational aspect of the program was appropriate for women. The belief that the confrontation aspects were appropriate was evenly distributed by age, with the exception of women between the ages of 46 and 50. Again it was the older women who had concerns about the appropriateness of younger women being "disrespectful" of older women by

giving criticism in regard to behavior. There was clear consensus that the women considered the confrontation aspects of the program helpful. A majority (61.8%) of the women viewed the confrontational aspects of the program helpful to them. The view that the confrontational aspects of the program were helpful did not change when responses were viewed by age. Again, it was found that the older women (46 – 50 years old) did not believe the confrontational aspects of the program were helpful to them.

One of the factors in assessing whether a treatment program is appropriate for women is the assessment of whether women participating in the program feel safe from abuse, physical, emotional or sexual. To assess if the program at KEY provided feelings of safety, women were asked about the rules of the program and the enforcement of those rules. A clear majority of women (78.9%) considered the system of "family" members being in positions of authority appropriate. But an even higher percentage of women (96%) expressed the view that "family" members had abused their authority. Interviews revealed that the new structure of four separate twenty-four-member pods had made changes in how promotion within the pod occurred. Originally, a "family" member had to earn a position of authority and there were more "family" members than positions of authority. In other words, there were more Indians than chiefs. Under the new structure, positions of authority are rotated among the twenty-four "family" members. Thus positions of authority are perceived not being earned. Because positions are given by rotation rather than by merit, the opportunity and occurrence for abuse of authority was viewed as increasing.

The conclusion, that the high complaint rate of abuse of authority is based on the change in how that authority is maintained by "family" members (as opposed to a situation in which the program itself is fostering an unsafe environment) is supported by other responses by the women in the program. The majority of the women (90.8%) believed that the program rules are appropriate, that the rules are helpful to the treatment process (86.8%), that sanctions for negative behavior are appropriate (73.7%) and that is appropriate for other "family" members to impose sanctions (72.4%). Agreement on the appropriateness of the sanctions remained when reviewing responses by age. Across all age groups, the appropriateness of the program sanction

structure was positively viewed.

As previously noted in the literature review section, one of the main issues with the conversion of the TC model from male prisons to female prisons is the proper use of confrontation. Women respond differently to confrontation than men do and for a program to be gender appropriate, the use of confrontation or hostility must be controlled. The TC model is appropriate if the program is fair and not hostile. When the women were asked if the confrontational aspect of the program was appropriate, sixty-four percent responded directly to the question of confrontation. One quarter of the women (26.3%) approved of the confrontational aspects of the program as long as it was not vindictive and forty (39.5%) percent of the women noted that they did not approve of the confrontational aspects of the program, if the confrontation was hostile. Eighteen percent of the women responded, in various ways, that the confrontational aspect of the program had therapeutic value.

The women viewed the rules as helpful to treatment because they helped teach responsibility, provided structure and instilled the idea that the world outside had rules that had to be followed. The women also noted that the rules provided an opportunity to handle situations that were not pleasant and learned how to control behavior. Analysis of responses to the appropriateness of sanctions did not show any negative views of the rules. "Family" members having authority and imposing sanctions were supported because fellow "family" members are more aware of behaviors of the family because they are around them 24 hours a day. The women noted that the "family" runs the pods, so "family" members should impose sanctions. Staff sets the rules for the pods so they are not arbitrary.

Part Four: Focus group analysis

There were a total of nine focus groups; six were conducted in CREST North and CREST South and three at the KEY Village at Baylor. The goal of the focus groups was to assess how the participants viewed the program with a specific focus on whether the program as implemented was appropriate for women. The assessment of how the actual participants in a TC view the program is important because the TC model is based on the concept that change is personal and

change under a TC is subjective to each participant. As DeLong explains:

> The TC is behaviorally oriented but the process of change is primarily understood by the participants themselves in subjective terms, through perception and experiences. Individuals not only must actively engage in the behaviors and attitudes to be changed but must feel the feelings associated with this engagement, understand the meaning or value of the change, and come to see themselves, others, and the world differently.[149]

Baylor Women's Correctional Institute

The focus groups at Baylor divided the women into groups based on their time in program; Group One had women who were in the program for up to 5 months, Group Two had women who were in the program between 5 and 9.5 months and Group Three had women between 9.5 and 13 months. Groups One had 7 participants, Group Two had 3 participants and Group Three had 9 participants. Alison Rose conducted the three focus groups.

The focus group discussions focused on two main issues: the confrontational and hierarchical structures of the program. The women in the focus groups were almost uniform in accepting the confrontational aspect of the program. They noted that the point of the confrontation aspects of the program was to learn how to be held accountable for their actions. The women were able to separate two things that the literature seems unable to separate; tone of a confrontation from the substance of the confrontation. The women noted that they were not intimidated by the tone of the confrontation or the fact of the confrontation itself. They noted that the confrontation was designed to modify behavior, to teach them to be accountable for their actions and be able to see past the tone of confrontation and receive information that would benefit them. Many of the women noted that when they are confronted, they look for things that are true to them and pay no attention to the rest. But in all cases they remained in control of their behaviors. They were very cognizant that it is not the confrontation per se, but the response to confrontation that matters. One woman noted that due to her family history of abuse, she did not like the yelling aspect of the confrontation but noted that it had the purpose of making her stronger in controlling her reactions.

The hierarchical structure was less uniformly supported in that some of the women noted that women higher in the hierarchy showed favoritism and that positions were given not in accordance to time in the program. Most of the women approved of the system because it created a structure and maintained order. Many noted that the point of the positions was not merit, but tools to teach members how to deal with responsibility and how to be compliant with authority and not display negative behavior when confronted. Many of the women noted that the point of the hierarchy and applied sanctions (whether justified or not) was to "just be alright with it." The hierarchical structure was seen as just another way to learn how to deal with things that happen and submit to authority. One woman noted that if she is told to do something or told to accept a sanction, the point is to "just do it" and not to respond negatively. The women as a whole did note that having addicts judging addicts was a good idea. Many of the women noted that they would prefer more contact with and discipline by trained staff.

CREST North

Three focus groups were held at CREST North (orientation, primary and work release). The orientation group was composed of ten males (there were no females in the orientation phase of the program during the time of focus group creation) six of whom were white and four were black. The primary focus group was composed of three females and seven males; of the ten participants five were white, four were black and one was Hispanic. The work release focus group was composed of three women, five men; of the eight participants four were white and four were black. The work release participants had been in the program between two and six months, the orientation participants had been in the program between ten days and one month and the primary participants had been in the program between one and half and four months.

The women in the primary group agreed that the program was not good for women. They noted that the reason was not because of the presence of men in the program but because the program does not allow for the women to "bond together" or provide program events that are gender specific to women. They noted that the program does not have programming that allows the women to have closer and more frequent contact with family members to repair burned

bridges. They noted that there are no "women or mother" days that are designed specifically for the emotional needs of women. Some of the men agreed and noted that the fathers should also have father days to mend relationships with their children. The program directors noted that there are presently programs that allow for these types of days. There is a system wide program called *Kids Connection*, which is operated by a non-profit organization that picks up family members throughout the state and brings them to the prisons in order to allow family members to mend relationships with family members. Two of the program directors noted that they have programs that have family days are set up in which barbeques and other events are organized to allow for family bonding with program clients.

In regard to the confrontation aspects of the program all three focus groups agreed that it has very little therapeutic value and that the yelling in the confrontation groups was not helpful. One of the concepts behind the TC program is the concept of "the family" in which each "family" member has responsibilities to the family and the TC provides behavior modification through a "family" structure akin to how a regular family operates. There was universal agreement that the "bonding" that occurs in a family environment is discouraged. Many of the group participants noted that "bonding" does not occur because a close friendship can be used as a basis for program failure and being returned to prison. The program directors agreed that the ability of clients to make and build relationships is limited and controlled in order to prevent inappropriate sexual relationships (both heterosexual and homosexual). They did not agree that friendships can not be made, but noted that many of the clients do not have a stable and healthy view of what a positive and appropriate relationship is. They noted that due to dependency issues, many of the relationships are made in order to escape the need to deal with serious emotional and behavioral issues. The program directors noted that the truth is that the clients' behavior in regard to relationships is controlled not discouraged.

Two out of the three focus groups were comprised of males and females. It was observed that the males did not intimidate any of the women in the group from voicing their opinions nor did they stop functioning (shut down) when a male disagreed with them. The women were asked if other women in the groups shut down and they noted that some of the women shut down but

that was because they did not want to speak in the first place, rather than being intimidated by men. Both males and females noted, that recovering addicts need to be around the opposite sex in order to learn how to relate to the opposite sex without sexual overtones and behaviors. The presence of the opposite sex, they noted, is also needed for "family members" to learn how to form friendships with the opposite sex and to see the opposite sex in a positive light. Many of the group members noted that this type of bonding is discouraged and needs to be encouraged. They agreed that it should be monitored and controlled, but not discouraged.

The focus groups agreed on two other factors of the program; first that there was a lack of organization between the DOC staff and the TC counselors, and second, that the program was suffering because too many people in the program were forced to participate, which reduces the therapeutic aspects of the program. In regard to the people in the program, many of the focus group members explained that the whole family could "buy" a sanction based on the behavior of one family member. The point of a "buy" is to have all suffer for one to build group responsibility. One family member explained the therapeutic value of a "buy". He explained that the goal is to bring home to the addict that the negative behaviors that an addict commits impacts others. He explained that he was a drug user and dealer and he was staying in the home of his girlfriend who was not involved in the drug trade. The police found drugs in her house and she was convicted of drug possession. He explained that "because of my foolishness" she can't get jobs that can support her and her children. He said she suffered for his actions and he came to grasp the impact of this through experiencing sanctions through a "buy". He said addicts don't consider how they affect others, a "buy" teaches that by having clients suffer for the acts of others.

One problem noted was that some members of the "family" just went through the motions and did not desire to change. It was noted that the therapeutic value of a "buy" is lost when a clients does not care about receiving a sanction or the fact that others receive the same sanction. If the" family" member does not want to be in the program (or is forced into it) and does not want to change, the value of a "buy" will be lost. One participant noted that too many people are in the program because they can get an early release by completion. This participant said that the

program should not promise release time nor should it be open only to those close to release. The program should be open to anyone who wants to deal with his/her addiction but participation should not have the benefit of early release. He noted that the motivation should focus on getting clean and dealing with addiction. One participant noted that if the motivation of participating in the program is getting over an addiction and not early release, the program would be smaller and would work better. Other focus group members agreed with this assessment. All of the focus group members were in agreement that the addict has to want to change before this program or any other will make any difference. They noted that the program has too many people and too many people who don't want to change and that these two factors are reducing the value of the program.

The focus groups were not without compliments for the program. All three groups noted in different ways that the program provided a way to reflect on behavior. One participant noted that the program allowed him to learn how to watch his behavior and think about doing or saying something before he does it. A different focus group member noted that the whole point of the sanction process is to teach people that not everything is going to go their way and they have to learn to be all right with it. It was also noted that, "the program teaches the addict how to control his emotions when things don't go right." One participant noted that he learned how to take time and reflect over the day and ask himself "what can I do tomorrow better than what I did today?" Other participants agreed with the observation made by another participant that the program allows addicts to "appreciate the simple things in life – grass, trees, being outside – without drug use." It was noted that the program "brings people to acknowledge what they have done and that they have a problem" and that the program will make a positive difference in behavior simply because it requires one to think about behavior and the consequences thereof. As one participants noted, the program "brings home the point, don't cry now; you should have stayed home" meaning "you did the crime and ended up here."

CREST South

The CREST South program is a modified TC program in that it shares facilities with a non-programmatic work release program and is on the campus of the Sussex Correctional Institute (a level 5 prison). A Level V prison is one in which the facility is secured and prisoners do not have the capacity to leave. Level V prisons hold people who sentenced to more than one-year incarceration for the commission of misdemeanors or felonies. The CREST South program is within the Department of Corrections (DOC) facility. Many of the security operations and procedures that CREST South uses are imposed by DOC and not by the TC programmatic staff.

The three focus groups included 15 males and 17 females. Of the total participants, 19 were black and 13 were white. Group one, orientation, was made up of 10 participants of which 4 were males and 6 were females; 6 participants were white and 4 were black. Group two, primary, was made up of 9 participants of which 5 were males and 4 were females; 7 participants were black and 2 were white. The third group, work release, was made up of 13 participants of which 6 were males and 7 were females; 7 participants were black and 6 were white.

All three groups noted that the "hostility" of the program was not helpful to treatment. Both males and females reflected on how one participant described the hostility as not being helpful because it involves "breaking down, but no building back up." The group participants noted, as did members of CREST North, that the program has too many people who are sentenced rather than those who want to be in the program. One CREST South participant noted that the only thing the program taught was "how to be more sneakier" in behavior. There was uniform agreement that the program is behavior modification based, not treatment based. It was voiced clearly that the program does not focus on drug treatment and education but on sexually transmitted diseases and behavior modification. One participant noted that people who come "off the street" to CREST South rather than from a KEY program (Baylor or Gander Hill) are at a disadvantage because they don't have the exposure to drug addiction education and treatment or how addiction affects the body or the mind. Many of the females, in addition to the males, noted that the facility builds a desire "to use drugs" due to the environment. Another participant noted that the program fosters an "act as if" mentality and the desire go through the motions to get

through the program. When an addict "acts as if" the addict is acting like he/she is learning something from the program or is otherwise benefiting from the program, but in truth the addict is just biding time until release and is not making any real change due to participation in the program.

One of the chief observations from the focus groups is that DOC runs the program and not the counselors or the "family". DOC handles security and can override counselors or the "family" on any matter it deems necessary. The staff from CREST South took issue with this assessment. They explained that when it comes to security, DOC sets certain rules, but the day-to-day operation of the program is not under DOC control. Staff noted that CREST South in on the campus of a DOC facility and it is fair to say that the CREST South program is not in a dedicated treatment facility. Staff noted that they share facilities with non-CREST inmates and don't have complete separation from DOC inmates; it is not true that DOC officers override staff in regard to CREST operations. The CREST South staff also noted that they enjoy the full support of the warden and that if they did not have it, then they would have serious problems. The other project directors agreed that DOC is in charge of security issues and their facilities are not treatment dedicated, but that they also enjoy the full support of the warden. It was admitted by the project directors that there are some DOC officers that want to treat the "family" members as prisoners and not as people who are in treatment. The directors noted that when such officers are too heavy handed they have avenues to deal with the officers through the DOC and the wardens. CREST South staff noted that one problem they have is the officers that work in the VOP (Violation Of Probation) center (which is on the same campus) also work in CREST South and sometimes these officers have to be reminded that the two populations are not to be treated the same. The VOP clients are intentionally handled with a hard hand because they are probation violators.

When the women were asked what impact having males in the program had on them, the majority noted that it was positive. Many of the women felt that it was safer to disclose personal information to men than to women. When asked why, many noted that men would keep the information to themselves while women will talk about confidential information with other

women. The program directors had an interesting response to this observation. One project director explained that the "person who said this must be in an immature place in her treatment" and a counselor explained "women seek relationships with men so as to see who they can get with." The project directors and counselors explained that women avoid dealing with other women because other women can see through their "manipulation" and see directly into what problems they are trying to hide. In other words, they seek male support because the males can't or won't see through them and that the men can be open to manipulation. When asked why would a women, presumably sexually abused, go and tell a group of men about the abuse and not other women; the program directors and staff explained that women who are abused are used to going to men to get comfort. The comfort can be negative or positive, but the behavior is still going to men for support. They have not learned to build positive relationships with other women and as such don't want to seek their support in treatment. This is why they feel more comfortable with men. The program directors explained that the women not wanting to talk with other women has less to do with other women not holding secrets than women not wanting to be held accountable for behaviors that lead to their addiction and criminal behavior. Thus being held accountable occurs with other women more than with men.

Other women in the focus groups noted that they came from all female facilities (violation of probation center (VOP) and /or Baylor) and being around males was a positive thing. Some women noted that they would prefer more single sex seminars but there was no general disapproval of being in a facility with men. They noted that they desired to have non-sexual relationships with men. One male noted that the presence of women allowed him to learn how to approach women with respect and without a sexual motive. Many of the other males in the groups agreed with this statement. They noted that the program staff spends too much time and effort trying to catch males and females in inappropriate behavior rather than fostering healthy relationships between males and females.

Both the KEY program at Baylor and CREST North and South programs are designed to habilitate "family" members. The CREST orientation manual [150] makes it clear that the CREST program is based on the philosophy that people who engage in long-term criminal activity and substance abuse need to be "habilitated" not rehabilitated because, as noted in the KEY orientation manual,[151] addicts never developed the social skills that society takes for granted. Both programs implement the therapeutic community model using the rational authority model[152] which presumes that the "client population needs discipline, direction, education and training in order to elicit pro-social change."[153] The KEY / CREST programs are in line with the literature on the concept of a TC. As Bouffard and Taxman summarized the literature:

> The traditional therapeutic community (developed and refined on samples of male participants) is designed as a total-milieu therapy approach, promoting the development of pro-social values, attitudes, and behaviors through the use of a positive peer culture. ... Contemporary TC's emphasize the use of the therapeutic milieu (i.,e., treatment group) to retrain addict/offenders toward pro-social value systems by combining cognitive behavioral models with traditional group-based, confrontational techniques. TC's emphasize . . . the reliance on the peer group itself as an agent of therapeutic change. The clarification of values has also been an important tool of the TC, integrating the substance abuser back into conventional society through the adoption of mainstream values.[154]

The vehicle for this habilitation of social skills that were not learned during childhood is "a family type environment, a self-sustaining and self-perpetuating Therapeutic Community [in which the] Director is an authority figure who, along with the intervention of the staff, attempt to re-parent, giving the clients the direction, nurturing and discipline that they may not have been given to them in the past."[155]

Both programs allow for "family" members to be promoted along a rigid authority structure in which the top position is the program coordinator and the lowest is the service crew.

The positions within the KEY Village and CREST programs are therapeutic in nature, in that they are designed to build upon positive behavior and teach responsibility and discipline. Positions within the authority structure can be given or taken away to build upon developed positive behaviors, to help the "family" members deal with success, failure and what they call "an injust." An "injust" is short for an in justice suffered by a family member. The point of an "injust" is learning how to deal with an event (such as a demotion or a false accusation) that is not fair. The goal of an "injust" is teaching the "family" member a fundamental truth of society; not everything is going to go your way and when it doesn't you have to learn how to deal with it and move on.[156] In other words, an "injust" is designed to test a "family" member's behavior to negative experiences and to teach that things happen and that "you're supposed to be O.K. with it."[157] Another "family" member explained that an "injust" exposes addicts to the feeling of suffering for the mistakes or behaviors of others.

The CREST North and South programs are primarily behavior modification in approach. The program staff view behavior modification as treatment. The CREST manuals are devoted to the behavior modification aspects of a TC program. CREST North is housed in a quasi-independent facility, thus it has less DOC participation in the program than CREST South. Both programs are crowded. One of the observations made during the focus groups at CREST North is that the facility is loud. Announcements have a very high decibel pitch. When asked about the loudness of the facility, both males and females explained that is so things can be heard. Apparently, the high decibel sounds did not affect the participants as much as the interviewer. While CREST North is housed in a self contained house that does not appear to be a DOC facility from the outside (its located in a residential area of the City of Wilmington), CREST South in on the campus of the Sussex Correctional Institute and as such has more contact with DOC prison guards. The difference is readily apparent. At CREST South, for example, it was observed that during a count (when inmates are counted to make sure an escape has not occurred and everyone is accounted for) male DOC guards walked into the rooms of female inmates without knocking or announcing. This by itself is a small thing, but there is a gender difference between a male guard walking into a room of male inmates and a male guard walking into a room of female inmates. In

CREST North, on the other hand, senior "family" members conduct the count for the house.

Both CREST North and South focus group participants made it clear that the program had too much hostility and had staff spending too much time "stalking" family members in regard to co-ed relationships. Many of the participants made it clear that the co-ed facilities allowed for learning how to form positive relationships with the opposite sex and that the presence of the opposite sex had therapeutic value simply because "its nice to see the opposite sex" after being with just males or females. They accepted that controls have to be made to prevent inappropriate behavior, but the participants voiced concerns that the staff establishes so much fear about relationships that the participants don't seek to establish them due to fear that they will be sent back to prison or the VOP center. The program directors explained that what the clients called "stalking" was proper monitoring of the clients. They noted that since addicts have a history of forming negative and unhealthy relationships, they don't know what a healthy relationship is. Thus their relationships are controlled.

Both the males and females made it clear that the program was too hostile and that there was more "tearing down than building up." The program was observed to have a structured atmosphere in which rigid protocols are used to address people in authority. It was observed that in Baylor, the housing units were decorated to personalize the atmosphere and it is obvious women live there. There were pictures on the walls, posters with pictures of children, and had a less "prison look" than one would expect in a prison. CREST South has a more sterile appearance. CRET North has less of a sterile appearance but the facility is crowded.

As noted in the review of the literature, women have various behaviors and histories that require programmatic adjustments to make a TC gender appropriate.[158]

> In general, men turn their anger outward while women turn their inward. Men tend to be more physically and sexually threatening and assaultive while women are more self-abusive and suicidal (women make more frequent but less lethal suicide attempts, and actually commit suicide less often than men). Women tend to engage in self-mutilating behaviors such as cutting as well as verbally abusive and disruptive behaviors.[159]

Reed explains that

> The dynamics that have been just described are more extreme versions of general differences in coping between women and men within the larger society. Men are more likely to externalize responsibility for failures and take credit for successes; they will try to minimize vulnerable feelings and take charge of their lives until they can no longer do so. Women often attribute success to luck, but take responsibility for failures. They look internally first for sources of their problems, and often feel powerless to affect their lives. [W]ithin drug dependence treatment programs there is much less knowledge or about and experience with techniques that are more useful for patterns that are more typical of women.[160]

Due to these differences in males and females, Dr. Haslet[161] asserted that co-ed TC programs are inappropriate for women because women shut down when confronted by males and that women with drug addiction problems also tend to have prior sexual abuse histories that are exacerbated by the presence of men. Other researchers on TC's have noted similar concerns.

> Finally, treatment approaches need to be varied based on the gender of the client. For example, many male drug treatment models (especially TC's) include confrontational techniques designed to break down clients' resistance to change and to challenge their preexisting, drug-supportive beliefs and attitudes. The appropriateness of these approaches for female clients, many of whom have experienced severe physical, emotional, and sexual abuse, has been questioned.[162]

This evaluation did not find these concerns expressed by the women (or men) in this study or the program staff for Key, CREST South or CREST North. It was noted that co-ed treatment was a benefit to them, for it provided opportunities to develop healthy and positive attitudes and behaviors towards the opposite sex. The conclusion that co-ed substance abuse treatment is not detrimental to women is also noted in the literature. For example, Stevens, Arbiter and Glider made the following conclusion after conducting an evaluation on a TC program in Arizona:

> Implications of this research suggest that women residents may play an important role in increasing the effectiveness of substance abuse treatment for men and women. If women in treatment are allowed to feel safe in addressing their

> treatment issues and demonstrate self-disclosure, treatment will be more successful not only for women but for men as well. Residential substance abuse treatment centers should strive to equalize the male/female resident ratio. Staff training should be given focusing on the special needs of women residents and how involvement of women residents can increase program effectiveness.[163]

The women (in CREST North and South) who voiced the view that the program was not gender appropriate stated that the reason was not due to the presence of men or that they felt unable to speak with men in the room. They voiced it was not "good for women" because the program did not have enough gender seminars, that it has too much hostility, too much behavior modification and too little drug treatment. Exchanges of disagreement between males and females were observed and the presence of fear or feeling uncomfortable on the part of the women (n=23) when disagreements occurred was not observed. The women were found to be able to hold their positions and views in the face of male and female disagreement. Many of the women made it clear that drug treatment programs needed to have the opposite sex in order to develop healthy relationships and behaviors towards the opposite sex.

As previously noted[164] there are various factors that make a TC appropriate for women. The program must address the whole woman in that her addiction, past criminal history, history of sexual abuse, as well as her emotional and behavioral patterns need to be addressed. Additionally, the program must consider the social context that women who have drug additions come from.

> In the past 20 years, theorists and researchers have identified the importance of social context when explaining the behaviors of individuals. The choices of the individual are seen as shaped by a combination of social, cultural, and economic factors. Gender-specific interventions must be based on an understanding of a woman's social relationships and be applicable to her social context.[165]

TC programs and staff need to keep in mind that drug addiction is not a single issue involving the use of a particular drug or the use of drugs that lead to antisocial behavior. The TC model presumes that drug addiction is the reflection of dysfunction in an individual not the dysfunction

of the individual. The use of drugs has a social context that is different in women and men. TC programs that are gender appropriate take into account the social and cultural factors of life that have differential impact on men and women. As Reed points out,

> it is very important to develop regular in-service training sessions that can help staff learn as much as they can about their own individual and collective culture, and about other cultural patterns. [Because counseling] is a transaction in which each person is affected by the characteristics and communication style of the other.[166]

There are social contexts to many behaviors. Some of these contexts have different results on women than on men. Put simply, women have different social contexts in regard to drug use and drug treatment and TC programs need to take these differences into account in order to be gender appropriate. Part of understanding differential social context of drug addiction for women is that all women in drug treatment programs are not the same. Women enter drug treatment programs with various histories, drug addictions, life experiences, educational (literacy) levels and cultural backgrounds at different stages of their lives. Males and females have differences in drug histories and life histories and the design and implementation of drug treatment programs should be allowed to recognize these differences.

1. **A review should be conducted on how people are placed in CREST North and South.**
   Currently a person can be placed in CREST North or South by court order, as a condition for release from Baylor or Gander Hill or by request by an inmate without being required to go through the KEY program. The program needs to have a reduced number in order to end the "crowded" aspect of the program and include inmates who "want" to make a change in their lives. Inmates who are placed in CREST North or South under order and who don't want to be there take away from the therapeutic nature of the program.

2. **Both Dr. Haslett and the program directors agreed that the more outside training for the staff is needed. The curriculum should also be reviewed to make sure that it is current and that it is relevant to drug treatment programming and gender appropriate.**

3. **An assessment is needed to determine what actually needs to change to improve the environment and therapeutic value of program operations and what views from the "family" members are based on the negative behaviors of addicts and people who are incarcerated.** The meetings with family members and program staff made clear that there are various differences of opinion as to the quality and nature of what is treatment and whether the program offers "family" members an environment for positive change. It is not proposed that the program does not provide such an environment but that the "family" members perceive it as not being a positive environment. Although the program was found to be gender appropriate, there appears to be differences in what the program directors and counselors define as treatment as compared to what the "family" members define as treatment. *This is significant because research has shown that people in treatment are more successful when they view program modality as treatment.*[167]

Endnotes

[1]Garrison, A. (1999). SODAT - DELAWARE INC. NALTREXONE ALTERNATIVE PROGRAM (SNAP) A HEROIN ADDICT OUTPATIENT TREATMENT PROGRAM: AN OUTCOME EVALUATION. Delaware Criminal Justice Council: Wilmington, Delaware. Garrison, A. (2002). *Drug Treatment Programs: Policy Implications for the Judiciary*. COURT REVIEW: THE JOURNAL OF THE AMERICAN JUDGES ASSOCIATION 38(4) (In Press).

[2] In 1999, approximately 6.3 million adults - 3.1% of the Nation's adult population - were under correctional supervision (that is, incarceration, probation or parole). Drug offenders accounted for 21% (236,800) of the State prison population in 1998, up from 6% (19,000) in 1980, and 59% (55,984) of the Federal prison population in 1998, up from 25% (4,749) in 1980. Also, in 1998, an estimated 26% (152,000) of all inmates under local supervision were incarcerated for drug offenses. This increase in the drug offender prison population mirrors the steady increase in arrests for drug offenses. Office of National Drug Control Policy (March 2001). DRUG TREATMENT IN THE CRIMINAL JUSTICE SYSTEM FACT SHEET at 1.

In 1998, Americans spent an estimated $66.5 billion on illicit drugs:

$39 billion on cocaine
$12 billion on heroin
$2.2 billion on methamphetamine
$11 billion on marijuana
$2.3 billion on other illegal drugs

Rhodes, W., Lane, M., Johnson, P and Hozik, L. (2000). WHAT AMERICA'S USERS SPEND ON ILLEGAL DRUGS, 1988 – 1998. Office of National Drug Control Policy at 4.

74 million Americans have tried an illicit drug at least once in their lifetime, 2.4 million have tried heroin at least once in their lifetime, 22.1 million have tried cocaine at least once in their lifetime and 4.6 million have used crack at least once in their lifetime. Office of national Drug Control Policy (1998). DATA SNAPSHOT: DRUG ABUSE IN AMERICA 1998 at 32-33

The impact of this increased use of drug use can be seen in the fact that the number of Americans incarcerated (prison only) reached more than one million (1,078,542) in 1995 for the first time in U.S. history. Garrison, A. (2002). *Drug Treatment Program: Policy Implications for the Judiciary*, Supra note 1.

See also, Chesney-Lind, M. (1991). *Patriarchy, prisons, and jails: a critical look at trends in women's incarceration*. THE PRISON JOURNAL 7 (1): 51 – 67, Henderson, D., Schaeffer, J. and Brown, L. (1998). *Gender-Appropriate Mental Health Services for Incarcerated Women: Issues and Challenges*. FAMILY AND COMMUNITY HEALTH 21 (3): 42 – 53.

[3] Hooper, R., Lockwood, L, and Inciardi, J. (1993). *Treatment Techniques in Corrections-Based Therapeutic Communities*. THE PRISON JOURNAL 73 Sept. / Dec. (3-4): 290 - 306; Rawlings, B. (1999). *Therapeutic Communities in Prisons*. POLICY AND POLITICS 27(1): 97 - 111; Inciardi, J. and Scarpitti, F. (1992). THERAPEUTIC COMMUNITIES IN CORRECTIONS: AN OVERVIEW, Presented at the Annual Meeting of the academy of Criminal Justice Sciences, Pittsburgh, PA, March 10 - 14; Wexler, H. and Love, C. (1994). *Therapeutic Communities in Prison* (181 - 208), in Tims, F., DeLeon, G., and Jainchill, N. (Eds) THERAPEUTIC COMMUNITY: ADVANCES IN RESEARCH AND APPLICATION, National Institute on Drug Abuse: Rockville, Maryland, and Wexler, H. (1995). *The Success of Therapeutic Communities for Substance Abusers in American Prisons*. JOURNAL OF PSYCHOACTIVE DRUGS 27(1) Jan.-Mar.: 57 - 66.

[4] DeLong, G. (1997). *Therapeutic Communities: Is There an Essential Model?* (3-18, at 4) In COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS, DeLong, G. (Ed.). Praeger: West Port, Conn.

[5] Ibid. at 4-5.

[6] Ibid. at 4.

[7] Ibid. at 5.

[8] Ibid.

[9] Supra note 3 and DeLeon, G. (1985). *The Therapeutic Community: Status and Evolution.* INTERNATIONAL JOURNAL OF THE ADDICTIONS 20: 823 - 844; DeLong, G. (1997). *Therapeutic Communities: Is There an Essential Model?* Supra note 4; Inciardi, J. (1993). DRUG TREATMENT IN PRISONS, Presented at the 1993 Summit on U.S. Drug Policy, U.S. House of Representatives, Committee on the Judiciary. Washington, D.C., May 7; Lockwood, D., Inciardi, J. Butzin, C., and Hooper, R. (1997). *The Therapeutic Community Continuum in Corrections* (87 - 96), in DeLeon, G. (Ed.) COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS. Greenwood Press: Westport, Connecticut.

[10] Inciardi, J. (1993), *Drug Treatment in Prisons*, Supra note 9. See also, Pan, H., Scarpitti, H.,Inciardi, J., and Lockwood, D. (1993). *Some Considerations on Therapeutic Communities in Corrections* (30 - 43), in Inciardi, J. (Ed) DRUG TREATMENT AND CRIMINAL JUSTICE. Sage Publications: London, England, and DeLeon, G. (1997). *Therapeutic Communities: Is There an Essential Model?* (3 - 18) in DeLeon, G. (Ed.) COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS. Greenwood Press: Westport, Connecticut.

[11] Hopper, R., Lockwood, D., and Iinciardi, J., (1993), *Treatment Techniques in Corrections-Based Therapeutic Communities*, Supra 3 at 291.

[12] Ibid. at 295.

[13] Inciardi, J. (1993). *Drug Treatment in Prisons*, Supra note 9 at 3-4.

[14] Lockwood, D., McCorkel, J. and Inciardi, J. (1998). *Developing Comprehensive Prison-Based Therapeutic Community Treatment for Women.* DRUGS AND SOCIETY 13 (1-2): 193 - 212, 195.

[15] Inciardi, J. and Scarpitti, F. (1992), *Therapeutic Communities in Corrections: An Overview*, Supra note 3.

[16] Ibid. at 13 - 14. See also, Graham, W. and Wexler, H. (1997). *The Amity Therapeutic Community program at Donovan Prison: Program Description and Approach* (69 - 96), in DeLeon, G. (Ed.) COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS. Greenwood Press: Westport, Connecticut, and DeLeon, G. (1994). *The Therapeutic Community: Toward a General Theory and Model*, Infra note 20.

[17] Inciardi, J. (1993). *Drug Treatment in prisons*, Supra note 4; Hooper, R., Lockwood, D., and Inciardi, J., *Treatment Techniques in Corrections-Based Therapeutic Communities* Supra note 3; and Inciardi, J., Lockwood, D., and Martin, S. (994). *Therapeutic Communities in Corrections and Work Release: Some Clinical and Policy Considerations* (259 - 267), in Tims, F., DeLeon, G., and Jainchill, N. (Eds) THERAPEUTIC COMMUNITY: ADVANCES IN RESEARCH AND APPLICATION, National Institute on Drug Abuse: Rockville, Maryland.

[18] Hooper, R., Lockwood, D., and Inciardi, J., *Treatment Techniques in Corrections-Based Therapeutic Communities* Supra note 3 at 292. See also, DeLeon, G. (1994). *The Therapeutic Community: Toward a General Theory and Model* (16 - 53), in Tims, F., DeLeon, G., and Jainchill, N. (Eds) THERAPEUTIC COMMUNITY: ADVANCES IN RESEARCH AND APPLICATION, National Institute on Drug Abuse: Rockville, Maryland.

[19] Hooper, R., Lockwood, D., and Inciardi, J., *Treatment Techniques in Corrections-Based Therapeutic Communities* Supra note 3 at 292.

[20] Ibid.

[21] Ibid.

[22] Ibid. at 296.

[23] Ibid. at 292.

[24] Ibid.

[25] Ibid.

[26] Ibid. at 292 - 293.

[27] Rawlings, B. (1999), *Therapeutic Communities in Prisons*, Supra note 3.

[28] Ibid. at 100.

[29] Inciardi, J. (1993). *Drug Treatment in prisons*, Supra note 4; Hooper, R., Lockwood, D., and Inciardi, J., *Treatment Techniques in Corrections-Based Therapeutic Communities* Supra note 3; Inciardi, J. and Scarpitti, F. (1992), *Therapeutic Communities in Corrections: An Overview*, Supra note 3; Rawlings, B. (1999), *Therapeutic Communities in Prisons*, Supra note 3; and Lockwood, D., Inciardi, J. Butzin, C., and Hooper, R. (1997). The *Therapeutic Community Continuum in Corrections*, Supra note 9.

[30] Hooper, R., Lockwood, D., and Inciardi, J., *Treatment Techniques in Corrections-Based Therapeutic Communities* Supra note 3

[31] Ibid. The "Peer encounter is the cornerstone of group process in the TC. The encounter group uses vigorous confrontational procedures as a mechanism for heightening a resident's awareness of the images, attitudes, and conduct that need to be modified. As such, the focus of the encounter is on behavior, with material drawn from peer and staff observations of the resident's daily conduct." Inciardi, J. and Scarpitti, F. (1992), *Therapeutic Communities in Corrections: An Overview*, Supra note 3 at 4.

[32] Inciardi, J. and Scarpitti, F. (1992), *Therapeutic Communities in Corrections: An Overview*, Supra note 3 at 2 - 3.

[33] Inciardi, J., Martin, S., Lockwood, D., Hooper, R., and Wald, B. (1992). *Obstacles to the Implementation and Evaluation of Drug Treatment programs in Correctional settings: Reviewing the Delaware KEY Experience* (176 - 191) in Leuketeld, C. and Tims, F. (Eds) DRUG ABUSE TREATMENT IN PRISONS AND JAILS. National Institute on Drug Abuse: Rockville, Maryland.

[34] Lockwood, D., McCorkel, J., and Inciardi, J. (1998). *Developing Comprehensive Prison-Based Therapeutic Community Treatment for Women*, Supra note 9. See also, McCorkel, J., Harrison, L., and Inciardi, J. (1998). *How Treatment in Constructed Among Graduates and Dropouts in a Prison Therapeutic Community for Women*. JOURNAL OF OFFENDER REHABILITATION 27(3/4): 37 - 59.

[35] Stevens, A and Glider, P. (1994). *Therapeutic Communities: Substance Abuse Treatment for Women* (162-180), in Leuketeld, C. and Tims, F. (Eds) DRUG ABUSE TREATMENT IN PRISONS AND JAILS. National Institute on Drug Abuse: Rockville, Maryland.

[36] Ibid.

[37] Ibid. at 173. See also, Winick, C. and Evans, J. (1997). *A therapeutic Community Program for Mothers and Their Children* (143 - 159), in DeLeon, G. (Ed.) COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS. Greenwood Press: Westport, Connecticut.

[38] Stevens, A and Glider, P. (1994). *Therapeutic Communities: Substance Abuse Treatment for Women.* Supra note 30.

[39] Ibid. Winick and Eveans, Supra note 37, found that age of onset of drug use, age entering program, level of education and years of primary drug use were positively correlated with length of stay (156) with age entering the program being the most important overall factor - "The older the woman, the more likely she is to achieve longer retention. This finding is consistent with the maturing-out hypothesis, which proposes that age is very highly correlated with cessation of drug use" (158). "Age at onset is positively related to length of stay. The older the woman at the time of beginning use of the primary drug, the greater the likelihood of success" (158).

[40] McCorkel, J., Harrison, L., and Inciardi, J. (1997). THE CONSTRUCTION OF TREATMENT AMONG GRADUATES AND DROPOUTS IN A PRISON THERAPEUTIC COMMUNITY FOR WOMEN, Presented at the 92nd Annual Meeting of the American Sociological Association Annual Meeting, Toronto, Canada, August.

[41] Ramsey, M. (1980). *Special Features and Treatment Needs of Female Drug Offender*, Infra note 162. See also, Infra note 154 and accompanying text. "Drug and alcohol abuse treatment programs are fewer and are not tailored to the specific needs of women. They have greater medically-related problems, a greater mental health problem, lack of vocational skills and child rearing problems." Yang, S. (1990). *The Unique Treatment Needs of Female Substance Abusers in Correctional Institutions: The Obligation of the Criminal Justice System to Provide Parity of Services.* MEDICINE AND LAW 9: 1018 – 1027, 1018.

[42] Stevens, A and Glider, P. (1994). *Therapeutic Communities: Substance Abuse Treatment for Women*, Supra note 30 at 177.

[43] Bouffard, J. and Taxman, F. (2000). *Client Gender and the Implementation of Jail-Based Therapeutic Community Programs*. JOURNAL OF DRUG ISSUES 30 (4): 881 – 900, 882. See also, Brown, V., Sanchez, S., Zweben, J., and Aly, T. (1996). *Challenges in Moving from a Traditional Therapeutic Community to a Women and Children's TC Model.* JOURNAL OF PSYCHOACTIVE DRUGS 28(1) Jan-March: 39 – 46.

"Overt barriers to treatment entry are typically a function of pregnancy, motherhood, or both factors." Coletti, S., Schinka, J., Hughes, P., Hamilton, N., Renard, C., Sicilian, D., and Neri, R. (1997). *Specialized Therapeutic Community Treatment for Chemically Dependent Women and Their Children* (115 - 128, 117) in DeLeon, G. (Ed.) COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS. Greenwood Press: Westport, Connecticut. See also *Infra* note 54.

[44] Delaware Health and Social Services, Division of Alcoholism, drug Abuse and Mental Health (1998), WOMEN-FOCUSED TREATMENT GUIDELINES & BEST PRACTICES at 1 (citations omitted) [hereafter cited as DHSS Report].

[45] Lockwood, D., McCorkel, J., and Inciardi, J. (1998). *Developing Comprehensive Prison-Based Therapeutic Community Treatment for Women*, Supra note 14.

[46] Ibid. See also, Stevens, A and Glider, P. (1994). *Therapeutic Communities: Substance Abuse Treatment for Women*, Supra note 30.

[47] DHSS Report, Supra note 44 at 6.

[48] DeLeon, G. and Jainchill, N. (1991). *Residential Therapeutic Communities for Female Substance Abusers.* BULLETIN NEW YORK ACADEMY OF MEDICINE 67(3) May - June: 277 - 290.

[49] Ibid. at 281. Research has shown that the issue of suicide is linked to the experience that women have. "The majority of women at Amity's Center for Women and Children have experienced assault. At treatment entry 80 percent of the mothers with children, 68 percent of the pregnant and newly postpartum women, and over 73 percent of the women without children reported having been assaulted at some time in their life. Furthermore, at treatment entry 61.1 percent of the mothers with children, 58 percent of the pregnant and newly postpartum women, and 73.9 percent of the mothers without children reported having been raped at some time in their life. Many women reported being both

assaulted and raped on numerous occasions. Given the extensive drug history, involvement with the criminal justice system, and number of assaults and rapes reported by the women, it is not surprising that many of the women reported having attempted suicide. For all three groups of women approximately 42 percent reported having attempted suicide." Stevens, S., Arbiter, N., and McGrath, R. (1997). *Women and Children: Therapeutic Community Substance Abuse Treatment* (129 - 141, 135-136) in DeLeon, G. (Ed.) COMMUNITY AS METHOD: THERAPEUTIC COMMUNITIES FOR SPECIAL POPULATIONS AND SPECIAL SETTINGS. Greenwood Press: Westport, Connecticut.

[50] Blume, S. (1990). *Chemical Dependency in Women: Important Issues*, AMERICAN JOURNAL OF DRUG ALCOHOL ABUSE 16(3&4):297 – 307 at 299.

[51] Wilsnack, S., Wilsnack, R., and Hiller-Sturmhofel, S. (1994). *How Women Drink: Epidemiology of Women's Drinking and Problems Drinking*, ALCOHOL HEALTH & RESEARCH WORLD: THE JOURNAL OF THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM 18(3): (173 – 181 at 173 – 174).

[52] Farrell, A. (2000). *Women, Crime and Drugs: Testing the Effect of Therapeutic Communities.* WOMEN AND CRIMINAL JUSTICE 11(1): 21 - 48 at 23.

[53] Reed, B. (1987). *Developing Women-Sensitive Drug Dependence Treatment Services: Why So Difficult*, JOURNAL OF PSYCHOACTIVE DRUGS 19(2): (151 – 164, at 152).

[54] "[T]he lack of child care is a barrier to treatment but particularly to long-term residential programs . . . compared to men, drug dependent women are more likely to volunteer for treatment and are often more motivated by concern for their families. But this very concern for their families interferes with their ability to fully participate in treatment. [C]hildren are more likely to become important to addicted women as they progress in treatment. Thus, many women drop out at an early stage of extended care programs due to guilt about not meeting their children's needs." DeLeon, G. and Jainchill, N. (1991). *Residential Therapeutic Communities for Female Substance Abusers* Supra note 46 at 283 - 284. See also Supra note 43.

[55] Turner, T.H., and Tofler, D. (1986). *Indicators of Psychiatric Disorder Among Women Admitted to Prison.* BRITISH MEDICAL JOURNAL 298(march 8th): 651 - 653, Teplin, L., Abram, K., and McClelland, G. (1996). *Prevalence of Psychiatric Disorders Among Incarcerated Women: Part I Pretrial Jail Detainees.* ACHIEVES GENERAL PSYCHIATRY 53 (June): 505 - 512, and Jordan, K., Schlenger, W., Fairbank, J., and Caddell, J. (1996). *Prevalence of Psychiatric Disorders Among Incarcerated Women: Part II Convicted Felons Entering Prison.* ACHIEVES GENERAL PSYCHIATRY 53 (June): 513 - 519.

[56] DeLeon, G. and Jainchill, N. (1991). *Residential Therapeutic Communities for Female Substance Abusers* Supra note 48 at 281.

[57] Reed, B. (1987). *Developing Women-Sensitive Drug Dependence Treatment Services: Why So Difficult*, Supra note 53 at 155.

[58] Ramsey, M. (1980). *Special features and treatment needs for female drug offenders*, Infra note 162 and Reed, (1987). *Developing Women-Sensitive Drug Dependence Treatment Services: Why So Difficult* Supra note 53.

One of the differences between male and female addiction is that addiction itself id defined on white males as

the model and behaviors not within this model are considered variations to the standard. As Reed points out "one consequence of the male definition for drug dependence is that drug dependent women experience double deviance: They are not properly female if they drink, use unacceptable drugs or engage in unladylike behaviors while they are intoxicated or high. In addition, they are not properly alcoholic or addicted, because their behaviors and psychological profiles do not fit the masculine patterns that are called alcoholism or addiction." Reed, B. (1987). *Developing Women-Sensitive Drug Dependence Treatment Services: Why So Difficult* Supra note 53 at 153.

[59] DeLeon, G. and Jainchill, N., (1991). *Residential Therapeutic Communities for Female Substance Abusers* Supra note 48 at 281 - 282.

[60] Ibid. at 282.

[61] Reed, B. (1987). *Developing Women-Sensitive Drug Dependence Treatment Services: Why So Difficult* Supra note 53 at 153.

[62] DHSS Report, Supra note 44 at 7-8.

[63] Zankowski, G. (1987). *Responsive Programming: Meeting the Needs of Chemically Dependent Women.* ALCOHOLISM TREATMENT QUARTERLY 4(4): 53-66.

[64] Lockwood, D., Inciardi, J., and Surratt, H. (1997). *CREST Outreach Center: A Model for Blending Treatment and Corrections* (70 - 82), in Tims, F., *et. al.*, (Eds) THE EFFECTIVENESS OF INNOVATIVE APPROACHES IN THE TREATMENT OF DRUG ABUSE. Greenwood Press: Connecticut. See also, Inciardi, J., Martin, S., Lockwood, D., Hooper, R. and Wald, B. (1992). *Obstacles to the implementation and evaluation of drug treatment programs in correctional settings: Reviewing the Delaware KEY experience* (176-191), in Leukefeld, C. and Tims, F. (Eds), DRUG ABUSE AND TREATMENT IN PRISONS AND JAILS. National Institute on Drug Abuse: Rockville, MD.

[65] Lockwood, D., Inciardi, J., and Surratt, H. (1997). *CREST Outreach Center: A Model for Blending Treatment and Corrections*, Supra note 49, Lockwood, D. and Inciardi, J. (1993). *CREST Outreach Center: A Work Release Iteration of the TC Model* (61-69), in Inciardi, J., Tims, F., and Fletcher, B. (Eds.) INNOVATIVE APPROACHES IN THE TREATMENT OF DRUG ABUSE. Greenwood Press: Connecticut, and Inciardi, J. and Lockwood, D. (1994). *When Worlds Collide: Establishing CREST Outreach Center* (63-78), in Fletcher, B., Inciardi, J. and Horton, A. (Rds.) DRUG ABUSE TREATMENT: THE IMPLEMENTATION OF INNOVATIVE APPROACHES. Greenwood Press: Connecticut.

[66] Lockwood, D. (1992). MODELING A MODIFIED TC DESIGN FOR WORK RELEASE. Presented at the Annual meeting of the Academy of Criminal Justice Sciences. Pittsburgh, PA, March 10-14, Lockwood, D. and Inciardi, J. (1993). *CREST Outreach Center: A Work Release Iteration of the TC Model*, Supra note 50 and Inciardi, J. and Lockwood, D. (1994). *When Worlds Collide: Establishing CREST Outreach Center*, Supra note 65.

[67] Lockwood, D. and Inciardi, J.(1993).*CREST Outreach Center: A Work Release Iteration of the TC Model*, Supra note 49 and Inciardi, J. and Lockwood, D. (1994). *When Worlds Collide: Establishing CREST Outreach Center*, Supra note 65.

[68] Lockwood, D. and Inciardi, J.(1993).*CREST Outreach Center: A Work Release Iteration of the TC Model*,

Supra note 65 at 63.

[69] See, Lockwood, D. and Inciardi, J.(1993).*CREST Outreach Center: A Work Release Iteration of the TC Model*, Supra note 64 and Inciardi, J. and Lockwood, D. (1994). *When Worlds Collide: Establishing CREST Outreach Center*, 50 for detailed discussion on design and implementation of CREST.

[70] Lockwood, D., McCorkel, J., and Inciardi, J. (1998). *Developing Comprehensive Prison-Based Therapeutic Community Treatment for Women*, Supra note 14.

[71] Inciardi, J. and Lockwood, D. (1994). *When Worlds Collide: Establishing CREST Outreach Center*, Supra note 65.

[72] Ibid. at 66.

[73] Farrell, A. (2000). *Women, Crime and Drugs: Testing the Effect of Therapeutic Communities*, Supra note 42, Lockwood, D., Inciardi, J. Butzin, C., and Hooper, R. (1997). *The Therapeutic Community Continuum in Corrections*, Supra note 9, Lockwood, D., Inciardi, J., and Surratt, H. (1997). *CREST Outreach Center: A Model for Blending Treatment and Corrections*, Supra note 49 , Neilsen, A., Sacpitti, F., and Inciardi, J. (1996). *Integrating the Therapeutic Community and Work Release for Drug-Involved Offenders: The CREST Program*. JOURNAL OF SUBSTANCE ABUSE TREATMENT 13(4): 349 - 358, Butzin, C., Martin, S. and Inciardi, J. (1996). IMPACT OF A THERAPEUTIC COMMUNITY WORK RELEASE PROGRAM AND EMPLOYMENT STATUS ON THE RELAPSE OF DRUG INVOLVED OFFENDERS. Presented at the 1996 Annual Meeting of the American Society of Criminology, Chicago, Illinois November 21, Inciardi, J. and Lockwood, D. (1994). *When Worlds Collide: Establishing CREST Outreach Center*, Supra note 65, Lockwood, D. and Inciardi, J.(1993). *CREST Outreach Center: A Work Release Iteration of the TC Model*, Supra note 65.

[74] Neilsen, A., Scarpitti, F., and Inciardi, J. (1996). *Integrating the Therapeutic Community and Work Release for Drug-Involved Offenders: The CREST Program*, Supra note 73.

[75] Ibid. at 356.

[76] Ibid. at 355.

[77] Ibid. at 356.

[78] Ibid.

[79] Inciardi, J. Butzin, C., and Hooper, R. (1997). *The Therapeutic Community Continuum in Corrections*, Supra note 9.

[80] Ibid. at 95.

[81] Neilsen, A., Sacpitti, F., and Inciardi, J. (1996). *Integrating the Therapeutic Community and Work Release*

for Drug-Involved Offenders: The CREST Program, Supra note 73.

[82] Lockwood, D., Inciardi, J., and Surratt, H. (1997). *CREST Outreach Center: A Model for Blending Treatment and Corrections*, Supra note 64.

[83] Ibid. at 77.

[84] Ibid.

[85] Ibid.

[86] Neilsen, A., Scarpitti, F., and Inciardi, J. (1996). *Integrating the Therapeutic Community and Work Release for Drug-Involved Offenders: The CREST Program*, Supra note 73 at 354 - 355.

[87] Ibid.

[88] Lockwood, D., Inciardi, J., and Surratt, H. (1997). *CREST Outreach Center: A Model for Blending Treatment and Corrections*, Supra note 64 at 77.

[89] Farrell, A. (2000). *Women, Crime and Drugs: Testing the Effect of Therapeutic Communities*, Supra note 52.

[90] Ibid. at 36.

[91] Ibid. at 37.

[92] Lockwood, D., Inciardi, J., and Surratt, H. (1997). *CREST Outreach Center: A Model for Blending Treatment and Corrections*, Supra note 64 at 77.

[93] Farrell, A. (2000). *Women, Crime and Drugs: Testing the Effect of Therapeutic Communities*, Supra note 52 at 36.

[94] Ibid. at 38.

[95] Connection with friends and relations was not found to be significant at .05, while treatment and treatment frequency was found significant at .05. Ibid.

[96] Ibid. at 39.

[97] Ibid. at 44.

[98] Lockwood, D., McCorkel, J., and Inciardi, J. (1998). *Developing Comprehensive Prison-Based*

Therapeutic Community Treatment for Women, Supra note 14.

[99] McCorkel, J., Harrison, L., and Inciardi, J. (1998). *How Treatment in Constructed Among Graduates and Dropouts in a Prison Therapeutic Community for Women*, Supra note 34.

[100] See, McCorkel, J., Harrison, L., Inciardi, J. Lockwood, D., Hooper, R., Scarpitti, F., Martin, S., Wald, B., Butzin, C., Pan, H., Nielsen, A. in Supra notes 3, 9, 10, 14, 19, 20, 33, 34, 35, 40, 64, 65, 66, 73.

See also, Martin, S. and Inciardi, H. (1997). *Case management Outcomes for Drug-Involved Offenders*, THE PRISON JOURNAL 77(2): 168 - 183; Martin, S., Butzin, C., Saum, C., Inciardi, J. (1999). *Three Year Outcomes of Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare*. THE PRISON JOURNAL 79(3): 294 - 320; Scarpitti, F., Inciardi, J., Pottieger, A. (1993). *Process Evaluation Techniques for Corrections-based Drug Treatment Programs*, JOURNAL OF OFFENDER REHABILITATION 19(3/4): 71 - 79; Inciardi, J., Lockwood, D., and Hooper, R. (1994) *Delaware Treatment Program Presents Promising Results*. CORRECTIONS TODAY February: 34 - 42; Butzin, C., Scarpitti, F., Neilsen, A., Martin, S., and Inciardi, J. (1999). *Measuring the Impact of Drug Treatment: Beyond Relapse and Recidivism*. CORRECTIONS MANAGEMENT QUARTERLY 394): 1 - 7; and Martin, S., Lockwood, D., Inciardi, J., and Freeman, C. (1992). PREDICTING RELAPSE AND RECIDIVISM AMONG RELEASED DRUG USING INMATES: THE EFFICACY OF TREATMENT ALTERNATIVES, Presented at the Annual Meeting of the American Sociological Association, Pittsburgh, Pa. August 20, 1992.

[101] Rose, A. (2000). 1999 DISCHARGED POPULATION OF THE KEY VILLAGE DRUG TREATMENT PROGRAM: BAYLOR WOMEN'S CORRECTIONAL INSTITUTE - PRELIMINARY DATA ANALYSIS. Delaware Criminal Justice Council: Wilmington, De. (See appendix one).

[102] Ibid. at 2.

[103] Ibid. at 3.

[104] Ibid. at 6.

[105] Supra notes 41 - 42, 48 - 49 and accompanying text.

[106] Rose, A. (2000). 1999 DISCHARGED POPULATION OF THE KEY VILLAGE DRUG TREATMENT PROGRAM: BAYLOR WOMEN'S CORRECTIONAL INSTITUTE - PRELIMINARY DATA ANALYSIS, Supra note 101 at 7.

[107] Due to data entry error, the data in the report by Rose on page 7 in regard to types of abuse is incorrect. The correct statistics are reported in this report.

[108] Supra notes 55 - 56 and accompanying text.

[109] Rose, A. (2000). 1999 DISCHARGED POPULATION OF THE KEY VILLAGE DRUG TREATMENT

PROGRAM: BAYLOR WOMEN'S CORRECTIONAL INSTITUTE - PRELIMINARY DATA ANALYSIS, Supra note 101 at 8 - 9.

[110] Supra notes 49, 55 and accompanying text.

[111] Rose, A. (2000). 1999 DISCHARGED POPULATION OF THE KEY VILLAGE DRUG TREATMENT PROGRAM: BAYLOR WOMEN'S CORRECTIONAL INSTITUTE - PRELIMINARY DATA ANALYSIS, Supra note 101 at 10.

[112] Ibid.

[113] Ibid.

[114] Ibid. at 11.

[115] Ibid. at 12.

[116] Ibid.

[117] Ibid. at 13.

[118] Ibid. at 15.

[119] Ibid.

[120] Haslett, B. (2001). EVALUATION OF THE GENDER APPROPRIATENESS OF THE FEMALE OFFENDER'S SUBSTANCE ABUSE PROGRAM. Delaware Criminal Justice Council: Wilmington, De. (See Appendix Two).

[121] For discussion of these differences see research noted in Supra notes 3, 9, 10, 14, 19, 20, 48 and 65.

[122] See Supra notes 48 and 65.

[123] Haslett, B. (2001). EVALUATION OF THE GENDER APPROPRIATENESS OF THE FEMALE OFFENDER'S SUBSTANCE ABUSE PROGRAM , Supra note 120 at 3.

[124] Ibid. at 5.

[125] Ibid.

[126] Ibid.

[127] Ibid.

[128] Ibid.

[129] Ibid. at 6.

[130] Ibid.

[131] Ibid. at 9 (emphasis added).

[132] DeLong, G. (1997). *Therapeutic Communities: Is There an Essential Model?* Supra note 4 at 9.

[133] DHSS Report, Supra note 44 at 6.

[134] Haslett, B. EVALUATION OF THE GENDER APPROPRIATENESS OF THE FEMALE OFFENDER'S SUBSTANCE ABUSE PROGRAM, Supra note 120 at 6

[135] "The lack of aggressive social conditioning in women directly relates to the inadvisability of using aggressive, confrontational techniques of the encounter group with them. The encounter group is the mainstay of traditional therapeutic community treatment techniques. While men respond to this approach, women will not, for they have been conditioned to believe that they are inferior and should not be assertive. Women are trained to be submissive, conforming, and dependent. None of these attributes appears in the social conditioning of men. ... The ramifications of this system have been an asset to drug treatment programming for men, but not for women. Basically, men are more able to separate their drug use of drugs from their other social roles which carry experiences of success. The total being of a man is not destroyed by his use of drugs; he is still a man. In contrast, when a woman is identified and stigmatized as a drug user, every aspect of her being is questioned and ridiculed. ... Consequently, in treatment programming, female drug offenders will enter therapy with much greater sense of alienation and disorientation than their male counterparts." Ramsey, M. (1980). *Special features and treatment needs for female drug offenders.* Infra note 162 at 357-358.

[136] Haslett, B. EVALUATION OF THE GENDER APPROPRIATENESS OF THE FEMALE OFFENDER'S SUBSTANCE ABUSE PROGRAM, Supra note 105 at 7.

[137] Ibid.

[138] Ibid.

[139] Ibid.

[140] Ibid. at 8.

[141] Ibid. (Emphasis added).

[142] Ibid. at 10.

[143] Ibid.

[144] Ibid. at 12 - 13.

[145] Ibid. at 13.

[146] Ibid.

[147] Correspondence with author after review of preliminary draft.

[148] The term "family" and women are used interchangeably.

[149] DeLong, G. (1997). *Therapeutic Communities: Is There an Essential Model?* Supra note 4 at 11.

[150] The CREST Outreach Center (1994). THE CREST CLIENT ORIENTATION MANUAL.

[151] Correctional Medical Services (1994). THE KEY PROGRAM ORIENTATION MANUAL

[152] Ibid. See also, Supra note 17 and accompanying text.

[153] Correctional Medical Services (1994). THE KEY PROGRAM ORIENTATION MANUAL, Supra note 151 at 6.

[154] Bouffard, J. and Taxman, F. (2000). *Client Gender and the Implementation of Jail-Based Therapeutic Community Programs*, Supra note 43 at 885 – 886.

[155] The CREST Outreach Center (1994). THE CREST CLIENT PRIENTATION MANUAL, Supra note 151 at 8.

[156] A family member at CREST.

[157] Ibid.

[158] See Supra notes 42 – 43, 48 – 60 and accompanying text.

[159] Henderson, D., Schaeffer, J. and Brown, L. (1998). *Gender-Appropriate Mental Health Services for Incarcerated Women: Issues and Challenges*, Supra note 2 at 46.

[160] Reed, B. (1987). *Developing Women-Sensitive Drug Dependence Treatment Services: Why So Difficult* Supra note 53 at 157.

[161] See Supra notes 136 – 141 and accompanying text.

[162] Bouffard, J and Taxman, F. (2000). *Client Gender and the Implementation of Jail-Based Therapeutic Community Programs*, Supra note 43 at 884. See also, Ramsey, M. (1980). *Special features and treatment needs for female drug offenders*. JOURNAL OF OFFENDER COUNSELING, SERVICES, AND REHABILITATION, 4 (4): 357 – 368 and Peugh, J. and Belenko, S. (1999*). Substance-involved women inmates: Challenges to providing effective treatment*. THE PRISON JOURNAL 79 (1): 23 – 44.

[163] Stevens, S., Arbiter, N., and Glider, P. (1989). *Women Residents: Expanding Their Role to Increase Treatment Effectiveness in Substance Abuse Programs*. THE INTERNATIONAL JOURNAL OF THE ADDICTIONS 24 (5): 425 – 435, 433.

[164] See Supra notes 40, 45 – 46 and accompanying text.

[165] Henderson, D., Schaeffer, J. and Brown, L (1998). *Gender-Appropriate Mental Health Services for Incarcerated Women: Issues and Challenges*, Supra note 2 at 46.

[166] Reed, B. (1985). *Drug Misuse and Dependency in Women: The Meaning and Implications of being Considered a Special Population or Minority Group*. THE INTERNATIONAL JOURNAL OF THE ADDICTIONS 20(1) 13 - 62, at 50.

[167] "[C]lient constructions of 'treatment' are a central conceptual device through which experiences in treatment are rendered meaningful and evaluated. Further, such constructions often serve as a basis on which decisions to prematurely leave the program are made." McCorkel, J., Harrison, L., and Inciardi, J. (1998). Supra note 34 at 39. "The TC is behaviorally oriented but the process of change is primarily understood by the participants themselves in subjective terms, through perception and experiences." DeLong, G. (1997), *Therapeutic Communities: Is There an Essential Model?* Supra note 4 at 11.

1999 DISCHARGED POPULATION OF THE KEY VILLAGE DRUG TREATMENT PROGRAM

BAYLOR WOMEN'S CORRECTIONAL INSTITUTE

Preliminary Data Analysis

Data Analysis by

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Alison E. Rose

Written by

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August 17, 2000

1999 DISCHARGED POPULATION OF THE KEY VILLAGE DRUG TREATMENT PROGRAM

Preliminary Data Analysis

General demographical statistics

Information was obtained from files of the 105 women discharged in 1999 from the Key Village drug treatment program located at Baylor Women's Correctional Institute. The current research evaluation is attempting to determine whether the Key Village is gender appropriate because this treatment philosophy was transferred from a drug treatment program in a men's prison. Current participants in the Key Village will be interviewed regarding their perceptions of the gender appropriateness of the treatment program. The interview questions will be constructed based upon the data analyzed from the women discharged in 1999.

The following information describes the general demographical statistics of the participants discharged from the Key Village program in 1999. The first area observed is race. The concept of race/ethnicity was broken down into five different categories. These include Caucasian, African-American, Asian/Pacific Islander, Hispanic, and other. The breakdown of these categories is displayed in Table I.

Table I. Race/Ethnicity of Key Village Participants Discharged in 1999.

Race/Ethnicity	Frequency	Percentage
Caucasian	N = 55	52.4%
African-American	N = 45	42.9%
Asian/Pacific Islander	N = 1	1.0%
Hispanic	N = 4	3.8%
Other	N = 0	0.0%
Total	N = 105	100.0%

As Table I illustrates, the participants of the Key Village in 1999 were comprised mostly of Caucasian (52.4%) and African-American (42.9%) women.

The second area observed was marital status. The categories for marital status were broken down into single, married, divorced, and separated. Table II portrays the categorization for the variable of marital status.

Table II. Marital Status of Key Village Participants Discharged in 1999.

Marital Status	Frequency	Percentage
Single	N = 63	60.6%
Married	N = 12	11.5%
Divorced	N = 21	20.2%
Separated	N = 8	7.7%
Total	N = 104	100.0%

As depicted in Table II, the majority of women were single (60.6%) with the second highest percentage being divorced women (20.2%). The combined percentages of unmarried women (88.5%) are substantial enough to consider an interview question based upon the support network of significant others as being integral in successfully completing the Key Village treatment program.

The third demographical area observed was the highest level of educational achievement obtained by the women prior to entering the Key Village treatment program. The categories for education were classified as completing less than a 9th grade education, 9th grade, 10th grade, 11th grade, 12th grade, 12th grade with additional vocational/technical training, 12th grade with additional college courses, or obtaining a Bachelor's degree. The breakdown of these categories follows in Table III.

Table III. Highest Level of Educational Achievement Obtained by Key Village Participants Discharged in 1999.

Education	Frequency	Percentage
Less Than 9th Grade	N = 6	5.7%
9th Grade	N = 11	10.5%
10th Grade	N = 20	19.0%
11th Grade	N = 23	21.9%
12th Grade	N = 29	27.6%
12th Grade with Vocational/Technical Training	N = 6	5.7%
12th Grade with Additional College Courses	N = 7	6.7%
Bachelor's Degree	N = 3	2.9%
Total	N = 105	100.0%

As Table III illustrates, unfortunately the largest portion of the women (57.1%) obtained less than a 12th grade education prior to being incarcerated. Interestingly, very similar percentages of the women had a 9th grade education or less (16.2%) compared to those who obtained higher than a 12th grade education (15.3%).

The fourth area observed was the length of the longest job held by the participants. Perhaps the longer an individual is able to stick with a job, the longer they will be able to persevere with their drug treatment program. Table IV displays the categories of length of longest job held. These categories include jobs held from one to twelve months, 13 to 36 months, 37 to 60 months, 61 to 84 months, 85 to 108 months, or 109 months or longer.

Table IV. Length of Longest Job Held by Key Village Participants Discharged in 1999.

Length of Longest Job	Frequency	Percentage
1-12 Months	N = 38	36.5%
13-36 Months	N = 35	33.7%
37-60 Months	N = 13	12.5%
61-84 Months	N = 5	4.8%
85-108 Months	N = 5	4.8%
109 or More Months	N = 8	7.7%
Total	N = 104	100.0%

As displayed in Table IV, 36.5% of the participants were not able to hold the same job for longer than one year. Over seventy percent were not able to maintain the same job for longer than three years.

The fifth area observed was age. The concept of age was broken down into seven different categories. The first category included women in the age range of 18 to 20 years old; the second was 21 to 25 years old; the third was 26 to 30 years old; the fourth was 31 to 35 years old; the fifth was 36 to 40 years old; the sixth was 41 to 45 years old; and the seventh was 46 to 50 years old. Table V portrays the categories based on age.

Table V. Age of Key Village Participants Discharged in 1999.

Age	Frequency	Percentage
18-20 Years Old	N = 11	10.5%
21-25 Years Old	N = 15	14.3%
26-30 Years Old	N = 27	25.7%
31-35 Years Old	N = 20	19.0%
36-40 Years Old	N = 18	17.1%
41-45 Years Old	N = 11	10.5%
46-50 Years Old	N = 3	2.9%
Total	N = 105	100.0%

As displayed in Table V, the largest age group category (25.7%) was comprised of women between the ages of 26 and 30. While almost twenty-five percent of the women were 25 years old or younger, interestingly, over thirty percent of the women were over the age of 35. Perhaps the larger representation of more mature women is a factor that needs to be considered when creating survey items and interview questions.

The presence of children could be an influential factor in a client's progress in a treatment program. Table VI details the number of children, if any, the women had prior to entering the Key Village program.

Table VI. Number of Children the Discharged Participants From the Key Village in 1999 Had Prior to Entering the Key Village Treatment Program.

Number of Children	Frequency	Percentage
0	N = 15	19.5%
1	N = 15	19.5%
2	N = 20	26.0%
3	N = 13	16.9%
4	N = 10	13.0%
5	N = 3	3.9%
7	N = 1	1.3%
Total	N = 77	100.0%

As depicted in Table VI, the majority of the women responding to this question (80.6%) were mothers. Of those women who have children, 62.3% had three or fewer

children when they entered the Key Village program. For interview and survey purposes, Table VII crosstabulates the number of children with the frequency of discharge status, or the successful/unsuccessful discharges from the Key Village in 1999. The category "Other" represents women who were discharged for medical reasons, or whose sentence ended while they were participating in the Key Village program.

Table VII. Number of Children Compared with Discharge Status of the Participants Discharged from the Key Village in 1999.

Number of Children	Successful	Unsuccessful	Other	Total
0	N = 9	N = 6	N = 0	N = 15
1	N = 9	N = 5	N = 1	N = 15
2	N = 12	N = 5	N = 3	N = 20
3	N = 8	N = 5	N = 0	N = 13
4	N = 5	N = 4	N = 0	N = 9
5	N = 2	N = 1	N = 0	N = 3
7	N = 1	N = 0	N = 0	N = 1
Total	N = 46	N = 26	N = 4	N = 76

Table VII displays successful versus unsuccessful discharges compared with the number of children the women discharged in 1999 had. A chi-square test was run to determine whether there was a statistically significant difference in the number of children the women had compared with their discharge status. No statistically significant difference was found at the .05 level. However, it is interesting to note that of the 76 responding women, those with children were all more successful than not.

Background history

Research has shown that a majority of incarcerated women have suffered some history of abuse during their lifetime. Table VIII depicts whether or not the participants discharged from the Key Village in 1999 experienced some type of abuse. Their responses are categorized into yes or no answers.

Table VIII. Abuse History of Participants Discharged From the Key Village Program in 1999.

Experience Abuse	Frequency	Percentage
Yes	N = 72	92.3%
No	N = 6	7.7%
Total	N = 78	100.0%

As portrayed in Table VIII, 78 women answered the question regarding their history of experiencing abuse, providing a response rate of 74.3%. Of those responding women, an overwhelming majority (92.3%) experienced some form of abuse during their lifetime. Unfortunately, this is quite a substantial statistic. For interview purposes, this is certainly an area that could be delved into when considering the drug and/or alcohol use/abuse history of the Key Village participants being studied.

For further clarification of abuse history, Table IX breaks abuse down by specific types. The categories include physical abuse, emotional abuse, sexual abuse, or combinations thereof.

Table IX. Specific Type of Abuse Experienced by Participants Discharged from the Key Village Program in 1999.

Type of Abuse	Frequency	Percentage
Physical	N = 1	1.4%
Sexual	N = 2	2.7%
Emotional	N = 12	16.2%
Emotional/Sexual	N = 12	16.2%
Emotional/Physical/Sexual	N = 28	37.8%
Emotional/Physical	N = 15	20.3%
Physical/Sexual	N = 2	2.7%
None	N = 2	2.7%
Total	N = 74	100.0%

As depicted in Table IX, the highest categorical percentage (37.8%) is represented by those women who experienced a combination of emotional, physical, and sexual abuse.

The next area observed was the history of psychiatric treatment. Table X displays the yes or no answers from the Key Village participants regarding previous treatment for emotional and/or psychological difficulties.

Table X. Psychiatric History of Key Village Participants Discharged in 1999.

Psychiatric History	Frequency	Percentage
Yes	N = 38	36.8%
No	N = 65	63.2%
Total	N = 103	100.0%

As displayed in Table IX, a 98.1% response rate was recorded to the item regarding previous psychiatric history with 63.2% of those respondents claiming no prior psychiatric treatment. Research has shown that history of abuse can cause emotional and/or psychological distress that may not present itself immediately, but manifest itself later in life. Therefore, when considering the number of Key Village participants who suffered from abuse, it seems many women needed treatment and did not receive it.

Although a majority of the Key Village participants responded that they did not have a psychiatric history, many reported having symptoms that could possibly need psychiatric intervention. Table XI displays the Key Village participant's yes or no responses to items concerning their history with bouts of deep depression, serious anxiety, and trouble concentrating or comprehending.

Table XI. History of Depression, Anxiety, and Trouble Comprehending Experienced by Key Village Participants Discharged in 1999.

Symptom	Frequency	Percentage	Total
Experience Depression	Yes N = 57	Yes 72.2%	N = 79
	No N = 22	No 27.8%	
Experience Anxiety/Tension/Nervousness	Yes N = 54	Yes 70.1%	N = 77
	No N = 23	No 29.9%	
Experience Trouble Comprehending, Concentrating, or Remembering	Yes N = 49	Yes 63.6%	N = 77
	No N = 28	No 36.4%	

Of those Key Village participants responding to the items depicted in Table XI, 72.2% experienced deep depression at some time in their lives. Also, 70.1% of the women had experienced serious anxiety, tension, and/or nervousness. Finally, over sixty-three percent experienced trouble comprehending, concentrating, or remembering during their lifetime. A minority of women also listed histories of hallucinations, paranoia, violent behavior, and suicidal thoughts and/or attempts.

Research has shown that many individuals must undergo multiple drug and/or alcohol treatments before they are able to manage their addiction. Table XII portrays the Key Village participant's yes or no answers in regard to history of prior drug and/or alcohol treatment.

Table XII. Prior Drug and/or Alcohol Treatment History of Key Village Participants Discharged in 1999.

Prior Drug and/or Alcohol TX	Frequency	Percentage
Yes	N = 79	77.5%
No	N = 23	22.5%
Total	N = 102	100.0%

As illustrated in Table XII, a sizeable majority (77.5%) reported previous drug and/or alcohol treatment prior to entering the Key Village program. This prior treatment could have been anything from a detoxification program to a lengthy drug or alcohol treatment program.

Table XIII clarifies the issue of prior drug and/or alcohol treatment of Key Village participants by grouping the number of prior treatments they have received into: (a) having no prior treatments, (b) one to five prior treatments, (c) six to ten prior treatments, or (d) eleven or more treatments.

Table XIII. Number of Prior Drug and/or Alcohol Treatments Received by Key Village Participants Discharged in 1999.

Number of Prior Treatments	Frequency	Percentage
No Prior Treatments	N = 22	22.0%
1-5 Prior Treatments	N = 55	55.0%
6-10 Prior Treatments	N = 16	16.0%
11 or More Prior Treatments	N = 7	7.0%
Total	N = 100	100.0%

As shown in Table XIII, the majority of women (55.0%) had one to five prior drug and/or alcohol treatments upon entering the Key Village program.

Successful or unsuccessful completion of a drug and/or alcohol treatment program does not automatically lead to the suspension of using drugs. Table XIII displays the

results from the last drug and/or alcohol treatment program the Key Village participants discharged in 1999 attended prior to entering the Key Village program.

Table XIV. Outcome in Last Alcohol and/or Drug Treatment Program Attended by the Key Village Participants Discharged in 1999.

Outcome in TX Program	Frequency	Percentage
Successful	N = 45	56.3%
Unsuccessful	N = 34	42.5%
No Previous TX	N = 1	1.3%
Total	N = 80	100.0%

As depicted in Table XIV, 56.3% of the Key Village participants discharged in 1999 were successful in their last treatment program, yet were not able to abstain from using drugs.

When studying an individual's drug abuse history, the age of first drug use is an important component. Table XV sorts the age of first drug use into five different categories. The first category is 15 years old or younger, the second is 16 years old to 20 years old, the third is 21 years old to 29 years old, the fourth is 30 years old to 39 years old, and the final category is 40 years old or older.

Table XV. Age of First Drug Use by Key Village Participants Discharged in 1999.

Age of First Drug Use	Frequency	Percentage
15 Years Old or Younger	N = 56	54.4%
16-20 Years Old	N = 26	25.2%
21-29 Years Old	N = 14	13.6%
30-39 Years Old	N = 6	5.8%
40 Years Old or Older	N = 1	1.0%
Total	N = 103	100.0%

Sadly, Table XV displays that over fifty-four percent of the Key Village participants started using drugs before they were 16 years old.

In order to gain further insight into the population under evaluation, it is useful to explore the type of drug(s) used most often by the participants discharged from the Key Village program in 1999. Table XVI displays the drug(s) of choice in five different categories. These include: heroin, cocaine/crack, cannabis, hallucinogens, or using cocaine and/or heroin while also using a separate drug of choice.

Table XVI. Drug(s) of Choice of Key Village Participants Discharged in 1999.

Drug(s) of Choice	Frequency	Percentage
Heroin	N = 3	2.9%
Cocaine/Crack	N = 15	14.6%
Cannabis	N = 2	1.9%
Hallucinogens	N = 1	1.0%
Drug Combined With Cocaine and/or Heroin	N = 82	79.6%
Total	N = 103	100.0%

As displayed in Table XVI, a substantial majority (79.6%) preferred a combination of drugs including cocaine and/or heroin.

It is interesting to note how the Key Village participants discharged in 1999 supported their addictions. Table XVII displays the means of supporting addiction in two variables. These include legal and illegal means. Legal means are defined as money donated by friends and family, work, welfare checks and disability checks. Prostitution, shoplifting, fraud, selling drugs, and robbery define illegal means.

Table XVII. Means of Supporting Addiction Used by Key Village Participants Discharged in 1999.

Means of Supporting Addiction	Frequency	Percentage
Legal Means	N = 27	26.0%
Illegal Means	N = 77	74.0%
Total	N = 104	100.0%

As displayed in Table XVII, an overwhelming majority (74.0%) used illegal means to support their drug abuse.

Discharge information

Table XVIII displays the discharge status of the Key Village participants discharged in 1999. The categories are successful, unsuccessful, or other. A successful discharge is defined as one where the participant completes the orientation and primary treatment phase of the Key Village program and is transferred to another facility to participate in the next phase of their treatment plan. This might be a work-release program, home-confinement, or an aftercare program. An unsuccessful discharge is defined as one where the participant fails to complete either the orientation or primary phase of the Key Village program. The category of "other" is designated for those participants who left the Key Village program voluntarily, because of medical reasons, or because their sentence ended while they were still involved in the Key Village program.

Table XVIII. Discharge Status of the Key Village Participants Discharged in 1999.

Discharge Status	Frequency	Percentage
Successful	N = 47	45.2%
Unsuccessful	N = 47	45.2%
Other	N = 11	9.6%
Total	N = 105	100.0%

As depicted in Table XVIII, an equal number of Key Village participants were successful (45.2%) and unsuccessful (45.2%) when discharged in 1999. Numerous variables were crosstabulated with the variable of discharge status and a chi-square test was run to determine if there were any statistically significant differences at the .05 level. There were no statistically significant chi-square values at the .05 level when the variables of race, age, religion, previous occupation, level of education, marital status, length of longest job, number of children, prior drug use, age of first drug use, type of drug used, abuse history, number of prior drug and/or alcohol treatments, medical history, and prior criminal history were crosstabulated with the variable of discharge status. Previous psychiatric history was the only variable providing a statistically significant chi-square value at the .05 level when crosstabulated with discharge status. Table XIX displays the crosstabulation of previous psychiatric history with discharge status.

Table XIX. Previous Psychiatric History Compared with Discharge Status of the Key Village Participants Discharged in 1999.

Psychiatric History	Discharge Status *		Total
	Successful	Unsuccessful	
Yes	N = 10	N = 20	N = 30
No	N = 36	N = 26	N = 62
Total	N = 46	N = 46	N = 92

* Category "Other" was removed from Discharge Status for chi-square analysis.

As determined by a chi-square test, Table XIX displays that significantly more participants were successful when they had no prior psychiatric history.

The final area analyzed was the week the participants exited the Key Village program. Table XX details the number of participants who exited the Key Village program during a particular week and which phase of the Key Village they were in when they exited. The phases include the orientation phase, which generally lasts for the first

month, and the primary treatment phase, which continues until the participant completes the Key Village.

Table XX. Week and Phase Exited by Key Village Participants Discharged in 1999.

Week of Exit	Orientation Phase *		Primary TX Phase *		Total
	Successful	Unsuccessful	Successful	Unsuccessful	
Weeks 1-5		N = 25		N = 2	N = 27
Weeks 6-10				N = 10	N = 11
Weeks 11-19			N = 2	N = 6	N = 8
Weeks 20-29			N = 4	N = 3	N = 7
Weeks 30-39			N = 8		N = 8
Weeks 40-49			N = 13	N = 1	N = 14
Weeks 50-59			N = 9		N = 9
Weeks 60-69			N = 7		N = 7
Weeks 70-79					
Weeks 80-89			N = 2		N = 2
Weeks 90-99					
Weeks 100-109			N = 1		N = 1
Total		N = 25	N = 47	N = 22	N = 94

* Category "Other" was removed from Discharge Status for comparison purposes.

As indicated in Table XX, the weeks with the highest drop out numbers were weeks one through five where 27 participants unsuccessfully exited the Key Village program. Twenty-five out of those 27 participants were still involved in the Orientation phase of the Key Village. Logically, it seems that the longer a participant is involved in the treatment program, the more likely they will be successful upon completion of the program. It is important to determine what factors are prevalent during the Orientation phase which produce such large dropout numbers.

EVALUATION OF THE GENDER APPROPRIATENESS OF THE FEMALE OFFENDER'S SUBSTANCE ABUSE PROGRAM

SUBMITTED BY

BETH BONNIWELL HASLETT, PH..D

FOR THE NATIONAL INSTITUTE OF JUSTICE GRANT, 1999 RTVX K016
AWARDED TO THE DELAWARE CRIMINAL JUSTICE COUNCIL

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Executive Summary

This report assesses the gender appropriateness of the TC program for female substance abuse offenders. The TC programs are designed to help clients recognize and confront their patterns of substance abuse and criminality. Generally, these programs have been successful in reducing recidivism among substance abuse offenders. However, these programs were designed for male substance abusers, and given the growing body of research on gender differences and the increase in female offenders, it seemed useful to evaluate whether or not the TC programs were appropriate for female offenders. The findings in this report are based on over 100 hours of observation and staff interviews at TC programs throughout Delaware.

These findings are grouped in four broad categories: external factors that influence the TC programs; physical facilities;the structure and curriculum of the TC programs; and the TC staff.

External factors. The TC programs run within the context of the DOC and various correctional institutions. More frequent dialogue between the TC directors and DOC would help develop more awareness of the TC program, its needs and its relationship to the correctional institutions. More funding is needed for women inmates, and for TC programs for women in particular. Community services also need to be expanded to help the transition of clients back into society. Because many female offenders have significant histories of abuse, more mental health providers should be available for inmates (e.g., licensed clinical psychologists, board certified psychiatrists, etc.)

Physicial facilities. It is critical that separate Crest facilities for women be established so that a psychologically safe environment can be provided for them. Although a new facility is being built, steps should be taken immediately to provide separate, temporary quarters. Existing facilities need to be modified to provide private space for client intake and counseling sessions, and a large group area for gathering the entire TC family.

Structure and functioning of the TC programs. The house structure and house rules need to be reviewed so that a clear therapeutic benefit can be established for the hierarchy and job functions. In addition, the TC staff needs to monitor carefully how clients carry out these responsibilities and to remove clients who may abuse these positions of responsibility. The curriculum needs to be updated and the overall curriculum needs to be sequenced over the Key and Crest phases. Additional materials for women should include information that is consistent with an introductory course in the psychology of women, and more information on sexual abuse and domestic violence, spirituality, health issues for women, and job training. General information on substance abuse should be tailored specifically for either a female or male audience.

TC Staff. Generally, the TC staff consists of dedicated, hardworking individuals who are genuinely committed to assisting their clients. And they carry out their tasks in less-than-optimal conditions, which includes a lack of space, lack of privacy and continuous change as a part of their daily work. Staff should be provided with more training and computers to help them handle the record keeping and client files. More staff should be hired with training in areas like social work, psychology, and communication to supplement the skills of the currently employed staff.

Gender Appropriateness of the Female Offender Substance Abuse Program

The Delaware Criminal Justice Council received a grant from the National Institute of Justice (NIJ) to review the gender appropriateness of the Therapeutic Community Substance Abuse Program being used in Delaware's correctional facilities. Various therapeutic communities (hereafter referred to as TCs) have been established throughout prisons in the United States and met with some success in reducing recidivism and substance abuse. Delaware's program was initially started in 1988 and used in male prisons. In 1994, the Key Village program was started at the Baylor Women's Correctional Institution and by May, 1999, 351 women had been admitted to the program and 114 had successfully completed it (32%).

The TCs were developed for male prisoners, and in light of the research establishing significant gender differences, it is appropriate to review the TC program for its gender appropriateness for women. Officials and staff working in correctional facilities have long noted behavioral and attitudinal differences between female and male prisoners (hereafter referred to as clients), as well as differences in patterns of substance abuse. In order to enhance the effectiveness of TC programs, it seems reasonable to assume some modifications in the traditional TCs may be needed in order to adapt to the unique needs of female prisoners.

Why should we be concerned about the gender appropriateness of TC programs? First, given our understanding of significant gender differences, it is useful to examine the TCs' effectiveness for women, especially since the TC programs were designed for male prisoners. If we want to decrease substance abuse and crime, it makes sense to design programs that do this as effectively as possible. Second, the rate of incarceration of women is growing very rapidly and at a faster rate than male incarceration, so we need to address the needs of women directly rather than assuming one model (the male model) fits all prisoners. Finally, and this is perhaps the most compelling reason, women are primarily responsible for child rearing and raising the next generation. If we reduce future substance abuse and crime by treatment of female offenders, we intervene in the generational cycle of substance abuse and crime. Clearly, the success of treatment programs—not only generally, but especially for women-- is in society's best interest.

The current investigation examines the gender appropriateness of TCs for female offenders, and makes recommendations as to how the program can be adapted to enhance its effectiveness for female offenders. I have been observing TC programs at various sites throughout Delaware, and interviewed staff about the TCs. I have not interviewed

clients directly about the TCs because focus groups and client interviews were conducted separately as part of this grant. However, I did observe client interactions, caseload meetings and group encounter sessions, and will include relevant client responses from those settings.

During my observations, it became clear that program effectiveness was a function of many factors, some of which were external to the curriculum and practices of the TCs. In order to gauge the effectiveness of TCs, I looked at a broad range of factors which influenced the delivery and effectiveness of the program generally, as well as at the specific curriculum and structure of the TC program. My training in organizational communication as well as gender issues will enable me to offer this broad perspective.

Throughout my observations, I have been very impressed with the dedication of both the staff and clients. Clients were very accepting of my presence, and staff at all facilities graciously answered my questions despite having a very heavy workload and other demands on their time. I have great respect for the hard work and dedication of both clients and staff.

In what follows, I will outline observations and recommendations in various areas, covering general organizational issues as well as specific curricular suggestions.

I. Relationships of the TC program with its external environments.

The TC program involves three phases: the Key Village, Crest and AfterCare. The Key Village offers an introduction to TC concepts and processes, as well as a discussion of the disease concept of substance abuse and other basic information concerning health, emotional and cognitive issues (roughly 6 months). Crest continues the emphasis on prosocial behaviors and adds elements preparing clients for their work release and eventual re-entry into society, hopefully to remain substance and crime free (roughly 6 months). AfterCare provides meetings and support for clients in work release for another 6 months. Full treatment consists of an 18 month commitment by clients, and clients can be dropped from the program for program violations (physical violence or threats of physical violence, drug or alcohol use, stealing or inappropriate sexual behavior). Research demonstrates that length of time in treatment is inversely correlated with rates of recidivism: put another way, the longer the treatment, the less likely a client is to experience relapse.

In Delaware, the TCs have many different environments affecting them. Outside influences range from the philosophy of the Department of Correction (DOC) to state funding priorities to the physical facilities which house the TC programs. In order to establish the context in which the TCs operate, let us briefly look at some of these influences.

Philosophy of the DOC and TC Philosophy. The philosophy of the DOC is generally a policy of incarceration and punishment, and the public is perceived as generally supporting those views. The TC philosophy, on the other hand, is that of habilitation; their view is that frequently substance abusers have not been given an opportunity to learn prosocial behaviors, such as responsibility and accountability. Within a safe and supportive environment, provided by a TC, clients are given information and support in their struggles to overcome substance abuse and criminality. Because TCs operate within the prison system, frequent meetings and a fuller understanding of the differing goals and pressures both TCs and the DOC face will enhance the goals of both. A viewpoint focusing only on client habilitation might underestimate the security and public safety issues confronting the DOC; conversely, DOC pressures might cause prison officials and staff to not recognize the opportunities created by TCs for habilitation and crime reduction, and to ignore or underestimate the very real efforts made by clients in treatment. While there are frequent interactions and good working relationships between the wardens and TC directors at all the sites I observed, I believe more opportunities to discuss pressure points and difficulties, in non-crisis circumstances, would be helpful. Such discussions might be helpful on a statewide level as well.

Facilities and Funding. All the facilities I observed appear to have serious overcrowding as well as being understaffed. With regard to the TC programs, new facilities at the Baylor Correctional Institution and in Dover will provide improved facilities. Facilities for women at the TC at the Sussex Correctional Institution need substantive expansion as the overcrowding is significant and women are not allowed off their tier generally. Crowding, coupled with the lack of movement or availability of other space, creates a very negative environment for clients.

Funding is an issue for DOC generally, as more funds are needed to adequately house today's prison population as well as prepare for future need. More funds are needed for women's facilities in particular. Women's needs have not been funded to match their proportion of Delaware's prison population: women represent approximately 6 % of the prison population, yet do not receive that level of funding. While the sheer pressure of overcrowded male prisons seems overwhelming, we should not overlook the importance of funding TC programs generally (because they are successful at reducing recidivism) and especially for women (because of their importance in nurturing future generations). Finally, I would recommend that a representative who is very knowledgeable about women inmates be appointed to the Medical Review Committee which apportions funds within DOC. Women's unique needs cannot be adequately addressed without representation by someone with expertise in women's needs.

The new work-release center for women at Baylor is a critical new facility that will be operational in approximately 18 months. Separate work-release centers for men and women are essential and the many individuals who worked to get this center funded are to be congratulated on their successful efforts. **The need for separate work-release centers is so important that I recommend that the DOC take immediate steps to**

provide separate facilities immediately, by creating work-release space at some central location as an interim measure.

Although I will support this recommendation elsewhere in more detail, placing women offenders in mixed-sex, work-release programs places them in a distracting, psychologically damaging environment. Briefly, female offenders usually have suffered serious domestic violence and/or sexual abuse (estimates suggest that 80 to 95% women prisoners are victims of domestic violence and/or abuse). At present, women in work-release centers are significantly outnumbered by men, by a ratio of 7-1 or higher, and frequently the encounter groups use hostile, confrontational styles as a means of interaction. For female offenders, they are placed in an intimidating, counterproductive environment which may mirror, to a frightening extent, earlier patterns of hostility and intimidation by their abusers. For both men and women, unhealthy patterns of interpersonal relationships may be facilitated by combined programs. While both men and women must learn new healthier patterns of interpersonal relationships, work-release centers are not the appropriate place; both women and men need to work on other issues first, such as self esteem and other prosocial behaviors.

I also recommend that Gwen Empson, Director of the Key Village, be involved in the design of the new facility so there is some representation from the TC programs as TC clients will be assigned to the new facilities.

Community Services. Although some jobs are available for work-release, more community and business support would enhance the TC programs. Clients may find positions, but lack transportation. Clients may also be eligible for aid from various community and health service agencies, but may be "last on the list" for services. It must be very discouraging, to say the least, to work very hard on overcoming substance abuse, only to find little support from the community. More efforts should be made to increase job opportunities (and to increase job skills training that is given within Crest and AfterCare). For women and their children, more transition housing needs to be available to assist their safe re-entry into the community.

VOP Centers. Although not a part of the TC program, VOP centers have been used to house TC clients. If a client is dropped from the TC program for serious violations, temporary placement at a VOP center may be appropriate. But using the VOP centers as temporary holding centers for TC clients should not be done. VOP centers offer "hard time" to violators, and for TC clients, there is a disruption of their programs because no training or family interaction is provided. Habilitation is very intensive, hard work, and such a disruption would seriously interfere with a client's progress. Finally, during my observations, I heard several TC clients say that they were told not to join the TC because you could be sent to a VOP center and that would lengthen your prison time. Whether or not this perception is valid, it is a serious concern among inmates, and could deter them from joining the TC program. Program directors have also expressed concern about the VOP centers and the lack of treatment provided to TC clients sent there.

II. Structure and Functioning of the TC Program

Before discussing each program element separately, I wish to note three pressure points affecting the overall program.

Client Flow Through the TC Program. First, it is important to note that clients flow through the TC program at different rates and from different starting points in the system. Because of this, it is extraordinarily difficult to establish and maintain a consistent therapeutic climate. For example, in an encounter group at Crest, you may have, simultaneously, some clients directly sentenced into Crest with minimal understanding of the TC community, "veterans" of the TC community (those who have been in the Key Village program for 6 months), and some clients repeating the program (clients who may be back at Crest for a "tune-up"). Thus, at any given time, one has a very diverse population in terms of their experiences in the program and their progress in dealing with their substance abuse and criminality. This blend makes it very difficult to provide and maintain a curriculum that meets clients' needs; counselors are in a very difficult position of dealing with individuals who are widely divergent in terms of where they are along the path to recovery.

My observations suggest that this blended population makes habilitation and recovery for clients even more difficult. Given the variation in sentencing, and degrees of substance abuse and criminality among clients, I do not know if this blend can be altered or restructured. But, in my opinion, it would be helpful to have conversations among the TC directors and judges to discuss sentencing, who might benefit from TC programs and who might not, and other related issues in order to strengthen the TC program. Some have noted, for example, that drug dealers should not be sentenced to TCs. It is important to note that research suggests that the longer the exposure to the TC program, the lower the rates of recidivism. Staff, in fact, have told me there is no such thing as an effective "short" program (6 months or less) for substance abuse. Perhaps this may lead to a reconsideration of the TC programs' operation: what clients are we most able to help? While the answers to these questions may be elusive, I believe the questions are important to discuss, and would enhance the effectiveness of the TC programs.

Client Selection and Treatment. An increasing number of TC clients, especially women, have mental health problems. Some directors have estimated that as many as 20-25% of clients have significant mental health issues, above and beyond depression. In addition, patterns of mental illness, substance abuse and criminality vary significantly between men and women. At present, the TC programs are not equipped to handle such clients. If such clients continue to be placed in TC programs, then TC programs must be assigned or hire qualified counselors to deal with mentally ill clients. Or the State of Delaware must provide appropriate counseling and treatment.

This is a general problem faced by DOC. There is only one psychologist to diagnose, supervise and maintain clinical services in the state prisons. The demand for such assistance far exceeds one person; each correctional facility should have its own licensed clinical psychologist, and counselors trained in dealing with mental health issues. Psychiatric service should be provided by a board certified psychiatrist. There is a broad underlying issue here as to whether the DOC should handle mentally ill individuals who have criminal records, or whether or not it is more appropriate to treat such individuals elsewhere.

My recommendation is that TC directors be the final authority as to whether or not clients are accepted into the TC programs. The directors, in conjunction with the clinical supervisors, appear to be the best judges of who might benefit from the TC treatment.

The TC Structure. The TC programs in Delaware are based on a rational authority model which is dependent upon a strict hierarchy and following a chain of command. In actual practice, this means that (1) clients are placed in supervisory positions over one another, and (2) clients are not able to directly access counselors on an individual basis (i.e., one needs to go through the chain of command). There is also a practice of placing clients in positions in the TC hierarchy which may make them uncomfortable (e.g., a client who is quiet being placed in a position which requires him or her to be an advocate for others).

Like most practices, the ones above can be exercised poorly with very negative consequences or exercised well with very positive benefits. I believe the TC directors and clinical supervisors should very carefully monitor how these practices are carried out. An important part of the family climate and various job responsibilities is to teach clients prosocial behaviors. In order to provide a safe environment, clients who exercise authority over other clients **MUST** do so fairly and without prejudice. If not, they must be replaced. In no case should any client be placed in a position where he/she can harass or abuse another client, nor should practices be permitted that allow clients to verbally abuse one another. All house rules and practices should be reviewed for their therapeutic benefits: over time, some practices may have become managerial practices rather than therapeutic practices. In my opinion, a fresh analysis of house rules and practices will help enhance the program's effectiveness.

TC practices also prohibit a client from speaking directly to staff unless they follow the prescribed chain of command. While this may be necessary for a number of reasons, there should be house rules describing the circumstances under which a client may directly approach a counselor or staff member (e.g., a medical problem, personal crisis, etc.). Clients whose job function is to act as an advocate or active listener may not always understand, or adequately report, a potentially serious issue. It may take some time to work out the details of direct access and circumstances under which it can be done, but I strongly encourage this modification of TC practices in both Key Village and Crest.

Placing clients in job functions that might be uncomfortable for them should also be carefully monitored. In some cases, it may not create personal growth, but simply increase the client's level of stress and result in a job function that is not being appropriately carried out.

III. Gender Issues Affecting the TC Programs

Some general concerns about the TC program and its practices have already been noted. In what follows, the discussion will consider the program in more detail and focus on gender differences and their program implications. Comments regarding Key Village and Crest will be combined because the program details are very similar.

Gender Differences. Gender differences among clients are consistently identified by staff. Staff who have worked with both male and female offenders agree that women are more open, more supportive of one another and generally more actively engaged in the therapeutic process. Those assessments were also born out in my observations over the past six months: women were more attentive, more openly supportive of one another, more readily expressed their feelings, and participated more in groups than did men. While men tended to be confrontational with one another in an aggressive, frequently hostile manner, women were confrontational but in a supportive fashion (e.g., "You need to tighten up and get your act together because you need to get home to take care of your babies. I know it hurts but you got to walk the talk.") Women are perceived to be more expressive, but also more manipulative, while men are viewed as more aggressive and less open.

Social science research also documents these gender differences. Women are found to be more open and self disclosive than men. Women seek connections with others through talk, while men often seek connections through activities, like playing sports. Women tend to build on one another's remarks whereas, men frequently ignore or challenge others' remarks. When interrupted or challenged by men, women tend to remain silent (Haslett, Geis & Carter, 1992; Tannen, 1990). These communicative differences suggest that women would likely benefit from, and do well in, a therapeutic community that depends on collaboration and support from one another. In my observations, it generally appeared that women seemed more genuinely involved in the TC process. For example, while all clients are expected to "act as if" and give "patches," the actions and support given by women appeared more sincere and less "rote."

Clients and their children. Children also appeared to play a bigger role in female offenders' lives than they did in male offenders. In well over 60 hours of observations of different TC activities, only 3 men explicitly referred to their children whereas roughly half the women did. Women frequently expressed concern over how their children were doing, how they were being cared for, stress about court proceedings concerning custody, and other child concerns. Children clearly played a major role in motivating their struggle to overcome their addiction and remain crime free. Being able to provide more interaction with their children would clearly be a major incentive and

motivator for the women, and more contact would help the family's stability. As noted in Newsweek magazine (November 13, 2000), "lost moms" are the fastest growing population in prisons and they find it difficult to reconnect with their children. In 1999, according to statistics collected by the U.S. Bureau of Justice, approximately 1.5 million children had at least one parent in federal or state prison—an increase of almost 1/3 since 1990.

Domestic Violence and Abuse. The final gender difference I would like to highlight is the background of domestic violence and/or sexual abuse for many female offenders. Research documents that a very high percentage of female offenders have a personal history of continued violence and abuse; staff at the various TC sites indicated approximately 85-95% of female offenders experienced abuse. While men may have been abused, their abuse stopped as they matured physically. The link between abuse and/or severe neglect, and delinquency, has been identified in criminology for many years and, according to study the National Institute of Justice (1996), "there seems to be little difference in child is abused or neglected in this pattern of consequent delinquency" (Pollock, 1998, p. 96). Included in this consequent pattern of delinquency would be drug usage and addiction, leading to crime and subsequent incarceration. In addition, recent studies indicate that early childhood abuse (and its trauma) may alter the functioning of thbe brain and lead to subsequent difficulty in establishing relationships with others.

While abuse is an important issue for both men and women, it is a critical treatment issue for women. The TC environment is to "provide a safe environment" in which to learn prosocial behaviors and remain substance and crime free. However, in the Crest facilities, men and women participate in mixed sex groups throughout their time at Crest. As mentioned earlier, neither men nor women need the distractions provided by a heterosexual environment. But the TC program and staff, I believe, have overlooked the degree to which the encounter groups and the TC hierarchy may inadvertently create an environment of male dominance associated with earlier patterns of abuse. The confrontational strategies used in the programs, often verbally aggressive and hostile, as well as the overwhelming number of males in the Crest program (better than a 7-1 ratio of men to women) and their predominance in the TC hierarchy, combine to form a psychologically threatening environment for women, which may mirror earlier abusive situations (e.g., angry, hostile men). Habilitation is a very difficult process without the added stress in the Crest environment. **For these reasons, I believe the Crest program should be a same sex program as is the Key program.** Some educational programming could be coed, but the basic functioning of the TC houses and groups should be same sex grouping. Until the new facilities are completed, perhaps trailers or some other space can serve as an interim facility. In addition, given the prevalence of violence and/or sexual abuse for female offenders, the staff treating female offenders should also be women. It may be very problematic for female offenders to develop a high level of trust with male counselors, and many may not be comfortable discussing issues of sexual abuse with male counselors.

Medical Concerns and Patterns of Abuse. Differences between men and women offenders in terms of type and pattern of substance abuse have been well

documented. The issue of polysubstance abuse is also well known. In addition, the greater numbers of female offenders experiencing mental health problems (i.e., dual diagnosis) has also been documented. In general, these issues are not being adequately addressed within the penal system. Staff and counselors do not have the appropriate training to cope with the increasing number of mental health issues presented by clients, and, as noted earlier, psychological and psychiatric services are very limited. These issues need to be addressed by more support and training if habilitation is to be successful; such services may be provided by the state or the contracting agency, such as Spectrum Behavioral Services.

The TC program structure discusses the disease concept of substance abuse, relapse triggers, the criminal mind, the process of addiction and other general concepts, but does not appear to adapt program information to specific clients (e.g., talking about female patterns of addiction with women, male patterns with men, etc.). While directors are knowledgeable about these issues, it is less clear that counselors are aware of these differences. However, some of these differences may be addressed in the individual treatment plans, which were not available to me.

IV. Gender Appropriateness of the TC Program

The treatment components in the TC program include behavioral, cognitive and emotional aspects. Of these three elements, the behavioral aspect appears to be the most heavily emphasized. Although a behavioral emphasis is needed at the beginning of the program, as incoming clients "learn" the system, it should become less important over the duration of the program. The cognitive and emotional aspects need to become more prominent because it is these two components that will allow the client to remain free of crime and substance abuse.

In the program literature, the concept of "rational authority" is used, but never clearly articulated. In my view, that concept is very elusive, and not very helpful in explaining the TC structure and rules. It seems more appropriate to use the metaphor of the "family," where there is an authority system, various "job" functions, and rewards/ punishments. This would also seem appropriate given the TC's focus on habilitation, and also make most sense to the clients. I recommend that the rational authority language be dropped from program materials, and the family metaphor be used instead. The most effective TCs I observed strongly emphasized the family metaphor, and clients referred to each other as family members.

Many clients are experiencing significant personal change. The use of Lewin's force field is quite useful in helping clients understand and cope with change. The day-to-day changes and upheavals experienced in the program can also be usefully explained by Lewin's concept. Generally, it appeared that both clients and staff coped well with day-to-day changes.

With this general overview, we next turn to a more specific assessment of the TC program.

The TC Structure. The three phases of therapeutic treatment, Key Village, Crest and After Care, move clients through a structured treatment process. Key Village primarily introduces the TC structure and process, and Crest continues the educational process of habilitation, as well as prepares clients for transition to society. After Care provides group and counseling support for clients working in the community. A shortened TC program consists of direct sentencing into Crest and then moving onto After Care. Although research data on the TC program found that the longer the exposure to the program, the lower the rate of recidivism for both men and women, the shortened program (just Crest and After Care) does no better than incarceration itself in reducing recidivism.

Key Village and Crest. These two phases are the primary treatment phases with After Care providing continued support for clients working in the community. Under the guidance of Director Gwen Empson, the Key Village program at BWCI has already modified the TC program to make it more appropriate for women. However, to maximize the effectiveness of the TC program for women, the curriculum needs more modification, and the Crest programs need to be provided in a same-sex environment. More specific comments about the programs are outlined below.

A. **House hierarchy.** The job functions and hierarchy appears to be useful for the purposes of teaching, monitoring and maintaining prosocial behaviors. However, each job function should be reviewed for its therapeutic as well as "house management" usefulness. As noted earlier, clients with positions in the house hierarchy must be carefully monitored by staff so that there is no abuse of a position's authority. The general chain of command should be modified so there is a recognized procedure for clients to have direct access to staff. Clients in "gatekeeping" positions may not always exercise good judgment in limiting access or in identifying problems.

B. **Orientation Phase.** The orientation materials provided seem clear. The new orientation materials written by Director Empson were well done and covered the educational issues in greater detail. As noted earlier, I would recommend an increased emphasis on the family metaphor for the program generally, but especially for women. There is a significant amount of procedure for clients to learn, and having house positions devoted to orientation seems to be very helpful.

C. **Encounter Groups.** The encounter groups play a significant role in helping clients adapt to their new social environment, dealing not only with client behaviors, but also identifying negative attitudes and denial. Several changes in the encounter groups, however, would make them more effective:

1. Encounter group size needs to be reduced. In the Key program at Gander Hill, for example, I observed encounter groups of 40-60 clients. I observed very few clients paying attention, and the noise level made it very difficult to hear what was going on (even though clients were shouting as they gave indictments). I recommend that the two groups of 60 be further divided into groups of twenty clients each, with each group having a counselor with them. This increases client involvement because a client's inattention can be more easily noted. At Crest South, Jim Elder has been experimenting with smaller groups and has found this to be more effective for both staff and clients. At Key Village, with the new pods of approximately 24 clients each, encounter group size is at a good number. In general, an encounter group size much over 20 greatly decreases its effectiveness just because increasing group size decreases group members' involvement.

2. A number of different communication strategies have been identified for clients to use in encounter groups. The most frequently used strategy is one of hostility. The orientation manual describes this as a venting of feeling, and notes that early groups may run almost entirely by hostility. In most encounter groups I observed, hostility was the predominant strategy used. At Key Village, when hostility was used, it was a more softened, constructive form of anger that was being expressed. My concern is that hostility, particularly the forceful, aggressive in-your-face style used in the TC community, is very non-productive. Such a style expresses anger, but does not offer the client or other listeners a constructive way to cope with the anger. It is also a technique that is risky when used in society at large. I believe that clients should be taught a sequence of strategies and expected to use each one. There are more constructive ways of expressing emotion and anger, and clients should appreciate and use them also

Director Jim Elder has been experimenting with two types of encounter groups: one session uses the usual tactics of hostility and in the other session, clients must use other strategies. Clients refer to this alternate session, interestingly, as the "love" encounter. But requiring clients to use a variety of strategies in dealing with others is very important. The use of the verbally aggressive hostile strategy is inappropriate with female offenders because of its intimidation and mirroring of past experiences of abuse/intimidation.

3. During the encounter groups, negative emotions and feelings are directed at others. In the EG structure, clients are charged with displaying negative behaviors and attitudes, but given no opportunity to respond other than by a "thank you for this life-saving information." I recommend that some opportunity be provided for interaction between clients, if both clients agree to this. Just venting and then moving beyond may not always

be an effective option. Counselors should be monitoring EG interactions to offer these opportunities when this might be useful.

4. In general, TC communities operate under a rule of "no dialogue" or minimum dialogue. This seems to be arbitrary and unhelpful. It is with daily interaction that clients might provide helpful support to one another or engage in general conversation. This would provide more opportunities to learn prosocial behaviors.

Environment. The Key Village environment at BWCI reflects the use of color and positive signs to encourage clients. Clients are able to have some room decoration (like curtains) and can wear their own clothing (rather than uniforms). Personal clothing is also worn at Crest facilities. I believe color and clothing choice enhance the environment and are really appreciated by clients. During the holiday season, Key Village pods had made decorations that made the rooms more welcoming.

The women's areas appeared to have more posters, signs and other messages than did the men's areas. Interestingly, the type of messages also differed with women's messages generally being more positive and supportive whereas the men's tended to be more negative in tone, with negative consequences emphasized.

There is a need for more private space (for counseling sessions, intake interviews and assessments, etc.) and for a larger public space in all the facilities. Gander Hill has a large group space, but did not offer any private settings for client/counselor sessions.

The Crest South program needs more space for female offenders, who have limited space and virtually no opportunity for movement off their tier. And at the Key Village, some access to a larger group space needs to be given. With some creative thinking and scheduling, perhaps the available spaces could be more effectively utilized.

Curriculum. The curriculum, in general, offered by the TC community, appears sound and covers important issues. The Key Village curriculum has been modified appropriately for women in that there is reflection time built into the schedule, and there are offerings in stress management and spirituality. The reflection and spirituality dimensions are especially important for women because they often nurture others (both their own and societal expectations) but frequently neglect their own nurturance. This is well substantiated in the social science research literature.

The information on the disease concept, addiction, the criminal mind, etc. seem to be fairly standard across the TCs. It would be helpful to modify these elements so they are tailored more specifically for each sex (and when the Crest phase becomes separate for men and women, this should be more easily done). Patterns of substance abuse and criminality vary as a function of sex of the offender, and that information needs to be the standard information presented to clients. Two directors, Jim Elder and Gwen Empson, also emphasized getting a GED as a minimum for their clients.

Each TC cite has several volumes of curricular materials (e.g., curriculum outlines for various life skills, addiction, the disease concept, etc.). However, these materials usually had to be borrowed (only one or few copies were available) and the materials I looked at were dated (most references from the 1970s, 1980s or early 1990s). I believe the resource materials available to counselors needs to be updated and strengthened.

In addition to materials being substantially upgraded, new areas of information need to be provided for women (and, when appropriate, for men). For women, there should be materials covered in an introductory psychology of women course (e.g., self-esteem issues, sexual abuse, systemic discrimination, patriarchy, etc.) Such materials need to be tailored for each audience, and would provide an overall framework for integrating all the program information (i.e., information about patterns of criminality, job training, life skills, and so forth). At present, there is NO integrating framework for the TC materials and such a course would provide it (thus enhancing retention and understanding of the material). More needs to be done on self-esteem and women's health issues.

For both women and men, much more needs to be done on anger and anger management. This also needs to be tailored specifically for each sex, because women internalize anger (self-blame and lowered self-esteem) while men externalize anger (blame others and express violence/hostility toward others). Anger produces stress and the emphasis needs to be more on handling anger, rather than stress. Both men and women need more discussion of healthy relationships, both within the family and more generally within the community.

Another area to expand for both men and women is vocational training and basic job skills (like interviewing, appropriate dress, and so forth).

One final general observation is that the curriculum does not seem to be well-sequenced; that is, the curriculum appears to be a series of separate topics, rather than building upon what has been learned previously. Some of this may be difficult, especially in Crest with some clients coming in via direct court sentencing. But more coordination between Key programs and Crest programs would be helpful. Some clients, in fact, mentioned to me that "the material gets old," so even clients are noting the repetitive information and the lack of new information which builds upon knowledge clients have already acquired. While some materials may need to be repeated, they should be presented in a different framework or new perspective so that clients continue to benefit. Added vocational training, as well as basic home repair, could be added to Crest programs.

Some classes, such as the parenting classes, draw on outside programs and agencies. More effort might be made to have experts in different areas give presentations on various topics; these presentations could be videotaped and the material shared with other sites. These materials would supplement other programs such as Project Reconnect and the Read Aloud Institute. Materials, such as videotapes on special topics, also need to be more available to both staff and clients.

After Care. The After Care program consists of supporting clients as they re-enter society and look for employment. Some clients have mentors in the community, and the mentor program seems to be a very valuable aspect of support. The required meetings and one-on-one counseling sessions appear to be very useful. Some effort has been made to try to get peer groups started outside the TC community, but those have not yet been successful.

It is during After Care where serious lack of support creates substantial problems that undercut the entire habilitation program. Clients have made very serious attempts to become substance free, yet as a society, and through our state agencies, we fail to offer work opportunities and support to assist them in making a living wage. With our lack of support, we make an already difficult re-entry even more difficult.

My discussions with varied DOC officials and TC staff pointed out many shortcomings. First, there is little job training available. More training needs to be offered in "non-traditional" areas, such as construction for women, and job skills, such as punctuality, courtesy and the like, must also be taught. Much of what we assume is part of everyday knowledge has not been learned by clients. Second, state social agencies, already overwhelmed by demands, often put "ex-cons" last on the list to be helped. In part, it may reflect their lack of training in how to handle this population, as well as negative perceptions about drug offenders. The state lacks transition housing generally, and there are very few transition houses for women and their children. Transitional housing should be available in every county. This need is particularly urgent for women since they are often caring for children and lack the social support network men may have (i.e., the men may have wives or significant others to support them—women often provide such support networks for men).

Parole and probation officers should be housed at every correctional facility in order to make it easier for clients to meet with their probation/parole officers. Transportation may be difficult for clients, and having a central location would be helpful. With Delaware's zero tolerance policy, offenders might be in violation simply because they cannot get to their probation officers.

V. Staffing the TC Program

Much of the success of any program depends upon the staff who deliver the program—the directors, clinicians and counselors in TC programs. The dedication of the TC staff is impressive, as is their ability to cope with the high level of daily change and the challenge of the program.

Many staffers in the TC program are themselves recovering addicts, so they know personally the challenges and difficulties of substance abuse. This is positive when dealing with clients because staffers "know" when clients are in denial, not confronting their addiction, failing to put forth genuine effort, and so forth. All are working on their certification, or maintaining their certification as drug and substance abuse counselors.

However, other staffers need to be hired with degrees in counseling, social service work, psychology, mental health, special education and/or education . While the current staff can readily identify "where a client is at," they may lack the expertise to assist clients in gaining further knowledge or insight. Such a "blended" staff would learn from each other, and provide an enhanced program of treatment to clients. In particular, more staff with expertise in mental health issues needs to be hired if TC programs are to include clients needing such services.

Not surprisingly, staff turnover is high, with Delaware's turnover rate (approximately 50%) exceeding the national turnover rate (approximately 40%). Although turnover rates may be due to a number of factors, one factor probably is the difficulty of getting the necessary training for re-certification. This is a responsibility for both the state and Spectrum Behavioral Services (SBS). The state, for example, does not give training for re-certification. SBSprovides very limited funds for training. While ATTC provides training, it provides training available for state agencies, and TC staffers may be "bumped" by other agency staff. Each director has to share limited training opportunities across their staff. More benefits and better salaries would also help reduce the high turnover rate.

I recommend that the state offer training and course work that can count toward re-certification. SBS needs to provide more funds for training, and offer more financial incentives for its staff. For example, if SBS offers to pay for training, it could require staffers to work for a certain number of years in exchange (as many private companies already do). The TC program already demands a great deal from its staff, and the staff, in turn, needs to have more training support. This is clearly an affordable "win-win" situation which will considerably enhance the TC program.

Finally, staff would benefit from having more computer support. With very minimal investment, computers could be provided for counselors to process case information more efficiently and to keep more accurate records, In particular, low cost voice recognition equipment could be integrated in the computers so that counselors could record their case notes immediately after a client interview, and then later check a printout of their notes for accuracy and completeness. This will cut down on "paperwork" significantly, allow counselors to spend more time with clients, and enhance staff morale. The computers could be networked so client information could be easily shared with the director and other staff.

I hope this overview of the TC program, with an eye towards its gender appropriateness, will be helpful in modifying treatment. It has been a pleasure to participate in this grant, and I hope the observations and recommendations contained in this report will help strengthen the TC program.

References

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STATE OF DELAWARE
EXECUTIVE DEPARTMENT
CRIMINAL JUSTICE COUNCIL
STATE OFFICE BUILDING - TENTH FLOOR
820 FRENCH STREET
WILMINGTON, DELAWARE 19801

TELEPHONE: (302) 577-5030
FAX: (302) 577-3440

Informed Consent Form for
Investigating Gender Appropriate Corrections
Based on Drug Treatment in Delaware:
An Exploration of the Village / Crest Aftercare
Therapeutic Community Drug Treatment Continuum

Program Participant Interview

The Delaware Criminal Justice Council is a state agency that conducts research on criminal justice programs. You are being asked to participate in a study regarding the therapeutic community drug treatment model to see if it works for women.

The interview you are being asked to participate in will last for about 45 minutes and will be audio taped. The audio tape will be destroyed after completion of the evaluation of the program.

The researchers will not release or make available any comments you make to the program staff or inmates. The comments that you make will only be used by or revealed to those conducting the research. Participation in this interview is voluntary and there are no risks to you if you decide not to participate in this interview. You also have the right to stop participating in the interview at any time at no risk to you.

Federal regulations give you the right to contact the principal investigator for this research if you have any questions in regard to this evaluation. The principal investigator is Arthur H. Garrison. If you have any questions in regard to this evaluation, you can write Mr. Garrison at the following address:

Arthur H. Garrison
Delaware Criminal Justice Council
State Office Bldg. 10th Floor
820 N. French Street
Wilmington, De 19801

If you have any questions in regard to your rights as a participant in this interview you may contact the human Subjects protection contact who is Dr. Marsha Miller. If you have any questions in regard to your rights as a participant in this interview you can write Dr. Miller at the following address:

Dr. Marsha Miller
Human Subjects Protection Contact
C/O
Arthur H. Garrison
Delaware Criminal Justice Council
State Office Bldg. 10th Floor
820 N. French Street
Wilmington, De 19801

Do you wish to participate?

By signing your name you agree to participate in this interview.

Please sign both copies of this form. The interviewer will give you one copy to keep.

---------- ----------
Participant Signature Date

---------- ----------
Interviewer Signature Date

STATE OF DELAWARE
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Informed Consent Form for
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Focus Group Participant

The Delaware Criminal Justice Council is a state agency that conducts research on criminal justice programs. You are being asked to participate in a study regrading the therapeutic community drug treatment model to see if it works for women.

The focus group you are being asked to participate in will last for about 1 hour and will include some of the other women in the program with you. The focus group will be an open discussion about the drug treatment program. The focus group discussion will be audio taped. The audio tape will be destroyed after completion of the evaluation of the program.

The researchers will not release or make available any comments that you make to the program staff. The comments that you make will only be used by or revealed to those conducting the research. Participation in this focus group is voluntary and there are no risks to you if you decide not to participate in this focus group. You also have the right to stop participating in the focus group at any time at no risk to you.

Federal regulations give you the right to contact the principal investigator for this research if you have any questions in regard to this evaluation. The principal investigator is Arthur H. Garrison at 302 - 577 - 8728. If you have any questions in regard to your rights as a participant in this focus group you may contact Dr. Marsha Miller at 302 - 478 - 8912. Procedures have been established to allow you to exercise the right to contact either Mr. Garrison or Dr. Miller.

Do you wish to participate?

By signing your name you agree to participate in this focus group.

Please sign both copies of this form. The focus group leaders will give you one copy to keep.

---------- ----------

Participant Signature Date

---------- ----------

Focus Group Leader Signature Date

National Institute of Justice
Gender Appropriate Evaluation
Interview Questions

Time:_____ (Started)

Interviewer (to be read as written): My name is Dorothy Lockwood and this is Alison Rose. We work with the Delaware Criminal Justice Council. The Delaware Criminal Justice Council is conducting a study to determine if the therapeutic community treatment program here at Baylor is meeting women's needs. Originally, the program was designed for males and now that it is being implemented with women we want to know if its being implemented keeping in mind the special issues and needs women have. Part of the study of the therapeutic community treatment program involves conducting interviews of the women who are currently in the program. I hope to conduct an interview with you to get your views about the program. Alison is here to assist me and take notes on the interview.

Before we begin I want to make sure that you understand that you have the right not to participate in this study and you have the right to stop participating in the interview at any time without any consequences to you. What you say will be confidential and none of the information that you provide will be identified to you personally. In other words nothing you will say will be connected to your name.

This interview should take about 45 minutes to an hour and is being audio taped. The interview is being audio taped in order to accurately and completely gather information from the interview. The tape will be held in secure place within the Criminal Justice Council and only those who are involved in the evaluation will have access to them. None of the treatment staff or staff form the Department of Corrections will have access to the tapes. Upon completion of the evaluation that tapes will be destroyed.

If you agree to participate in this evaluation, please review the informed consent form. The form puts in writing what I have just told you. The Principal Investigator of this evaluation is Arthur H. Garrison at the Delaware Criminal Justice Council. The human subjects protection contact for this evaluation is Dr. Marsha Miller. Federal regulations gives you the right to contact Mr. Garrison in regard to questions you may have about the nature of the evaluation. You also have the right to contact Dr. Miller in regard to questions about your participation in this interview.

If you have any questions and or concerns in regard to this evaluation, you may send those questions or concerns to the following address: Arthur H. Garrison, Delaware Criminal Justice Council, State Office Bldg. 10th Floor, 820 N. French Street, Wilmington, De 19801. Any concerns or questions that you have in regard to your participation in this interview are to sent to Mr. Garrison who will forward them Dr. Miller for her response to your concerns. The signed consent form, which you will receive from me, provides the address for Mr. Garrison.
Please review the informed consent. (Wait, watch interviewee read form)

Do you wish to participate?

(If yes) Please sign the second page. (Interviewer sigh in appropriate place).

(If signed).

O.K., thank you for agreeing to participate in this evaluation. I will be asking you a series of questions. Some of them are yes - no types questions. Others are questions in which I will be asking for your opinions. Please feel free to answer as completely as you wish. The questions will center around how the program is designed, implemented and your opinions about the quality of the program. Some questions will be of a personal nature in regard to your drug use history and other types of personal information. As I said before, all answers you give will be confidential and only reviewed by those involved in conducting the evaluation. But you have the full right to refuse to answer any particular question.

Do you have any questions? (Interviewer, answer any given).

O.K., let's begin.

Notes for
Interview Questions

1. Basics

Name:_____

Age:_____

Race:_____

Time in program (months):_____

Offense:_____

2. Questions dealing with prior drug use:

1. Have you been in drug / alcohol treatment before?

Yes No (Circle One)

If so, how many times have you participated in treatment?

_____

2. How long were in each of the treatment programs that you participated in?

_____

_____

_____

_____

_____

_____

3. Did you ever participate in the village program before now?

Yes No (Circle One)

If so, how many times did you participate in the village program before now?

_____

If so, how long did you participate in the village program before now?

_____

3. Questions dealing with the first four weeks (orientation)

1. Did you find the orientation phase a difficult adjustment for you?

Yes No (Circle One)

2. If yes, it what ways was it difficult

_____

_____

_____

_____

_____

_____

If no, how would you characterize it

_____

_____

_____

_____

_____

3. Do you think the orientation phase should be longer?

Yes No (Circle One)

If yes, how much longer

If no, why not

4. What changes, if any, would you make to the orientation phase?

5. Did the program get harder or easier as you went through it?

Harder Easier (Circle One)

It what ways?

_____

_____

_____

_____

_____

_____

4. Questions dealing with confrontation aspects of the program

1. How do you feel about the confrontational aspects of the program?

_____

_____

_____

_____

_____

_____

2. Do you feel this is appropriate for females?

Yes No (Circle One)

Why?

_____

_____

_____

_____

3. Has the confrontational aspect of the program helped you?

Yes No (Circle One)

Why

4. Are you able to address issues you have with family members on a one-on-one basis, or do you have to go through the hierarchical channels?

5. How useful was the hierarchical system in your treatment process?

6. Is it appropriate for family members to have a role in the hierarchical structure of the house? Yes No (Circle One)

Why:

_____

_____

_____

_____

_____

_____

7. Have family members abused their authority in the hierarchical structure?

Yes No (Circle One)

If yes, How and how often?

_____

_____

_____

_____

_____

_____

8. How has your position of authority in the hierarchical structure improved your treatment in the program? Yes No (Circle One)

Why:

_____

_____

_____

_____

5. Questions dealing with sanctions and program rules

1. Do you feel that the program rules are appropriate?

   Yes No (Circle One)

   Why / why not?

   _____

   _____

   _____

   _____

   _____

2. Do you think that the program rules help with the treatment process?

   Yes No (Circle One)

   Why

   _____

   _____

   _____

   _____

   _____

   _____

3. Do you feel that the program sanctions are appropriate?

Yes No (Circle One)

Why

_____

_____

_____

_____

_____

_____

4. Do you think that the program sanctions help with the treatment process?

Yes No (Circle One)

Why

_____

_____

_____

_____

5. Do you think it is appropriate for another family member to impose sanctions?

Yes No (Circle One)

Why / why not?

_____

_____

_____

_____

_____

_____

6. Questions dealing with staff / participant interaction

1. Do you feel there needs to be an increase or a decrease in the individual sessions?

Increase Decrease (Circle One)

Why?

_____

_____

_____

_____

_____

_____

2. Did you find these individual sessions helpful in your treatment?

Yes No (Circle One)

Why

_____

_____

3. Do you feel there needs to be a increase or decrease in the group sessions?

Increase Decrease (Circle One)

Why?

_____

_____

_____

_____

_____

4. Did you find these group sessions helpful in your treatment?

Yes No (Circle One)

Why

_____

_____

5. Do you feel there needs to be an increase or a decrease in the peer group sessions?

Increase Decrease(Circle One)

Why?

_____

_____

_____

_____

_____

_____

6. Did you find these peer group sessions helpful in your treatment?

Yes No (Circle One)

Why

_____

_____

_____

_____

_____

_____

7. Questions dealing with program activities (responsibilities) as opposed to general population

1. Before entering the Key Village program this time, how many months did you spend in general population?

_____

_____

2. Over your lifetime, how many times have been in prison?

_____

3. Which was harder, the daily schedule of general population or the daily schedule of the program?

General population Program (Circle One)

How and Why?

_____

_____

_____

_____

_____

_____

4. How did your responsibilities change when you left general population and entered the program?

_____

_____

_____

8. Questions dealing with being ready of change

1. What did you expect to get out of participating in the Village program before you entered it?

2. How did you feel about coming in to the program?

3. How have your expectations changed, if at all?

4. Why did you stay with the program?

9. Questions dealing with supports systems

1. Who, outside of the program, have been supportive of you while you have been in the program?

2. Are you aware of support services that are available to you after your release from the program?

3. What are some of the support services that you think you will need after your release from the program?

_____

_____

_____

_____

_____

_____

4. Within the program, who has been most supportive to you while you have been in the program. This can include counselors, peers, ect.

10. Questions about children visits / children as a motivation

1. Do you have children? Yes No (Circle One)

   How old are they? _____

   If yes go through questions 2 - 5 if not move on to next grouping of questions.

2. Did having your children visit help motivate you to stay in the program?

   Yes No (Circle One)

3. How do you feel about having children visit in the program?

_____

_____

_____

_____

_____

_____

4. How does having children affect you while in the program?

5. How worried are you about your children?

11. Questions dealing with physical aspects of the program

1. What do you think of the physical facility (space) of the program?

2. What do you think about having a 24 family member pod as compared to a 42 member pod?

3. Do you feel you have enough privacy in the facility?

4. Do you feel you have more privacy than in general population?

5. What changes would you make to the physical environment?

_____

_____

_____

_____

_____

_____

12. Questions dealing with mental health

1. Do you find that you feel depressed a lot of the time?

Yes No (Circle One)

If so, what types of things make you feel depressed?

_____

_____

_____

_____

_____

_____

2. Has being in the program helped you deal with feelings of depression?

Yes No (Circle One)

Why:

_____

_____

_____

_____

3. Do you find that you feel anxious a lot of the time?

Yes No (Circle One)

If so, what types of things make you feel anxious?

4. Has being in the program helped you deal with feelings of anxiety?

Yes No (Circle One)

Why:

5. Do you find that you feel angry a lot of the time?

Yes no (Circle One)

Why: What types of things make you feel angry?

6. Has being in the program helped you deal with feelings of anger?

7. Have you ever had a mental health diagnosis?

Yes No (Circle One)

If so, what was the diagnosis?

14. Do you feel there is a need for additional vocational and educational training or services to assist in your continued drug free lifestyle when you leave the program?

Yes No (Circle One)

If so, What kinds

15. What do you feel is the single most important aspect of your treatment?

16. What was the most significant experience you had while in the Key Village program?

17. What was the most valuable tool you will be able to take with you from the village?

18. Do you think the tools in interacting with others that you have learned in the program will help you deal effectively with others when you leave the program?

_____

_____

_____

_____

_____

_____

19. **How would you amend the Key Village Program? What would you add, remove, or change?**

_____

_____

_____

_____

_____

_____

Time:_____ (Ended)