V. EFFECTIVE DRUG TREATMENT STRATEGIES FOR FEMALE SUBSTANCE ABUSERS: PROCESS, OUTCOME AND COST EFFECTIVENESS

Developing Comprehensive Prison-Based Therapeutic Community Treatment for Women

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SUMMARY. Experience and research have affirmed that treatment works for drug-involved offenders. Nonetheless, adapting these treatment models for drug-involved women offenders remains a challenge. One treatment modality, the therapeutic community (TC), has proven effective for women. This article discusses the adaptations necessary to the TC model to make it appropriate and effective for drug-involved women. Several themes are discussed including the staffing structure, staff-client interactions, the safety of the treatment environment, characteristics of the residential community, programming, and the treatment program's relationship with various social service agencies. In addition, the program elements specific to effective TCs for women in the criminal justice setting are also discussed. The experiences of developing, implementing and operating a specific TC for drug-involved female offenders provide examples of establishing an effective TC for women. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com]*

INTRODUCTION

Experience and research have affirmed that treatment works for drug-involved offenders. Indeed, a variety of modalities have proven effective–from therapeutic communities (Lockwood & Inciardi 1993; Wexler, Falkin & Lipton, 1990) and methadone maintenance (Ball & Corty, 1988) to a number of compulsory treatment initiatives (Anglin, 1988; De Leon, 1988; Leukefeld & Tims, 1988). Treatment Alternatives to Street Crime (TASC) programs across the United States have demonstrated that it is possible to combine treatment and correctional management in a number of environments (Cook & Weinman, 1988; Hubbard, Collins, Rachal, & Cavanaugh, 1988). Research within prison settings has also shown success for various treatment approaches (Chaiken, 1989; Forceir 1991; Wexler et al., 1990).

Nonetheless, adapting these treatment models for drug-involved women offenders remains a challenge. Following the National Institute on Drug Abuse's development of research protocols in 1974, numerous studies have demonstrated that women's treatment needs and treatment experiences differ markedly from those of men (Center for Substance Abuse Treatment, 1994; Winick, Levine, & Stone 1992). Women, for example, encounter a variety of gender-specific barriers that often discourage their efforts to enter treatment. Barriers to entering treatment involve such obstacles as a woman's role as primary caregiver to children, limited access to treatment programs, and pregnancy.

Once in treatment, many women face barriers to successful completion. The availability of women-only treatment facilities is extremely limited.

Most women enter co-ed programs in which staff members are predominately male and male residents outnumber female residents by ratios of 10 to 1 and higher. Furthermore, treatment regimens and services are designed for male clients and generally fail to address correlates of women's substance abuse. This situation serves to further marginalize women, and aggravates, rather than alleviates, issues surrounding low self-esteem, self-blaming and learned helplessness. The result is that many women leave treatment prematurely (Beschner, Reed & Mondanaro, 1981; Ramsey, 1980; Reed, 1987; Zankowski, 1988).

The 1980s brought concerns regarding treatment for women to the forefront. The cocaine and crack epidemics produced new profiles of drug abusing women: young, African-American, with several children, from low income neighborhoods, limited educational attainment, little to no vocational experience or skills, extensive sexual abuse victimization, and histories of trading sex for drugs and money (Inciardi, Lockwood, & Pottieger, 1993). Many of these women have flooded the criminal justice system. Drug Abuse Forecasting (DUF) statistics indicate that as many as 88% of female arrestees in some metropolitan areas test positive for illicit drugs (Wish & Gropper, 1991). In addition, the number of women in prisons increased by 200% in some jurisdictions with as many as 80% of incarcerated women in need of drug treatment.

Despite the limited treatment resources available to women, there has been some progress in addressing their treatment needs. The fundamental treatment components essential for effective and appropriate treatment for women have been identified, and a variety of programs have been successful in adapting modalities to incorporate these components. One treatment modality, the therapeutic community (or *TC*), which was originally designed for and by men, has proven effective both for male offenders (Lockwood & Inciardi, 1993; Wexler et al., 1990) *and* for women (Stevens, Arbiter & Glider, 1989).

The success of the TC modality for treating women is attributable to its unique philosophy and programmatic structure (for a more general description of therapeutic communities see De Leon & Ziegenfuss, 1986; Yablonsky, 1989). Specifically, treatment in TCs is based on the idea that substance abuse is a disorder of the whole person. This approach invites clients and practitioners to explore the many issues and experiences that frame the client's substance use, thereby ensuring that gender-specific issues facing women clients will be addressed. Second, TCs seek to improve interpersonal skills and coping strategies so that clients may better handle the problematic situations they encounter in their everyday lives. This theme is particularly salient for women, since many women's psychiatric disorders are triggered by interpersonal relationships (Jack, 1991;

Kessler & McLeod, 1984). In addition, through job assignments and other program activities, TCs teach prevocational and vocational skills, including responsibility and sound work habits. This aspect is of enormous practical importance for drug-involved women, since few have experience in legal jobs. Finally, the rituals and ceremonies which mark rehabilitative progress are easily reformulated to include those specific to the growth and development of women (Stevens et al., 1989).

This article provides an overview of those program elements necessary for the treatment of women substance abusers, and examines the process through which such elements can be successfully implemented into the TC. In addition, we explore the conditions under which a TC for women can prove an effective option for treating incarcerated women offenders. Our analysis is based on data collected during a three-year process evaluation of BWCI Village, a prison-based TC for women in New Castle, Delaware.

ADAPTING THE THERAPEUTIC COMMUNITY MODEL FOR WOMEN

Over the past two decades, a variety of treatment modalities have restructured their programming to better serve women (Ramsey, 1980; Stevens et al., 1989; Wellisch, Anglin & Prendergast, 1993; Zankowski, 1988). Several themes have emerged from these adaptations that appear essential to the development of gender-sensitive treatment. These themes include: the structure of staffing and the nature of staff-client interactions; the "safety" of the treatment environment; characteristics of the residential community; the content of programming; and the treatment program's relationship with various social service agencies.

First, the structure of staffing is important in TCs because staff members serve as role models for the resident community. Staff members that are unaware of, or minimize women's treatment needs are likely to foster a treatment environment that is insensitive (and occasionally hostile) to female clients. Preliminary research indicates that having a woman director appears to significantly increase the success of both co-ed and women-only programs (Ramsey, 1980; Stevens et al., 1989). Further, due to multiple and varied treatment concerns for women clients, staff with experience from other professional fields is also essential (Stevens et al., 1989; Zankowski, 1988). Staff with expertise in women's health care is necessary not only for health reasons, but for educational purposes as well. Many drug-involved women are at high risk for health complications and have little knowledge about health issues, particularly in regard to gynecological care, sexually transmitted diseases, and prenatal care (Inciardi et al., 1993). Staff with knowledge and experience in working with clients on

parenting, childhood abuse, and sexual abuse are also essential in providing appropriate and comprehensive treatment to women (Stevens et al., 1989; Zankowski 1988).

Not only is it important to staff programs appropriately, but specialized training is also fundamental. Treatment providers must be cognizant of women's experiences on the "street," and their involvement in prostitution, predatory crime, drug networks, and violent relationships. In addition, training on drug-abusing women's relationships with their children is beneficial (Stevens et al., 1989; Zankowski, 1988). Educating staff in these areas aids counselors in gaining the perspective of their clients, allowing them to better work with the client from "where she is" when she enters the TC. Counselor familiarity and sensitivity to life on the street lessens the chances of clients feeling alienated or hostile toward treatment. Sensitivity training also decreases the risk of staff inadvertently perpetuating or condoning hierarchical or otherwise problematic interactions between women and men within the TC. A trained staff prevents the formation of unhealthy relationships and teaches male and female clients how to interact with one another in ways that encourage mutual respect and understanding.

Second, treatment providers must work to promote a safe environment for women to engage and progress in treatment. One of the first steps is to ensure that program policies encourage a supportive treatment environment. For instance, many TCs use coercion, rewards, and punishment to ensure participation in program activities. Inappropriate use of punishment and/or excessive use of coercion to encourage participation may only serve to alienate women, particularly since decreased participation may be the result of inappropriate activities or an environment that is otherwise hostile to women clients. Punishing women for non-participation without examining the causes of such behavior may perpetuate feelings of alienation, low self-esteem, and lack of trust. A "safe" treatment environment is one that encourages women's participation through the scheduling of appropriate activities and supportive rewards.

The third requirement for gender-sensitive treatment involves the nature of the community. Much of the TC treatment model is based on group activities and group counseling. Successful group counseling relies on bonding and trust among members. Many women who have been involved in drug use and criminal activity do not trust other women and may find it difficult to trust and bond with others, more generally (Ramsey, 1980). Treatment interventions such as gender specific groups (segregated by sex), individual counseling, leisure activities and seminars may be necessary to teach women to bond in positive ways and develop a sense of trust.

In addition, TCs are characterized by a structured hierarchy in which clients gain increased authority as they progress through treatment. Many women involved in drugs and criminal activity are not accustomed to positions of authority and many male clients are not accustomed to women holding positions of power. Seminars, role-taking groups, and staff role models are essential for encouraging women clients to assume positions of authority and in assisting male clients to interact in positive ways with women who are above and below them in the program hierarchy.

Creating a safe equitable environment based on mutual respect between men and women is greatly dependent on establishing the first cohort of female residents who have progressed through the TC process. Establishing this cohort is difficult, primarily because until this is accomplished women residents have no peer role models. Staff may need to implement safeguards and interventions to ensure that the first cohort is established. Two methods of ensuring a stable and strong first cohort are targeted recruiting and over-recruiting. Through targeted recruiting, clients most ready for treatment are selected. This process increases the likelihood that the women will engage in and progress through treatment as a group, eventually becoming role models for newer clients. After the first cohort is recruited, a broader range of clients can be included in the recruitment criteria. Over recruiting ensures that a sufficient number of women enter treatment together to create a critical mass necessary for group acitivities. In this instance, new recruits enter treatment as a group rather than one at a time. Once a cohort is established, clients can enter the program one at a time.

In addition, staff must also be attuned to the development of this cohort and withdraw as soon as the older women residents are promoted into positions of authority. This cohort ensures that women are integrated into the TC structure. It also enables the program to pair older and newer female residents so that the older residents can assist the newer residents in treatment engagement (Stevens et al., 1989).

The fourth condition for successful treatment of women is providing gender specific programming (Reed, 1987). As noted earlier, women's addiction experiences differ from men's, and often involve issues surrounding abusive relationships, role overload, and self-derogation. Within TCs, gender specific programming is essential to all treatment interventions including seminars, branch groups, encounter groups, and individual counseling. Focused attention must be paid to developing relationship skills for women. In addition, activities aimed at increasing contact with children and developing parenting skills are necessary. As with men, experience with leisure activities and appropriate use of free time must be addressed in treatment. Ensuring that leisure activities are enjoyable and compatible with women's interests and talents is another aspect of appropriate programming. As noted earlier, health care, particularly gynecological care, and health education for women are essential (Reed, 1987; Stevens et al., 1989; Zankowski, 1988).

The fifth condition for successful programming is coordination with social welfare agencies. One of the barriers to treatment for women is their involvement with other services and agencies, and their child care responsibilities. Extricating themselves from other services may threaten sources of income and destabilize child care arrangements. Treatment programs for women must be aware of these potential barriers and coordinate services within the existing network of social welfare agencies. Coordination and sound working relationships with courts, child protective services, and other social service agencies during treatment is essential to women's progress in treatment (Reed, 1987; Zankowski 1988).

In sum, adapting therapeutic communities for women is not merely a task of admitting women into an existing TC. Rather, it requires intentional planning and development with regard to staffing, programming, services, and the overall treatment environment.

THERAPEUTIC COMMUNITIES IN CORRECTIONAL SETTINGS

The TC modality has functioned primarily as a community-based, coed treatment option. During the past twenty years, however, the TC model also has been adapted for treating male offenders in prison settings and has been effective in reducing recidivism and relapse rates (Field, 1989; Holland, 1978; Inciardi & Lockwood, 1994; Wexler et al., 1988). Similar to adapting the therapeutic community model for women, the model must also be restructured to treat offenders and to function effectively in correctional environments.

Ideally, TC treatment for offenders is comprised of three stages, with the first stage–primary treatment–beginning in prison. In this setting, TC residents are segregated from the negative prison environment in which drug use, drug dealing, violence and manipulation are routinized aspects of inmate life. During primary treatment, residents are inducted into the TC culture and learn prosocial ways of behaving and interacting with others. The second stage of treatment is transitional, in which residents move from the prison to a community-based work release center or halfway house. Here, the TC process emphasizes community reintegratation. Residents seek and maintain employment as well as reunite with their families. The final or tertiary stage of treatment is an aftercare phase. In this stage, graduates live and work in the community and continue their

involvement with the TC. They begin the lifelong process of recovery through involvement with 12-Step support groups such as AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) and maintain ties to the TC through support groups and volunteered time (Inciardi, Lockwood & Hooper, 1994).

This continuum of TC treatment has proven successful for offenders (Inciardi et al., 1994; Wexler et al., 1990). Nonetheless, the relative success of prison-based TCs is contingent upon several conditions. First, surveillance and custodial responsibilities of the institution must be separate from, but coordinated with, the treatment program. When things are operating as expected and residents are conforming to program policies, custodial mandates and treatment goals do not conflict. On the other hand, when residents deviate from behavioral guidelines, correctional reaction usually conflicts with preferred treatment policies. In order to avoid conflict between treatment and correctional staff in these situations, TC and prison administrators must clearly delineate which behaviors and actions are to be addressed by treatment staff and which are to be addressed by correctional staff (Inciardi & Lockwood, 1994; Wellisch et al., 1993; Wexler, Blackmore & Lipton, 1991).

Further, cross-training involving correctional and treatment staff is essential (Inciardi & Lockwood, 1994). Both groups need to understand and respect the others' responsibilities and goals. Greater exchange of information and training, leads to more coordinated efforts and stronger communication. Some prison based TCs are able to hire correctional officers who are trained in the TC model (Jones, 1980). Such staffing reduces the risk of conflict and enhances compatibility of goals. Including treatment administrators in the selection of correctional officers can also reduce potential conflict. Unfortunately, these types of staffing arrangements are rare.

Appropriate, trained, experienced treatment staff is integral to the success of TCs (Lockwood & Inciardi, 1993; Wellisch et al., 1993). Traditionally, TCs have been staffed primarily by TC graduates. More recently, a heterogeneous staff with both TC graduates and counselors with formal education and credentialing has proven effective (Inciardi & Lockwood, 1994). In the prison setting, it is difficult to hire TC graduates despite successful employment histories and training, because of their histories of criminal activity. Nonetheless, having TC graduates on staff provides residents with necessary role models, staff who fully understand their position and history, as well as staff who are able to quickly identify manipulative behaviors and deceptive practices. Many prison administrators are willing

to accommodate these staffing needs by making allowances in the hiring procedures and criteria (Inciardi et al., 1992).

Cooperation with hiring appropriate TC staff is one of many forms of support and endorsement from correctional authorities essential in successful treatment for offenders (Wellisch et al., 1993). Lack of support, even from mid-level administrators, will undermine the development of the TC (Inciardi & Lockwood, 1994). Just as the correctional officers must be educated and trained on the philosophy and operation of a TC, so must prison administrators. Most have been promoted through the ranks of the correctional system and adhere to the traditional philosophy of surveillance and custody. Informing administrators of the benefits of a TC, particularly in regard to the management of inmates, will increase cooperation and success.

There are several key steps in ensuring cooperation and coordination between the prison administrators and the TC staff. The first and most obvious is to obtain official written endorsement and agreements to cooperate and coordinate with establishing the TC. The second is to establish formal communication channels between the TC and the correctional authorities (Wellisch et al., 1993). Strong communication is not only necessary for planning and implementing the TC, but also for the day to day management of clients. Ensuring that there is a liaison who understands therapeutic and custodial goals, and who is respected and has authority within both organizations greatly enhances the efficient and timely implementation of the TC as well as continued development (Inciardi & Lockwood, 1994).

Although coordination between the correctional system and the TC is required, it is also essential that the TC is separate and independent of the prison system (Inciardi, Martin, Lockwood, Hooper & Wald, 1992; Jones, 1980; Wellisch et al., 1993). In other words, TC staff and residents need to maintain autonomy with regard to managing the program. Ideally, the TC residents should be separate from other inmates in order to limit their exposure to the negative prison environment where street values are condoned (Field, 1989; Levinson 1980; Wexler & Lipton, 1993). TC staff must be allowed to respond to rule violations with treatment strategies rather than correctional sanctions. Additionally, rewards, like punishments, should be distributed at the discretion of TC staff based on program guidelines as opposed to "good time" standards used for other inmates.

Coordinating treatment completion with release from the correctional institution as specified by the sentencing order is one of the most difficult tasks of integrating treatment with corrections. However, making the transition from the prison TC to the community is fundamental to the success

of any prison-based treatment program (Inciardi & Lockwood, 1994; Wellisch et al., 1993). Here, again, the difference between treatment and punishment emerges. Within the treatment framework, completion of treatment is marked by client development and progress. On the other hand, release from prison or correctional supervision is predetermined by the sentencing order from the court. This situation creates a double-bind for treatment staff. On the one hand, clients who have successfully completed the program but are unable to obtain early release often become alienated and begin to regress. At the other extreme are offenders who are released prior to successful program completion due to sentencing requirements. Often, these offenders are at risk for recidivism and relapse. A strategy to coordinate treatment completion and prison release is a necessary part of the planning process. In fact, it often becomes part of the intake and orientation process. TC staff must begin to coordinate with the correctional authorities, release boards, the parole board and the courts, as soon as the resident enters treatment (Inciardi et al., 1992; Lockwood & Inciardi, 1993)

Release from prison and graduation from the TC are not the final steps in developing effective treatment for offenders. Implementing viable transitional and aftercare programs in the community to complete the continuum of treatment is a key factor (Wellisch et al., 1993). This is particularly so for offenders graduating from a TC. For instance, TC graduates from an in-prison TC who were released to the community with no transitional or aftercare provisions quickly relapsed and returned to crime (Inciardi et al., 1992).

BWCI VILLAGE: A PRISON-BASED TC FOR WOMEN

Despite the success of prison-based TCs for reducing recidivism and relapse among male offenders, efforts to incorporate this model to treat women have been limited. The remainder of this paper describes the development and implementation of BWCI Village, a promising new TC designed to meet the treatment needs of substance-abusing women offenders. The case of BWCI demonstrates that treatment for women begins with gender-specific adaptations to the therapeutic framework; however, the success of the program is ultimately determined by the program's relationship with the surrounding correctional environment.

In January 1994, through funding from the Center for Substance Abuse Treatment (CSAT), BWCI Village accepted its first cohort of women residents. BWCI Village is a 42-bed program and occupies a separate building on the campus of the only women's correctional facility in Delaware–Baylor Women's Correctional Institution (BWCI). The program is operated by an independent treatment and medical provider, Correctional Medical Services, Inc., which also operates corrections-based drug treatment programs elsewhere in Delaware and numerous other jurisdictions.

The program requires that for entry, potential residents have six to eighteen months remaining on their sentence and no diagnoses of severe mental disorders. As of January 1996, a total of 134 women had been admitted to BWCI Village; 30 had graduated from the program, with the vast majority of these moving on to a transitional, work-release TC and or some other form of community aftercare support.

The program has several unique characteristics that distinguish it from a traditional, male-oriented TC. First, the treatment staff is comprised solely of women. While the decision to hire a female-only staff was not an intentional one, the program found that this particular adaptation assisted in the development of a "safe" environment for residents, allowing them to explore issues they might avoid in the presence of men. The absence of men on the treatment staff has generated a need for counselors to seek out positive male role models for clients to interact with. Currently, the program has trained two male correctional officers for duty in the facility and invites other positive male figures (prison psychiatrists, teachers, and volunteers) to interact regularly with clients.

Like other TCs, the counselling staff members come from a variety of backgrounds. The director and two counselors have formal education combined with work experience in co-ed, community-based TCs. A third counselor is a TC graduate, another is a former correctional officer, and the final counselor has experience working with substance-abusing clients in a non-TC treatment setting. All counselors participate in group therapy and individual counselling sessions, but each has an area of treatment specialization. The aftercare counselor, for example, maintains a caseload of all clients who are preparing to exit the program. She assists residents in developing an aftercare plan, accessing resources (including continued treatment and housing), and preparing for release from prison and graduation from the TC. Other specialty areas include organizing leisure activities and recreation, HIV education and awareness, addiction education, spirituality sessions, multicultural awareness, parenting sessions, and domestic violence/abusive relationships.

In regard to the correctional staff, BWCI Village's experience has been much like other prison-based TCs. Many of the correctional officers originally selected for the program were uncomfortable with the TC approach. It took over a year to identify correctional officers who understood the philosophy and were able to effectively participate in it, in addition to

fulfilling their responsibilities to the prison. Typically, officers found to be ineffective in the program tended to have an authoritarian style of interaction with residents and were uncomfortable with "inmates" having authority in the treatment setting. The program currently maintains a roster of five trained officers who supervise the program in shifts. Each of these officers is an active participant in the community and in one case, an officer accepted an offer from the program staff to become a counselor.

The second characteristic of BWCI Village that distinguishes it from traditional TCs is the content of programming. It has successfully incorporated a variety of services deemed essential in treating women. The program provides medical and health education which focuses on general health and gynecological care, pregnancy, body image, nutrition, the effects of drug use on the body, and stress reduction. In addition, the program is expanding health care education to include accessing medical resources in the community. The program provides all residents with anonymous HIV and TB testing, and holds HIV education seminars twice a month.

An outside provider conducts an eight week parenting course with all program residents. Women must complete this course of instruction prior to having their children stay with them at the program. In this regard, BWCI Village is not able to accommodate a full-time children's program but has created space for a children's room in the facility. Women who have progressed in treatment and who have completed the parenting program are able to have their children stay overnight in the TC once every two months. Additionally, most women are able to visit with their children during the prison's regular visiting hours. The program also provides job readiness and job seeking skills. BWCI Village residents are encouraged to participate in the educational and vocational training provided by the prison. Treatment schedules are adapted to allow for training courses. Courses include GED, food services, clerical, nurse's aid, and computer training.

Through the TC process women learn assertiveness skills, goal setting skills, stress and crisis management, communication and interpersonal skills, and relationship skills. In addition, BWCI Village has developed a component where women learn to reduce stress and increase self control through meditation and other relaxation techniques. The TC counselors address sexuality and intimacy issues, including emotional dependency and co-dependency on an individual basis as needed. Following the program's first year, it became clear that it was necessary to supplement programming with a stronger emphasis on domestic violence and abusive relationships. The vast majority of BWCI residents have extensive histories of sexual victimization, violence, and abuse which are coterminous with addiction experiences. Since none of the original staff had specialty training in these areas, a counselor who had experience treating battered and sexually victimized women was hired. The addition of domestic violence programming has strengthened the program considerably and has better prepared staff to effectively respond to unique features of women's substance abuse.

BWCI, like other TCs, teaches residents how to use and understand the 12-Step model. Women are expected to participate in AA and NA meetings and to begin to develop a support system which includes AA and NA groups. These groups are the initial component of an aftercare plan. All women graduating from BWCI Village leave the program with a plan and resources to continue treatment. Most will go on to a work release TC, but others will be released to halfway houses and directly into the community. The women who do not continue TC treatment are transferred to outpatient programs as their aftercare plan. In sum, through the TC process and added services, BWCI Village has evolved into a comprehensive treatment program which includes a continuum of care designed specifically for women.

While these adaptations have proven effective for meeting the treatment needs of drug-abusing, female offenders, the success of any prison-based program is largely contingent on the program's relationship with the correctional environment in which it operates. The power of the institution to allocate resources, foster a pro or antitreatment correctional culture, influence program intake and discharge, and provide security is extremely influential in determining the effectiveness of the program. BWCI Village's first two years were marked by many of the common barriers to implementing TCs in prison settings (Inciardi et al., 1992; Inciardi & Lockwood, 1994). These center primarily around working with the prison system. Although it has been well documented that coordinating with prison administrators as part of the planning process is integral to developing successful treatment for offenders, the only focused planning occurred during the preparation of the BWCI Village grant application.

Prison administrators and staff involved in the planning process were pro-treatment in their efforts to endorse the proposal, allocate resources (including the separate facility), and in pledging support and cooperation. When the women's TC was proposed, TC's had been well-established and accepted by the Department of Correction in both male and co-ed institutions. This positive attitude toward treatment masked how little was actually known about treatment, particularly treatment in a TC setting. In reality, the institution's familiarity and experience with treatment was

largely limited to occasional group sessions conducted by community-based outpatient providers and AA/NA meetings. As a result, no provisions were made for educating the correctional staff on the TC model and the implementation process. While the structure and challenges presented for clients in the TC were understood and accepted fairly readily by the security staff, the support and services staff had much more difficulty in understanding and accepting the TC model. The consequences of this proved crucial to the program's growth and development over the two year period.

One of the primary barriers to program implementation for BWCI Village was hostile actions undertaken by some prison staff members. Correctional counselors, administrators, and officers are frequently responsible for selecting residents from the general prison population for the TC. Early recruitment efforts were hampered when several of these individuals discouraged inmates from entering the program, encouraged current residents to prematurely leave the program, and otherwise validated unfounded rumors regarding the program's harsh treatment of clients. In addition, confusion regarding release policies led a few officials to promise some recruits early release for their participation in the program. This information was misleading in that release from prison is entirely contingent on the discretion of courts and parole boards. These early promises, however, left many clients resenting the program and caused them to regress in their treatment.

The lack of training for correctional personnel dampened recruiting efforts during the first twelve months. Ambiguity regarding who (treatment vs. corrections staff) had primary responsibility for recruiting clients into treatment made intake of new residents slow and, at times, stagnant. Slow intake and inappropriate referrals resulted in delayed development of the first cohort of senior residents. Of the first sixteen BWCI Village clients, only five remained in the TC. Four ultimately graduated and moved to the work release TC, with the fifth still at BWCI Village. The remaining women in the first cohort were returned to the prison population without completing treatment.

Coordination between the institution and the program improved markedly during the second year of operation. In large part, this was attributable to the desire of both parties to clarify organizational boundaries and improve treatment services for women. Additionally, both parties recognized the need to redress existing deficiencies regarding TC training for all correctional staff. In January 1995, CSAT sponsored cross training for TC and correctional staff. This would have undoubtedly been more effective had it been held during the program's initial start-up; however, the session

allowed both parties to air grievances, express perceptions of the program and its progress, ask questions, and coordinate recruiting, placement, and security efforts.

The cross-training session did not solve many of the organizational conflicts between the program and the correctional facility, but it did establish several important ground rules for coordinating services and setting precedents for future communication. Several solutions to recruiting and retention efforts have emerged over the course of time. First, the warden and several other high ranking administrators publicly announced their support for the program and refused to tolerate staff members who attempted to undermine it. Second, a member of the program staff was appointed to the classification board to review placement of incoming inmates. In addition, names of all inmates with histories of drug and alcohol use and appropriate sentence lengths are now forwarded to the program. Third, the director of the program regularly attends meetings with correctional supervisors. This allows her to combat anti-treatment philosophies among correctional staff. Fourth, a manual outlining security policies for program residents was jointly produced by treatment and correctional staff. This manual details procedures, policies, and organizational boundaries for all treatment and corrections staff. Fifth, the warden opened prestigious institutional jobs to senior residents of the program. This assisted in developing a pro-treatment correctional environment by reserving institutional privileges for women in treatment. With these changes, recruiting and retention efforts have improved dramatically.

Nonetheless, problems still remain that inhibit organizational communication and impact on program effectiveness. There continues to be a lack of a strong, authoritative liaison. The director of the treatment program has periodically assumed the role of liaison but has limited effect due to her position and alliance to the TC. Lack of a neutral liaison continues to generate territory disputes between treatment and corrections staff (McCorkel & Gluck, 1995). Further, while communication channels have improved, there is no established routine structure for interactions between treatment and corrections staff.

Second, although BWCI Village staff work with the prison administration in selecting appropriate candidates for the program, new residents continue to experience a culture shock as they enter the TC and progress through the orientation phase. Participating in a TC requires engagement, accountability, responsibility and a high level of activity, creating a very different setting than the typical prison. In general, residents find that they do not have the same degree of autonomy that they were able to maintain in the general prison population. Perhaps like other institutions, BWCI

sees itself as a caregiving institution. Staff has had difficulty recognizing that recovery is often a very difficult process; at times it is perceived by clients to be more difficult than life as a drug addict on the streets. Failure to create an environment that is truly "pro treatment" often leads incoming residents to perceive treatment as being a harsh form of punishment, increases attrition rates, and encourages staff to support clients to pursue less demanding and less effective activities.

Many of the new residents experience another type of transition when they enter the TC. A significant proportion of the women in the general prison population have been prescribed sedatives or other psychotropic medications. Women who enter BWCI Village are assessed on several dimensions, including current prescription drug use. It is the policy of the TC to run a drug-free environment. Although concessions are made for residents who truly need psychotropic medications, most prescription drug use is terminated upon entering the TC. Weaning new residents from unnecessary medication has required another level of coordination and communication between BWCI Village staff and the medical providers in the prison system. The consequences of withdrawing drugs also create treatment issues that must be addressed. Allowing women to act out in response to emotional issues, internal conflicts, anger and stress rather than sedating them is frequently a point of contention between treatment staff on the one hand, and the medical provider and prison administrators on the other. Fortunately, the TC is structured to address these situations by resolving the underlying issues causing the behavior.

Third, the prison continues to foster competition among treatment providers within the institution. The result is that many programs are interested in recruiting a specified number of clients to maintain external funding support. The BWCI Village program, because it involves nearly one-sixth of the prison population, was viewed as a threat to the existence of other service programs. Classification of inmates was often made on the basis of program numbers rather than actual treatment need. BWCI Village has attempted to mitigate this problem by allowing residents (following graduation from the orientation phase) to participate in other programs. While this has alleviated some of the problems of recruitment, the institution continues to foster competition among service providers.

The case of BWCI Village is extremely informative because it demonstrates that even programs which are modified to treat women offenders often face difficulty in recruiting and keeping them. Ultimately, this is the result of the program's relationship and coordination with the correctional institution of which it is a part. Failure to clarify organizational boundaries

and establish effective communication channels threatens to jeopardize recruiting efforts, retention, and individual treatment progress.

DISCUSSION

Although BWCI Village has faced many of the common barriers to implementing a TC, it has persevered and after its second year shows potential as a successful prison-based TC for women. The experiences at BWCI Village as well as other TCs for offenders provides beneficial lessons for others contemplating developing prison-based TCs. Some struggles of implementing a new TC can not be avoided. For instance, establishing the first cohort of experienced TC residents comes only with time and continuous effort in teaching novices the TC process. It is expected that many of the first admissions will not succeed in the TC and that it may take as long as a year before the first residents have progressed to a level of truly taking the responsibility of "running the house."

However, most of the barriers to implementation can be eliminated or at least diminished through careful and thorough planning. Planning and coordination are particularly important when developing a TC for offenders. Defining TC eligibility criteria, establishing the selection process, meshing prison release and treatment completion, and delineating between correctional tasks and treatment tasks must be beneficial and agreeable to both the prison and the TC. A strong authoritative liaison who understands both corrections and TCs is essential in both the planning and implementation phases. Cross-training between the TC staff and the correctional staff, including administrators, is integral to the success of a TC for offenders. Sufficient planning will also ensure that appropriate and necessary services, especially for women, are included in the TC program. And finally, hiring TC experienced staff and staff with a formal education whose experiences and training are complimentary is central to the success of the TC. The more the staff understands and has had experience with TCs the more quickly the TC will evolve.

Over the past several decades, the TC model has been adapted to serve women. During the same time period, the TC has been developed for offenders in a variety of criminal justice settings. And as the BWCI Village example demonstrates, the TC is also an appropriate model for women offenders. In establishing a TC for women in prison, both the adaptations necessary to serve women and the planning and coordination necessary for offenders must be accomplished to produce a viable and successful TC.

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