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Short-Term Impact Evaluation of the Lake County Adult Probation Women's Specialized Services Program

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Prepared by

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Professor of Criminal Justice and Psychology

Loyola University Chicago

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Table of Contents

List of Tables

Executive Summary

Numerous probation departments have created gender-responsive programming for women (see Ritchie, 2006). These programs provide clients with mental health (MH), trauma-related, and substance abuse (SA) treatment as well as coordination with other agencies that provide ancillary services to address the unique needs and problems of women (Bloom, Owen & Covington, 2005). Keeping with this nationwide trend, Lake County's women's specialized services program aims to provide a higher quality of supervision and services to women offenders who have suffered trauma through empowering the offenders to improve their mental health, familial and intimate relationships, and self-sufficiency so that they may lead productive law-abiding lives and also effectively parent their children in a safe environment. An integral part of this program is psycho-educational trauma counseling that provides participants with information on the nature and symptoms of trauma in their lives, on Post Traumatic Stress Syndrome and coping strategies, healthy and unhealthy relationships, parenting, and the community based resources and treatments that are available to address employment, educational, financial, child care, housing, physical health, and mental health needs. The program aims to prepare women to be more receptive to accepting treatment and service referrals, and through their participation in treatment and services empower women to become law-abiding productive citizens. Probation officers, in conjunction with the Assistant Director of Probation and the Mental Health Evaluator of the Psychological Services Division, select and refer women offenders to trauma counseling based on their traumatic experiences and resulting emotional and cognitive symptoms. This report describes the development of the program,

modifications to the program, and the impact of the program on referral rates, participation in referred services and treatments, compliance with probation conditions, and recidivism.

A quasi-experimental design using a comparable control group and three samples of trauma clients was used. Each of the three years of the women's specialized services program, substantial changes were made to the trauma counseling including the hiring of a new agency to conduct the trauma counseling and increasing the weeks of trauma counseling. Data were collected on all clients referred to trauma counseling. A comparable control group was selected by obtaining referrals from probation officers of clients who had similar traumatic childhood and interpersonal traumas, but were not referred to the trauma program. To assess the impact of the trauma counseling, clients who were referred to trauma counseling and did not show up or attended only one or two sessions were not included in the analyses. For all analyses, the final sample consists of 80 clients who completed psycho-educational trauma counseling (43 from the first provider and 31 from the second provider and 30 from the third provider) and 125 who were not referred or did not attend the trauma group but had a similar history of trauma.

The control group was a comparable sample to the overall trauma sample except in two respects. T Two differences are due to the structural design of the women's specialized services program: About 40% of the trauma group and only 21.8% of the control group participated in COG and 42.5% of the trauma group compared to 28% of the control group had a mental health assessment. Trauma clients also were more likely to be unemployed or have sporadic employment over the last twelve months and less likely to be employed full-time than control client. These differences in employment are a direct result of how the sample was drawn with the control sample having similar trauma backgrounds, but having logistical reasons such as a full-time job or the location of their residence as the reasons why they could not attend the

trauma counseling. The control group, however, did not consist of clients who attended one or two sessions of trauma treatment and then dropped out of the treatment. Trauma clients also were significantly more likely to have reported current alcohol use in the last six months than were control clients. Except for these differences, the trauma and control groups were comparable and did not differ on prior arrests, convictions, probation sentences, or previous incarcerations and past or current use of illicit drugs or prior substance abuse treatment. The differences that occurred between trauma and control group on mental health characteristics may be due to better recorded data for the trauma clients. Trauma clients were significantly more likely to indicate that they suffered from prior trauma and were on depression medication.

An initial evaluation of the program included the trauma counseling groups of the first and second service providers (see Stalans, Seng, & Lurigio, 2006). The substantive parts of the curriculum have not changed drastically from the second provider to the third provider, though there is an increased focus on providing referrals to the clients and individually tailoring topics to meet each group's specific needs. Topics for classes, which are discussed more in the first year report, include signs and symptoms of trauma, effects of trauma, how trauma affects their relationship with children and other adults, safety plans, identifying the women's basic needs, and discussing how to move beyond the past traumatic experiences. During the third year of operation, the developers believe that women have had more access to community-based referrals. Pamphlets and brochures are constantly available and are also handed out, and individuals receive on-going referrals upon request. Therapists estimate that each client receives about two or three referrals to community-based services. The developers believe that the third providers are doing a good job with referrals, but could improve by referring more clients to their own agency for substance abuse needs and focus a little more on substance abuse in the trauma

counseling. During trauma counseling, clients also learn several coping skills including relaxation, meditation, emotional regulation, and how to think about the costs and benefits associated with issues.

Under the operation of the third provider, the women's specialized program changed in several significant ways. Lake County Probation Department now has three women probation officers who have specialized caseloads consisting only of women offenders, which anecdotally has improved referrals to the trauma counseling program and case management of the trauma clients. Another change has been that the number of groups has decreased from three to two groups each year, which is a direct result of decrease funding. Each group consists of fifteen clients. Trauma counseling under the third provider expanded from 8 weeks to 10 weeks to allow adequate coverage of some topics that were particularly helpful to clients. Under the third provider, as a rule of thumb, at least three speakers from community agencies are brought in for each group. The topics and speakers are tailored to the clientele in each group, which is consistent with gender responsive services. The trauma counselors during the first session will ask the women clients about their needs to determine the speakers and topics for part of the classes. The most popular topics for speakers are domestic violence, sexual abuse, affordable housing, and employment. Another important change in the operation of the women's specialized program is that clients indicate their referral needs on their weekly evaluation forms and provide their contact information so that they can obtain the referral soon after their request for it. Clients may be referred to Psychological Services therapist for mental health, anger management, parenting and crisis counseling, and also receive additional referrals to programs of the Lake County Probation Department and/or community-based agencies.

During this third year of operation, the probation department has made more referrals to programs within the department. For example, some of the clients after successfully completing the trauma counseling are enrolled into a 22 weeks Moving On program that Lake County Probation Department operates, and some of the clients are enrolled in the parenting class that Lake County Probation Department operates. Another change is a more formal policy on how to handle clients who show up late for the trauma sessions. The new policy on lateness during the third year was "if the client is more than 15 minutes late, she typically will not be admitted to the session. Clients must inform the Assistant Director of Probation or their probation officer if they are going to be late and if they are late must provide a reason for their tardiness." If clients successfully complete the trauma counseling, they receive credit for 40 hours of community service. Successful completion of treatment is defined as attending seven of the ten week sessions. .

The trauma group clients as a whole were more likely to receive mental health services than the control group. Moreover, 23% of the trauma clients were referred for psychological counseling to the Lake County Psychological Services Division compared to only 2.5% of the control group; this difference occurs for the second and third year of the implementation of the program (the second (33%) and third provider (38.7%) agencies). The third provider (86.7%) compared to the control (64.9%) group provided a significantly higher percentage of clients with referrals. A significantly higher percentage of clients from the third provider (35.3%) than the control group (5.0%) received a referral to employment services. The clients in the third provider group compared to the clients in first and second provider group also were significantly more likely to be referred to only one or two substance abuse treatment services whereas the clients in the first and second provider groups were more likely to receive referrals to three or four substance abuse

agencies. Moreover, since the third provider received the contract, they have referred only 9.7% of the clients in the trauma group to substance abuse treatment at their agency, which is a significant decline compared to the 41.2% of the clients of the second provider group and the 47% of the clients of the first provider group. Trauma and control groups did not differ on referrals to address welfare or public aid, childcare, or domestic violence issues.

A high percentage of women, both in the control and trauma group, participated when given referrals for mental health, domestic violence, welfare, child care, substance abuse, employment services, and other types of referrals. The majority of probationers participated in mental health referrals, employment services, and substance abuse.

The third trauma provider group was significantly less likely (43.3%) than the control group (61.6%) to have a violation of probation petition filed, and only 10% of the third trauma provider group compared to 33.1% of the control group had their probation revoked. These findings may suggest that the probation officers have accepted the women's specialized services probation program and provide more informal sanctions for noncompliance. There was no significant difference between the control and trauma groups on the percentage of offenders who completed substance abuse treatment programs.

Although trauma clients have received a higher rate of referrals to employment services and mental health treatment, this greater access to help has not translated into many changes in their social lives, employment status, or mental health status. The trauma and control groups did not differ on positive urine tests, changes in social support or residential stability, changes in educational achievement or employment status, and satisfactory completion of mental health treatment or substance abuse treatment. The overall trauma group and the control group had similar rates of recidivism. However, after controlling for the amount of time at risk, the trauma

group of the second provider had a significantly higher rate of recidivism at 10 months and at 20 months than did the control group, and were significantly more likely to be arrested sooner than the control group. This finding may be due to initial relapse while in mental health and substance abuse treatment or differences between the 2nd provider trauma group and control group on dual diagnoses of mental illnesses or other unmeasured characteristics. In assessments of the impact on recidivism in the first 29 months during supervision, the trauma group does not show any significant reduction in recidivism.

However, future research will need to assess whether the trauma group shows any positive impact on recidivism. It is quite possible that the program has a greater impact for certain groups of offenders, and will show an impact on recidivism after clients' complete their needed services and treatment. The small sample sizes for each provider, unfortunately, do not allow examination within different groups, and examinations for the total trauma group are less informative when each year the trauma counseling was changed in ways that improved the quality of the specialized women's probation program. Future research will need to examine whether the program has differential impact for depressed clients, stimulant users, those who receive jail, those who have stable compared to unstable residences, and those who are caring for children.

Chapter 1: Introduction

Generally, the majority of offenders for all crimes are men. However, over the last several decades, women represent a larger proportion of persons arrested for crimes, suggesting a narrowing of the gender gap in criminal offending. Using Uniform Crime Reports data, Heimer (2000) found that the percentage of women compared to men arrested for all crimes except murder increased from 1960 to 1997. Although not all women arrested for crimes are convicted, over 1 million women are currently under criminal justice supervision in the United States, and 85% of these women offenders are sentenced to community supervision (Bloom et al., 2003). As of 2007, 969,533 thousand women were on probation and 96,887 women were under parole supervision. Women represented 23% of all probationers, and 12% of released inmates serving parole (Glaze & Bonczar, 2009). At mid-year of 2008, researchers estimated that 12.7% of inmates in jail were women (Minton & Sabol, 2009).

The significant percentage of women arrested and under criminal justice supervision has stimulated research on whether men and women commit crimes for different reasons, and have different risk factors for reoffending. Academics, corrections professionals, and the National Institute of Corrections have recognized that women and men offenders have different needs, different pathways to offending, and require different supervision strategies (e.g., Austin, Bloom, & Donahue, 1992; Bloom et al., 2003; Morash, Bynum, & Koons, 1998). In line with the empirical-based gender differences, probation departments have recently begun to enhance the effectiveness of supervision through increasing referrals to gender-responsive services and providing innovative psycho-educational programming so that women offenders may lead productive law-abiding happy lives (Bloom & Covington, 2001; Bloom et al., 2003).

Keeping with this nationwide trend, Lake County's women's specialized services program aims to provide a higher quality of supervision and services to women offenders who have suffered trauma through empowering the offenders to improve their mental health, familial and intimate relationships, and self-sufficiency so that they may lead productive law-abiding lives and also effectively parent their children in a safe environment. An integral part of this program is psycho-educational trauma counseling that provides participants with information on the nature and symptoms of trauma in their lives, on Post Traumatic Stress Syndrome and coping strategies, healthy and unhealthy relationships, parenting, and the community based resources and treatments that are available to address employment, educational, financial, child care, housing, physical health, and mental health needs. The program aims to prepare women to be more receptive to accepting treatment and service referrals, and through their participation in treatment and services empower women to become law-abiding productive citizens. Probation officers, in conjunction with the Assistant Director of Probation and the Mental Health Evaluator of the Psychological Services Division, select and refer women offenders to trauma counseling based on their traumatic experiences and resulting emotional and cognitive symptoms. This report describes the development of the program, modifications to the program, and the impact of the program on referral rates, participation in referred services and treatments, compliance with probation conditions, and recidivism.

Brief Review of Prior Research

Overall, as a group, women and men follow different pathways into and out of criminal activity. Moreover, women and men generally are arrested for different offenses. Women offenders are typically arrested for drug, property, or public order offenses, and only 15% are arrested for violent offenses (Bloom, Owen & Covington, 2005). Similarly, only 27% of female inmates have been arrested for a violent offense (James, 2004). Two key pathways to criminal offending are committing offenses to address poverty, or achieve greater economic resources than what can be achieved through legitimate means, and turning to crime through maladaptive coping strategies and life circumstances of individuals who suffer repeated trauma from childhood and adult victimizations.

Pathway: Rational Offending to Address Economic Marginalization

Men and women often turn to crime to compensate for the lack of opportunities to earn money from legitimate sources. Being economically disadvantaged and marginalized is a central reason why both women and men commit property crimes (Chesney-Lind, 2000). A majority of studies show that women are less likely than men to be employed when entering community supervision, prison, or SA treatment, and generally earn significantly less money if employed (Bloom et al., 2003; Pelisser & Jones, 2005). However, while under supervision or during reentry from prison, employment is related more to men's recidivism than to women's (Benda, 2005). Men are socialized early to define their self-worth around their work and achievements, and thus, lack of employment may affect their view of themselves and society, and they may seek alternative illegal ways of earning money for social status.

However, women's response to poverty reflects less opportunity to earn enough money to support their children through legitimate means, their greater need to support children due to

being single mothers, and the fact that prior abusive familial and intimate relationships contributed to their poverty (Chesney-Lind, 2000). Moreover, women offenders are more likely than men offenders to be the primary caretakers of children, with 70% of women probationers caring for minor children (Bloom et al., 2003; Greenfeld & Snell, 1999). Based on a sample of all discharged probationers, 46% of women probationers compared to 29% of men under supervision of a large urban probation department were living with minor children when they entered probation. Moreover, 13% of all women probationers were pregnant during probation (Buurma et al., 2001). In all jurisdictions, most women probationers who are primary caretakers of their children face parental responsibilities without a partner and need affordable childcare if they are to obtain or keep employment. In addition, many mothers need parental training, need public aid to support their children until they find a job that provides income above the poverty level, and need to establish a support network. Some research suggests that women probationers who have children are more motivated to change and lead law-abiding lives. Women offenders with illicit substance abuse histories were less likely to be arrested for a new crime while on probation if they were caretakers of children than if they were not living with children (Buurma et al., 2001).

In addition to affordable child-care, women probationers have needs for adequate housing, financial services, and vocational training (Lurigio, Stalans, Roque, Seng & Ritchie, 2006). In one large urban county, 63% of the male probationers received less than $15,000 annually and only 10% were receiving public assistance whereas 79% of women probationers were living on this amount of income and 36% were receiving public assistance (Buurma et al., 2001). Research, using statewide Illinois probation data, also has found that women compared to men probationers are more likely to have annual incomes below the poverty standard and to be

unemployed, even though 63% of both men and women probationers have a high school education (Olson et al., 2000). According to Seng and Lurigio (2005), the absence of affordable day care and the lack of financial and emotional support place heavy burdens on women probationers. Thus, women offenders compared to men offenders are more likely to be the sole caretaker of children, to live in poverty, and to be unemployed.

Pathways to Criminal Offending: Trauma of Interpersonal Victimization and Substance Abuse

Trauma from interpersonal victimization is a key pathway for women offenders; at least 40% of women offenders have a history of victimization (Bloom et al., 2003). Women offenders have much higher rates than men offenders of sexual and physical abuse as children and intimate partner violence as adults (see Bloom et al., 2003; Chatham et al., 1999; Langan &Pelissier, 2001). Each year, about 1.4 million women are physically assaulted, raped and/or stalked by an intimate partner compared to about 250,000 men (Tjaden & Thoennes, 2000). In a sample of women serving probation sentences, 22% reported intimate partner violence and 42% reported psychological or verbal abuse from their intimate partners in the last six months (Lurigio, Stalans, et al., 2004). Lifetime prevalence rates for sexual assault and intimate partner violence are even higher. Over one-third of adult women in national, general population surveys reported that they were victims of childhood sexual abuse (Kilpatrick & Resnick, 1993; Briere & Jordan, 2004). About one third of women in prison were victims of childhood sexual abuse and this abuse continued into adulthood whereas 11% of male inmates report childhood sexual abuse, but this abuse did not continue into adulthood (Chesney-Lind, 2000). Researchers, based on survey data, estimate that 14 to 20% of adult women will be raped and 8 to 24% of women will be stalked at some point in their lifetime (Beiere & Jordan, 2004). Moreover, women are more

likely to be survivors of multiple traumatic experiences such as childhood sexual abuse and adult intimate partner victimization (e.g., Hadar, 1998).

Based on feminist theories, trauma plays an important role in women's lives and choices because they are socialized to place importance on social bonding and relationship building. Research shows that women compared to men generally place greater importance on relationships and connections with other people, and may define their self-worth based in part on their relationships (Bloom & Covington, 2001; Miller, 1976; Gilligan, 1982). Bylington (1997) observed that "defining themselves as similar to others through relationships is fundamental to women's identities" (p. 35). Due to the priority women place on relationships, it is not surprising women's traumatic relationship experiences often contribute to eventual criminal activity. Social bonds with family and intimate partners are significantly are more likely to be related to women's criminal offending than men's (Alarid et al., 2000; Benda, 2005). Women offenders with children and law-abiding intimate partners are less likely to recidivate; those with histories of childhood abuse or a criminal partner are more likely to do so (Benda, 2005). As this prior research highlights, women's trauma from abusive familial and intimate relationships must be addressed so that they may choose the pathway of a law-abiding productive life. Without appropriate counseling and treatment, prior and/or current abusive relationships will continue to have adverse effects on their self-esteem and mental and social functioning (e.g., Benda, 2005; Bloom et al., 2003).

Link between Trauma and Substance Abuse

Women are more likely than men to start using drugs because of life crises, such as interpersonal victimization, and to use drugs to alleviate the pain of victimization (e.g., Chatham et al., 1999; Langan & Pelissier, 2001; Messina et al., 2000). The use of negative coping

strategies to alleviate the emotional, social, and economic trauma associated with sexual or physical childhood and adult victimization can be the impetus for women's criminal offending. The linkage between trauma and drug addiction suggests the need for integrating trauma and SA treatment for women offenders (Bloom et al., 2005).

Although women and men may differ on the primary contributory factors for SA, they are similar on the frequency or severity of SA (Pelisser's and Jones 2005). However, findings are mixed on whether substance-abusing women are more likely to be poly-drug users or to have more severe psychological problems (Pelisser and Jones, 2005). Findings are also inconsistent on whether women are more likely than men to remain in SA treatment (Greenfield et al., 2007). Further, women and men who complete SA treatment are more likely to abstain from substances if they receive ancillary services, such as housing, education, and employment (Grella, 2008).

A sizeable group of traumatized women have co-occurring needs in the area of substance abuse and emotional stability (Holtfreter & Morash, 2003). Traumatized women, especially those who experienced intimate partner violence or childhood sexual abuse, often start using or increase their use of alcohol and illicit drugs to cope with the traumatic experiences (see Kubiak, 2004). Moreover, longitudinal research supports that women increased their use of alcohol and drugs after their partners physically attacked them (Logan et al., 2002). The majority of battered women living in poverty also reported that they used alcohol, nicotine, and marijuana to cope with the violence and most reported that their substance use had increased after the violence (Eby, 2004). Furthermore, research suggests that battered women who develop post-traumatic stress disorder (PTSD) may have the highest risk of developing a substance abuse or dependence problem (Roberts, 2002). Research finds that 50% of women entering community-based substance abuse treatment also have PTSD; women with PTSD are more likely to relapse and

start using alcohol or drugs again after successfully completing substance abuse treatment than are women without PTSD (Kubiak, 2004).

Effects of Trauma on Women's Mental Health

As survivors of intimate partner violence or childhood sexual abuse, women suffer from lower emotional, mental, physical, and social functioning. Clinicians have found that many survivors of abusive relationship have post-traumatic stress disorder (PTSD), which is a mental disorder that occurs after a traumatic event that produces extreme fear, horror, or helplessness. It has four main categories of emotional and behavioral symptoms: (a) re-experiencing the trauma through intrusive memories, distressing dreams, and flashbacks; (b) reliance on avoidant coping strategies in an attempt to avoid thinking about the traumas (e.g., using alcohol or drugs, avoiding certain places or activities that trigger memories); (c) emotional numbing such as detachment from others, inability to experience positive emotions, and major depression; and (d) hyper-arousal as indicated by symptoms such as hyper-vigilance, overreactions to non-threatening behaviors or objects, anxiety, difficulty concentrating, and insomnia. In addition to PTSD, clinicians may use the diagnosis of complex PTSD when individuals have multiple severe traumas such as childhood sexual assault and intimate adult partner violence. Some research suggests that women with complex PTSD are less responsive to treatment (e.g., Kilpatrick & Resnick, 1993) whereas other studies indicate that trauma counseling is effective for women with complex PTSD (Hadar, 1998; Resnick et al., 2003). These inconsistent findings indicate the importance of examining which sub-groups of women are most responsive to trauma counseling to make recommendations on how referral decisions as well as case management plans can be improved.

Women are at a higher risk of developing PTSD because research shows women experience a greater number of traumatic events and have more intense symptoms of re-experiencing the trauma than do men (Kubany, 2004). Whereas 10.4% of American women in the general population will have PTSD at some point in the their lifetime, 45 to 84% of battered women in shelters or seeking help in counseling have PTSD (Kubany et al., 2004; Kessler et al., 1995). Furthermore, more than one-third of individuals diagnosed with PTSD still have the condition five years later whether treated or not treated for PTSD (Kessler et al., 1995).

Central cognitions that contribute to the intractability of PTSD are guilt and self-blame. Guilt is a very common emotion among intimate partner or sexual assault victims. Studies have found that 50 to 75% of sexually or physically abused women expressed moderate to large amounts of guilt about their victimization (Kubany et al., 2004). Their guilt extends beyond blaming themselves for "contributing to or allowing" the violence to occur, but also covers guilt about a failed marriage or relationship, about allowing the children to witness the violence, about their decisions to stay in the relationship, and other decisions such as using illicit drugs even if the batterer forced them to do so. Thus, programs should incorporate education and counseling to address the self-blame and guilt of abused women so that PTSD symptoms will be eliminated.

Half of women who have PTSD also will develop major depression. Moreover, major depression rarely occurs in the absence of PTSD in samples of battered women or rape victims (Resick, 2004). Traumatized women also frequently report more physical health problems and higher levels of stress than non-traumatized women (e.g., Eby, 2004). Common physical health problems include heart pounding or racing, headaches, sleep problems, muscle tension, poor appetite, severe aches and pains, ulcers, stomach pain, painful intercourse, chest pains, and low energy. Interestingly, the majority of battered women recognize that these psychosomatic

physical symptoms are the result of intimate partner violence (Eby, 2004). Some women probationers reported that referrals to address physical health problems improved the quality of their life the most (Lurigio, Stalans et al., 2004).

Probation Officers' Views about Women

Women programs historically have not been gender-responsive, with many neglecting intimate partner violence, trauma issues, and childcare needs (e.g., Marcus-Mendoza et al., 1998). Although many studies have shown that the experience of being in prison is markedly different for women and men (e.g., Greer, 2000; Pollack, 2002; Sharp, 2003; Stinchcomb & Fox, 1999), fewer studies have addressed whether probation officers' case management techniques have become more gender sensitive as more women have been placed on probation (Erez, 1989; Klosak, 1999). Lake County's program is consistent with the nationwide trend toward providing more gender-responsive services and supervision of women probationers to address needs that may be impediments to complying with probation conditions and leading law-abiding lives.

A few studies have now documented that probation officers generally believe that women offenders require more supervision time because of their greater needs for community-based services, their mental health issues, and women's desire to discuss their problems (Norland & Mann, 1984; Oregon Policy Group study, 1995; Seng & Lurigio, 2005). Probation officers indicated that women probationers consume an inordinate amount of officers' time with their complaints about "minor problems" and are interested in forming dependent relationships with probation officers (Norland & Mann, 1984, p. 127). As part of the evaluation study of the Cook County's Adult Probation Department's (CCAPD) promotion of women education and resources (POWER) specialized women unit, Seng and Lurigio (2005) interviewed a large sample of probation officers who supervised women offenders about their perceptions of and preparation

for dealing with women offenders. Probation officers reported that women compared to men probationers have greater needs for services that addressed intimate partner violence, parenting skills, vocational training, welfare and government supplements, training on how to budget and handle finances, and the need for affordable childcare and housing (Oregon Policy Group study, 1995; Seng & Lurigio, 2005; Lurigio, Stalans et al., 2006).

Whereas officers observed that the overall performance of men and women clients was similar, they viewed women as less likely to be arrested but as more difficult to supervise (Seng & Lurigio, 2005). Women and men probationers, based on probation outcome data in Illinois, had similar technical violation rates and probation revocation rates, but had modest significant differences in arrest rates and treatment noncompliance (Olson et al., 2000). While on probation, women were less likely to be arrested for a new crime (27% compared to 33%), but were more likely to dropout or fail to appear for court-mandated treatment (28% compared to 22%) (Olson et al., 2000). Women who are living with violent intimate partners may not comply with treatment especially substance abuse treatment because of threats and violence from their partners, which further highlights the need for trauma counseling (Roberts, 2002). Furthermore, probation officers reported that when women and men broke the same types of rules (e.g., failure to report to their officers), they were likely to do so for different reasons, which were gender-related (e.g., failure to report because of lack of child care).

Although probation officers recognize that women need gender-responsive services, they are often unprepared to offer referrals and facilitate women's utilization of community-based services. For example, two-thirds of Cook County adult probation officers indicated that they were unprepared to address women offenders' needs such as affordable housing and childcare, intimate partner violence, and financial services (Seng & Lurigio, 2005). Officers wanted

training to become more responsive to women's unique needs as well as acquire additional information about gender-specific needs and the availability of services. They also noted that an extensive and reliable resource network would help them handle women clients' problems more effectively (Seng & Lurigio, 2005). Officers also have reported that gender responsive services are often unavailable in the community or services are designed expressly for men probationers and are therefore less effective for women probationers (Oregon Policy Group Study, 1995). Similarly, Motiuk and Blanchette (1998) noted that risk assessment tools in probation are designed for men offenders and are inappropriate and ineffective for use with women offenders (see also Klosak, 1999). In a national survey, probation officers also reported it was difficult to work with women offenders "in a system designed to supervise the behavior of men" (Bloom et al., 2003, p. 24).

Prior Evaluations of Probation Programming for Women Offenders

Numerous probation departments have created gender-responsive programming for women (see Ritchie, 2006; Stalans, 2009), which involves integrative mental health (MH), trauma-related, and substance abuse (SA) treatment as well as coordination with other agencies that provide ancillary services to address the unique needs and problems of women (Bloom, Owen & Covington, 2005). According to a 2005 national survey of SA treatment programs, 41% provided special services for women clients , such as housing, employment assistance, child care, and other social services (Grella, 2008).

A core component of the diverse gender-responsive programs is the integration of trauma and SA treatment, supplemented with ancillary services such as parenting, childcare, and domestic violence. Several studies have evaluated integrated trauma and SA treatment programs and services compared to traditional SA programs for women (for comprehensive reviews see

Greenfield et al., 2007; Grella, 2008). For example, the Women, Co-occurring Disorder and Violence Study evaluated nine sites that provided integrated trauma-informed SA treatment for women with co-occurring SA and MH disorders and victimization histories. Women in the integrated trauma-informed SA programs, compared to those in traditional SA programs, were more likely to abstain from drug and alcohol use at six- (Coccozza et al., 2005) and twelve-month follow-up (Morrisey et al., 2006). Women in integrated treatment also improved on symptoms of post-traumatic stress syndrome at twelve-month follow-up (Morrisey et al., 2006).

The majority of women with substance use disorders are served in mixed-gender SA treatment programs, which generally provide fewer women-focused ancillary services than gender-sensitive SA treatment programs (Grella, 2008). Research supports the effectiveness of gender-responsive programming and its emphasis on women-only treatment groups. Women in women-only groups, compared to women in mixed-gender groups, stay in treatment longer and are twice as likely to complete treatment (Greenfield et al., 2007). In addition, women in women-focused SA programs have better drug outcomes and are less likely to be arrested at one-year follow-up than those in mixed-gender SA programs (Niv & Hser, 2007; for a review see Sun, 2006). Nonetheless, other research suggests that mixed-gender SA treatment leads to similar legal and drug outcomes as gender-sensitive treatment (see Greenfield et al., 2007).

Further research should investigate whether women-only SA programs are more beneficial for certain groups of women offenders than for others. Prior studies have not determined whether the effects of the specific elements of women-only programs, such as the provision of ancillary services and the degree of empathy and rapport with treatment providers are confounded with effects of group composition per se. For example, research has found that empathic counselors foster positive outcomes for women and men in SA treatment . The

guidelines of gender-responsive programming suggest that women clients who have female therapists have better outcomes than those who have male therapists. However, several other studies have found that matching clients with counselors on gender has no added benefit on treatment outcomes. Nevertheless, clients perceive same-gender therapists as more empathic and express more satisfaction with treatment than those with opposite-gender therapists (Greenfield et al., 2007; Grella, 2008).

Gender-specialized probation programs generally adopt case management models, and provide parallel, but separate treatment for trauma counseling and substance abuse treatment. These programs empower women to change their lives by referring them to community-based agencies for ancillary services to address their unique needs and trauma counseling to prepare and motivate them to participate in intensive MH and SA treatment (See Chan et al., 2005; Lurigio et al., 2005; Stalans, 2009). Women offenders in these specialized probation programs are often mandated to participate in traditional SA treatment. Evaluations of three different specialized women's programs have found no overall difference between women in specialized programs and those supervised on regular probation with respect to substance abuse or recidivism at six-month or one-year follow-up (see Chan et al., 2005; Lurigio et al., 2005; Stalans, 2009). However, in one evaluation, women probationers with prior incarcerations and a drug history were less likely to be arrested for a new crime while under probation supervision if they participated in a specialized women's program instead of being placed on standard probation (Lurigio et al., 2006).

The Lake County program differs in several ways from the specialized women's probation programs that have been evaluated. Instead of probation officers providing psycho-educational group counseling, professional therapists provide trauma counseling in the Lake

County program. Probation officers in the Lake County program also are not in a specialized unit and may have a regular large caseload, whereas POWER probation officers were in a specialized program with a reduced caseload. In the Lake County program, the professional therapists who provided the psycho-educational trauma counseling have the initial responsibility of serving as advocates for women offenders and facilitating their participation in community-based services during the initial two months whereas probation officers made referrals and monitored participation in the other programs. Lake County, similar to other probation programs, provides parallel trauma and substance abuse treatment rather than the integrative trauma and substance abuse treatment curricula that have shown some positive results.

Format and Purpose of Report

This report describes the short-term impact evaluation of the Lake County's women's specialized services program. Chapter 2 describes the evaluation design. Chapter 3 describes the implementation and development history of the program. Chapter 4 describes the description of the trauma counseling program and changes across time in the trauma counseling. Chapter 5 describes the short-term impact evaluation of the program.

Chapter 2: Evaluation Design

The impact evaluation centers around a comparable control group quasi-experimental design. Our initial plans to collect data from the probation files and case notes of 100 clients who participated in the psycho-educational trauma counseling ("trauma group") and a random sampled control group of 100 clients who did not participate in trauma counseling but had a similar history of traumatic experiences had to be revised due to substantive changes in trauma counseling that occurred in October of 2005 when a new service provider was selected. Because substantive changes including a new service provider were made, only half of the 100 cases from the original service provider were collected and the other half were collected from the second service provider. Our final sample consists of 211 clients with 125 control cases, 50 clients that completed the program from the first provider, 36 clients that completed the program from the second provider, and 46 clients who were referred to participate in the trauma program with the third provider. However to avoid contamination and weaken the potential effects of the trauma group, seven clients from the first provider and five clients from the second provider who attended only one or two sessions of the program were removed, and 16 clients from the third provider were removed. Of the sixteen clients removed from the third provider, eight of the clients were referred but never participated in any session, six clients only participated in 1 session, one client only participated in two sessions, and one client did not successfully complete the program and only participated in five of the ten sessions. Thus, our final sample for this initial one year evaluation consists of 80 clients who completed psycho-educational trauma counseling (43 from the first provider and 31 from the second provider and 30 from the third provider) and 125 who were not referred or did not attend the trauma group but had a similar history of trauma. In addition, due to the ethical guidelines about the confidentiality of

psychological records in research, the original sampling procedure was changed. The control cases were selected by having probation officers identify clients who had experienced trauma but had not completed the trauma counseling group; although the control group is not a completely random group of all probation clients it is representative of the probation clients with trauma who could have been referred and it is not overly biased by clients who were referred but did not show up for the trauma group. Most of the control clients were never referred to trauma counseling because they could not make the meeting time due to employment or transportation issues.

Research assistants coded probation officers' event records on referrals, violation of probation petitions, communication with community-based agencies and trauma counselors, probationers' missed office visits and noncompliance with treatment, positive drug tests, number of missed mental health visits, number and nature of referrals received, and whether participated in referrals for all of the third provider trauma clients as well as updated the data records for all clients who were active on probation at the time that data collection was completed during the first report. The data collection from the probation files was completed by April 11, 2008. The criminal history information was obtained on August 6th, 2008. Time at risk was calculated from the date of the start of probation to Aug 3rd, 2008.

The control group and trauma groups are compared on the following outcome measures and examine whether the trauma group increased these positive outcomes: (1) the rate of referrals to different types of services; (2) whether trauma clients were more likely to participate or show up at the services once they were referred; (3) whether trauma clients were more likely to attend mental health treatment for a greater number of months; (4) whether trauma clients were more likely to satisfactorily complete mental health treatment, participate in a higher

percentage of the substance abuse treatment referrals, and participate in substance abuse support groups. Analyses also tested predictions that trauma clients should be less likely to have these outcomes: (a) whether trauma clients were less likely to have a positive drug test; (b) number of missed scheduled office visits with their probation officers and mental health treatment; and (c) stability of residence, changes in employment and education. Finally, the trauma and control group are compared on new arrests for any crime, for property crimes, for drug or alcohol related crimes, and for violent crimes.

During this data collection, for all active cases research assistants updated the coded information to capture additional referrals, violation of probation petitions filed, missed office visits, positive urine tests, noncompliance with treatments, and satisfactory completion of treatment. Data are presented separately for the three providers because the content and nature of the program changed dramatically with each provider. Data also are presented comparing all three providers to the control group. Coded data from 230 (125 control, 105 trauma group clients) probation files including demographics, mental, substance abuse, and social support and probation outcomes including referrals, treatment compliance, violation of probation petitions filed, and new crimes.

Interview Data with Development Team and Therapists

Semi-structured open-ended interviews with the two key professionals who developed the program were conducted. The interviews focused on the nature of changes, barriers in operation, the goals, structure, and operation of the women's specialized program in the third year. Before the interviews, the developers of the program read a draft of the final report excluding the description of the program operation. The interviews also covered clarifying sections of the reports. The interviews lasted between 1.5 hours. Before these interviews, the researcher

reviewed the curriculum of the trauma program. Interviews with the therapists focused on the nature of the trauma counseling, curriculum, referrals, operation, and the therapists' educational experience.

Chapter 3: Program Development

This Chapter on Program Development was initially included in our final report for the first year of the evaluation. An updated version of the program development includes a description of the changes to the trauma counseling program during the third year. The Women's Specialized Services Program for female offenders was developed and is directed, by the Assistant Director of Adult Probation and a Mental Health Evaluator from the Psychological Services Division. The Assistant Director has a MA degree in management and has worked in the juvenile and adult divisions of Lake County Probation for 31 years. She has served as the supervisor of the domestic violence, DUI, and gender specific caseload units. The mental health evaluator has a Masters Degree in Clinical Psychology, and 20 years of clinical experience of which about half of her clinical time involved working with trauma survivors. Her background is cognitive-behavioral therapy and psychometrics, and her job responsibilities include testing, diagnostics and making recommendations for treatment. The development team has developed an expertise in women offenders through researching various programs and the academic literature as well as through their job experience; the two different backgrounds of the developers provide beneficial collaboration in responding to the continual development of the program and addressing program operation issues. The program is formally known as the women's specialized services program and the two developers work as a team.

The program had its genesis in observations by the team that numerous women probationers were victims of multiple traumas but were not receiving treatment or any real services related to trauma. If they were referred to services in the community they either did not go or the community-based services found that the women probationers did not fit their service population. While some of these women were participating in a department–run Cognitive

Orientation Group (COG) program, it was clear that additional, more trauma focused services were needed. In early September, 2003, the Chief of Probation informed his department that funds were available through the Illinois Criminal Justice Information Authority for special programming in probation. The team designed and developed the women's trauma program and wrote a grant proposal, something neither team member had done before.

Based on their review of the literature that supported a link between trauma and offending behavior and provided some idea of program models, the team developed a grant proposal based chiefly on contractual services for an educational program for women probationers with a history of single or multiple traumas, such as sexual abuse, domestic violence, or other violence-related traumas. Conceptually, the program was seen as being a doorway to treatment through providing psycho-educational counseling and individually-tailored referrals.

Overview of Program Goals

Based on program documents and conversations with the team, the developers of this program had several goals that they believed the psycho-educational counseling for trauma symptoms and (the effects of trauma on the lives of women offenders) could achieve. The psycho-educational counseling is not "treatment", but it does provide some positive coping and relaxation skills that may reduce the symptoms of trauma, the abuse of alcohol and illicit drugs, and the inability to meet daily living demands. While, of course, the program's ultimate goal is to reduce recidivism and increase compliance with probation condition, there are several intermediate goals that may increase the chance that overall recidivism and noncompliance among participants would be reduced.

Program Goals:

- To have probation officers at Lake County Adult Probation believe that the specialized women service program will have an impact on women offenders' compliance with probation. Probation officers will make referrals to the program and will become increasingly aware of trauma history of women offenders.

- To provide quality psycho-educational groups for female probationers identified as having experienced trauma and provide two months of advocacy so that women obtain the referrals to community-based agencies that they need and have more motivation and understanding to participate in the treatments and services that they need to lead more productive law-abiding lives.

- To have psycho-educational groups provide participants with information on the causes and effects of trauma in their lives with explanation of Post Traumatic Stress Syndrome and the treatments available to them.

- To help participants recognize the need for treatment and become "treatment ready" and to encourage participation in treatment. Thus, of probationers referred to various types of agencies, the trauma group compared to the control group will have a higher percentage that go to the agency and participate. Moreover, the trauma group will have a higher percentage that successfully completes mental health counseling or substance abuse counseling.

- To increase the number of referrals given to women offenders such that the trauma group compared to the control group will have a higher percentage of clients receiving referrals to a variety of agencies

- To provide individually tailored referral plans for women who complete the trauma psycho-educational counseling group

- To establish linkages between the participants and existing mental health services in the community as needed.

- To have probation officers monitor and assist in establishing successful linkages to mental health services and other community-based agencies in the community. Thus, based on coding of event records in the trauma group, the probation officers should have frequent communication with community-based agencies. The probation department will have an up-to-date list of referral agencies with current contact numbers, names, and addresses. Community-based agencies will have knowledge of the specialized service program for women offenders at Lake County Probation.

- To implement the program in a timely and efficient manner

- To reduce substance abuse through clients' greater understanding of the effects of trauma and more positive coping skills as well as greater willingness to participate in and

This description of intermediate goals is based on interviews with the development team. The development team consisted of the Assistant Director of Adult Probation and a Mental Health Evaluator from the Psychological Services Division of the Administrative Office of the Nineteenth Judicial Circuit (see www.19thcircuitcourt.state.il.us/psyserv/psyc.htm#missionreport for more information on organization and services of the Psychological Services Division). Our interviews with the developers and reading of the grant reports have allowed us to outline the history of how the program was developed.

History of Program Development

The grant document was submitted to the Lake County Board in November 2003 and matching funds approved with the condition that contractual services were to be secured through a formal bid process. The team developed an RFP issued in January, 2004 and held a pre-proposal meeting on February 5 attended by eight interested service providers. However, only two proposals were received by the deadline date of February 19. Following a standard county bid review procedure, both proposals were assessed and evaluated, and the proposal from the first service provider was selected on March 19, 2004. The agreement (number 401107) between the Probation Department and the Illinois Criminal Justice Information Authority was signed on April 4, 2004.

The program is funded with Federal Anti-Drug Abuse Act funds administered by the Authority. The Authority administers grants within seven program areas. The women's specialized service program (a.k.a. "trauma program") is funded from program area 3 which is

designed "to support programs that enhance treatment effectiveness, quality and services so that those who need treatment can receive it."

Administratively, the program is "housed" in the probation department with the Assistant Director of Probation reporting to the Chief Probation Officer and the Mental Health Evaluator reporting to the Chief of Psychological Services. It should be noted that the lengthy delay between grant development and actual signing of the agreement, in this case about a seven month process, is, in our experience, quite normal. Table 3.1 provides a description of the key milestones in the development of the program. In the following paragraphs, we highlight the central events that describe the history of the development of the program.

Following planning meetings with the staff of the first service provider,[1] the program began formal operation with the first trauma group meeting on June 2, 2004. The first group was to have 25 members and to consist of six weekly meetings. A number of problems developed with the operation of the trauma groups. Initially, there were insufficient referrals to the program from probation officers due to a number of factors. Some officers were not in tune with the needs of female probationers and saw no need for the program. More importantly however, was the quality of probation officers' training provided by the first service provider in July, 2004. According to the team, the training content was too simplistic for the experienced, competent and professional probation officers that constituted the staff of the Lake County Adult Probation Department. In essence, the officers became more resistant to the program due to the quality of the training. In addition, not unexpectedly, many women probationers were reluctant to participate and group attendance was sporadic. However, those who did attend found the experience positive.

[1] Given that only one service provider was selected at that time, we have decided not to reveal the name of any service providers in our reports.

Table 3.1 Key Milestones in Development of the Women's Specialized Service Program at Lake County Adult Probation Department

Summer 2003	Team identifies need for special trauma program for women offenders
September, 2003	Chief Probation Officer identifies the Illinois Criminal Justice Information Authority as a potential source of funds for such a program.
November, 2003	Grant proposal written by program team and submitted first to the Lake Country Board for approval of matching funds
January, 2004	First RFP developed to obtain service providers for psycho-educational trauma counseling.
March, 2004	First service provider selected to provide psycho-educational trauma counseling
April, 2004	Funding in the amount of $22,386 awarded as grant number 401107 from the Illinois Criminal Justice Authority for the period October, 2003 to September, 2004
June, 2004	First trauma group run by first provider.
July, 2004	Probation officer training provided by first provider.
August, 2004	Second trauma group started by first provider
October 2004	Third trauma group started by first provider
October, 2004	Continued funding via grant number 43107 in the amount of $33,425 for the period October 2004 to September, 2005
January, 2005	New provider sought due to internal staffing problems uncovered at agency providing the psycho-educational trauma counseling
February, 2005	Fourth trauma group started by first provider.
March, 2005	New RFP developed and pre-proposal meeting held.
May, 2005	Second provider selected. Group size reduced to 15 from 25, and number of sessions increased from six to eight.
August, 2005	First group by second provider; the team and one probation officer routinely attended the group and participated.
January, 2006	Final funding via grant number 404107 in the amount of $58. 495 for the period January 2006 to September 2007.
February and March 2006	Second group conducted by second provider; group sessions are increased from six to eight and probation staff do not attend sessions except for first five minutes and last five minutes
July 2006	Third group started by second provider; group sessions are not attended by probation staff except for first and last five minutes.

The first service provider conducted four groups. According to quarterly reports on file with the Authority, three of the groups met in 2004. The first group met from June 2 to July 7 with 23 women referred and 15 completing; the second met from August 4 to September 8 with 27 women referred and 10 completing; and the third met from October 20 to November 23 with 25 referred and 15 completing.[2] The final group met from Feb and March of 2005. The trauma psycho-educational counseling groups were renamed the "women's specialized services group" to avoid any stigma attached to attending a trauma group and also to allow for future provision of multiple services to women offenders.

In January, 2005, due to a number of internal staffing problems at the agency running the trauma groups (i.e., first service provider), it was decided to seek another service provider. A new RFP was issued March 22, 2005 and a pre-proposal meeting attended by seven potential providers was held on March 31. Several proposals were received and after a rigorous proposal review procedure, the second service provider was selected. The contract was signed May 26, 2005.

A number of significant changes in the program were included in the new contract. Groups were to be smaller, 15 rather than 25, allowing for better use of information and more individual attention to participants. The number of group sessions was increased from six to eight and a greater emphasis placed on outreach services during the group itself in order to respond to the numerous crisis situations encountered by women probationers. Finally, probation officer training was not included in the contract.

[2] In order to obtain these numbers from the statistical data provided by the developer, the criteria for completing for the first group is three of the six classes, for the second group it would have to be at least five of the six classes, and for the third group it would have to be at least four of the six classes. Thus, there appears to be no firm rule on what constitutes completion during this first year of implementation.

The new contract was signed on May 26. In addition to the above noted changes, two other important procedural changes occurred at this time. It was decided to have the team conduct pre-group orientation meetings with potential group participants to review program rules, deal with transportation, absenteeism, tardiness and other practical issues so the group could immediately begin with its content and focus. Also, a female probation officer volunteered to supervise a caseload of only women offenders. In August 2005, the 1st group of the second provider met.

At the end of the third group of the second provider in September 2006, the lead therapist of the second provider announced that she had obtained employment elsewhere. For several reasons, probation wrote a RFP to obtain bids from service agencies who were interested in providing the trauma counseling and providing referrals to agencies so that women clients' basic life survival and skill needs such as housing, childcare, and so forth were addressed. The third provider was awarded the contract, and began its first group on the 28th of March of 2007. The first group sessions ended on June 6th, 2007. The second group of the third provider was conducted between July 11th, 2007 and September 12th, 2007. The third group of the third provider was conducted between February 20th, 2008 and April 23rd, 2008.

Probation Officers' Support for Program

The team noted that probation staff appears supportive of the women's specialized services program and resistance has waned. Eight different probation officers referred women to the first group and nine different probation referred women to the second group, and eleven different officers referred women to the third group with the second provider, suggesting, as the team concluded, that resistance to the program has waned. They were particularly impressed with the attitudes of some male probation officers who seemed especially sensitive to women's

trauma issues. In fact, of the 18 probation officers who have referred cases to the program, 12 are male probation officers. The referring officers, that we interviewed, reported that it is a good program (of course, officers who have not referred cases may have a different opinion). Based on interviews with the 15 referring officers, a majority of the officers (57.1%) believed the program was helped their clients learn to deal with trauma. Three officers rated the program as very helpful, one rated it somewhat helpful and two found it not helpful at all. One did not answer the question. Overall, most officers (76.9%) rated this as a good program, three rated as excellent, and one as fair. Two did not answer the question. Thus, for the most part, the referring officers' opinion of the program was positive. Opinions about the degree to which this program was effective at reducing women offenders' recidivism were mixed. One rated it as very effective, ten effective to moderately effective and two stated it was too early to tell. Two did not answer the question. Based only on the probation officers' surveys, which were conducted during the second year of the program, it appears that the officers' support for the program increased over time. Based on interviews with the developers after the third year of operation, they noted that officers were more insistent that their clients attend trauma group sessions and the officers are stricter when clients miss sessions.

Conclusions

Program development occurred without undue delays. The developmental history also shows that the program developers were flexible in having the program evolve to meet the goals of the program. Initially there were insufficient referrals to the program by probation officers due in large part to the substandard training provided by the first service provider. The probation officers' initial resistance appears to have waned, and based on interviews the program appears to be accepted by the probation officers that have referred cases to trauma counseling.

Chapter 4: Description of the Women's Specialized Program during the Third Year of Operation

This chapter provides a description of how the psycho-educational trauma counseling and Women's Specialized Services Program operated during the third year since implementation. A prior report provides a description of the program has it operated during the first two years (see Stalans, Seng, & Lurigio, 2007). The description of the third year of operation is based on interviews with the facilitators of the trauma psycho-educational program as well as the development team of the Women's Specialized Services. In 2007, a new service agency was contracted to provide the psycho-educational trauma counseling. The service agency is well-established in the community and specializes in dealing with women who have both substance abuse and mental health problems, and it also had experience providing services to women who were being supervised on probation. Based on the archival data, probation officers have referred many women clients to this agency. In the sample of control and trauma clients, 41.6% of the women clients had received a referral to the service agency that was contracted to run the trauma program during the third year. According to the program developers, the agency also is very familiar with community-based agencies that address the basic life needs of these clients. Based on the interview with the director of this agency for the community-based survey part of this research in July of 2006, the agency does provide services that address the unique needs of women, and could handle additional referrals of women offenders serving probation sentences at Lake County Adult Probation.

During its third year, the psycho-educational program has continued to keep some of the similarities of the program as it operated under the other two service providers. Table 4.1 provides a description of the common features of trauma counseling across the three service providers.

Table 4.1. Common Features of Trauma Counseling

Category	Brief description of feature
Number of facilitators	All providers used two therapists to facilitate the group.
Partnership with probation officers	Assistant Director of Probation served as the main probation contact for therapists. The majority of probation officers never had verbal contact with the therapists.
How officers encouraged clients to participate	Majority of probation officers used incentives to encourage participate and few officers used sanctions. Clients who complete trauma counseling receive credit for 40 hours of community service hours.
Probation client management	The developers consistently showed up during the first and last five minutes of group to handle crises and issues.
Written policies	Probation developed the policies on lateness, excused absences, and termination due to too many absences.
Goals of trauma counseling	From the service providers' perspectives, to provide information to clients about the symptoms and effects of prior trauma and through this increased understanding to motivate clients to accept mental health treatment and other resources in the community and to provide such referrals when clients were ready to participate either while attending group or after all groups were completed.
Topics covered in group	Information about post-traumatic stress, healthy/unhealthy relationships, parenting issues and resources in the community were presented by providers, and the development team suggested these topics which therapists also agreed were important
Meetings with development team to discuss topics for the group	After the end of each group, the development team and providers would meet to discuss changes in the topics or the materials to insure that some consistency was maintained from group to group and to make any necessary changes to obtain the most informative and effective topics.

Two facilitators conduct the trauma psycho-educational counseling together. Though the first two service agencies used the same facilitators for all sessions, the third service agency has two facilitators that regularly conduct the group and has trained two other therapists to serve as a replacement facilitator if one of the regular facilitators cannot make the group. The two alternative facilitators have both watched group sessions and have been introduced to the women clients. The therapists are very experienced and educated. For example, the therapists have much training, including 40 hours of training in domestic violence, 40 hours of training in sexual

abuse, licensed alcohol and substance abuse counseling. Formal educational achievement is also impressive with a M.A. degree in Human Services, and also almost completion of a Ph.D. in counseling psychology.

The goals of trauma counseling have remained the same. The psycho-educational counseling seeks to inform women of the symptoms and effects of prior traumatic events and to provide clients with referrals to community agencies and probation programs that will address their basic life needs, their mental health needs, and their substance abuse issues. However, the third provider also allows the clients to develop goals and aspirations that the trauma counseling can achieve. For example, clients have suggested goals such as sleep at night, reduce relationship problems, control their anger, and reduce substance abuse.

The substantive parts of the curriculum have not changed drastically from the second provider to the third provider, though there is an increased focus on providing referrals to the clients and individually tailoring topics to meet each group's specific needs. Topics for classes, which are discussed more in the first year report, include signs and symptoms of trauma, effects of trauma, how trauma affects their relationship with children and other adults, safety plans, identifying the women's basic needs, and discussing how to move beyond the past traumatic experiences. During the third year of operation, the developers believe that women have had more access to community-based referrals. Pamphlets and brochures are constantly available and are also handed out, and individuals receive on-going referrals upon request. Therapists estimate that each client receives about two or three referrals to community-based services. The developers believe that the third providers are doing a good job with referrals, but could improve by referring more clients to their own agency for substance abuse needs and focus a little more on substance abuse in the trauma counseling. During trauma counseling, clients also learn

several coping skills including relaxation, meditation, emotional regulation, and how to think about the costs and benefits associated with issues. The providers describe the psycho-educational counseling has very structured. The trauma counseling provides both information and social support. Women clients support each other emotionally and validate each other's feelings. The third provider conducts a healing circle where each client is asked what they are bringing to the circle and each client notes a positive attribute that they are bring to the circle. Social support is also provided through the formal structure of the program; there is a graduation ceremony where each client receives a certificate and everyone brings food for the congratulatory celebration after the graduation.

The flow of referrals of women to trauma counseling is still slow, and it has been difficult to identify women early during their probation sentence that will benefit from trauma counseling. The referral process is still very informal. However, Lake County Probation Department now has three women probation officers who have specialized caseloads consisting only of women offenders, which anecdotally has improved referrals to the trauma counseling program and case management of the trauma clients.

Under the operation of the third provider, the women's specialized program changed in several significant ways. One important change has been that the number of groups has decreased from three to two groups each year. Each group consists of fifteen clients. This decrease is the direct result of a decrease in program funding. Table 4.2 provides a description of the trauma counseling for the first two providers, which provides a reference for comparison

Table 4.2 Changes in Trauma Counseling Across the First Two Service Providers

Characteristic	First Service Provider	Second Service Provider
Length of group	Six weeks	Eight weeks
How successful completion is defined	During the first year of implementation, the number of sessions that clients could miss and still be successfully completed varied from 1 to 3 of the 6 sessions.	During the second year, the rule for successful completion became firm and clients were considered successful if they completed 6 of the 8 sessions.
Number of clients referred for each group	25	15
How therapists present information	"collective, primarily group discussion, and move through the material together, also generate peer support"	Balance of educational material and discussion; clients offer information about services in the community and peer support may naturally develop but it is not a primary goal of therapy
Who is therapists' primary client	The probation program and its staff are my primary clients and their interests come first	The offender is my primary client and her interests come first
Follow-up advocacy	The two months of advocacy was not formally established and therapist had contact only on an as needed basis.	All clients are assigned a caseworker and have up to three months to complete the eight individual sessions that they have with their caseworker. Advocacy can beginning while clients are still completing the eight weeks of trauma counseling, but many clients will wait until after trauma counseling is completed.
Nature of trauma counseling	The counseling had more of a support group orientation and information about trauma was a secondary goal.	The counseling was psycho-educational and the emphasis was on teaching clients about trauma. Personal experiences were brought up by clients, but it was not a focus to provide therapeutic support.

and how the program has changed over three years. The changes during the third provider are compared to the second provider in the following text.

Trauma counseling under the third provider expanded from 8 weeks to 10 weeks to allow adequate coverage of some topics that were particularly helpful to clients. This is a very important changes that may lead to more impact of the program because other research has shown that the longer clients are in counseling the greater the impact of the counseling (Hader, 1998).

Under the third provider, the content of the program has changed to include regular speakers from community-based service agencies that address domestic violence, sexual assault, and housing, which allows women with specific needs to be referred to resources. While operating under the other providers, speakers from outside agencies also were brought in, but the inclusion of speakers has been incorporated more permanently into the curriculum. As a rule of thumb, at least three speakers from community agencies are brought in for each group. The topics and speakers are tailored to the clientele in each group, which is consistent with gender responsive services. The trauma counselors during the first session will ask the women clients about their needs to determine the speakers and topics for part of the classes. The most popular topics for speakers are domestic violence, sexual abuse, affordable housing, and employment.

Moreover, gender-specific substance abuse program is provided by the agency that runs the trauma groups, and a gender-specific substance abuse program has been implemented in the western part of Lake County so that clients who live in this area do not have to travel as far to participate in substance abuse treatment. Another important change in the operation of the women's specialized program is that clients indicate their referral needs on their weekly

evaluation forms and provide their contact information so that they can obtain the referral soon after their request for it.

The therapists in conjunction with Psychological Services of Lake County conduct an evaluation of each client during the 6th week and any additional referrals, if needed, are given. As in previous years of operation, during the last week session, the therapists in conjunction with the Psychological Services developer meet individually with each client and provide additional referrals. As in previous years, there is no formal advocacy or crisis management after successful completion of the trauma counseling. Clients may be referred to Psychological Services therapist for mental health, anger management, parenting and crisis counseling, and also receive additional referrals to programs of the Lake County Probation Department and/or community-based agencies.

During this third year of operation, the probation department has made more referrals to programs within the department. For example, some of the clients after successfully completing the trauma counseling are enrolled into a 22 weeks Moving On program that Lake County Probation Department operates, and some of the clients are enrolled in the parenting class that Lake County Probation Department operates. Another change is a more formal policy on how to handle clients who show up late for the trauma sessions. The new policy on lateness during the third year was "if the client is more than 15 minutes late, she typically will not be admitted to the session. Clients must inform the Assistant Director of Probation or their probation officer if they are going to be late and if they are late must provide a reason for their tardiness." If clients successfully complete the trauma counseling, they receive credit for 40 hours of community service. Successful completion of treatment is defined as attending seven of the ten week sessions.

Conclusions

Over the last three years, the psycho-educational trauma counseling has changed in significant ways that have improved the quality of the counseling program. The developers of the program have strived to improve the curriculum and structure of the psycho-educational trauma counseling, and have been an integral part of the case management of clients who attend trauma counseling. The changes in the psycho-educational trauma counseling have been very responsive to the unique needs of women offenders, and have moved in the direction of providing more individually tailored referrals as well as some group sessions that are tailored to a particular groups needs. Thus, as the program has developed, the changes have met the original idea of providing psycho-educational trauma counseling with individually tailored referrals that would encourage women to have more positive, productive, and law-abiding lives. One important change has been that the length of the program increased from 6 weeks to 8 weeks and then to 10 weeks in the third year. This expansion of the curriculum reflects in part the clients' desires to have additional counseling and information, and speaks highly of the program and its responsiveness to clients' needs and desires. Anecdotally, the clients who complete the program express much satisfaction with the program, which may motivate the clients to continue in mental health and substance abuse treatment programs. Another important change was the creation of more firm policies on lateness so that the psycho-educational trauma counseling could be conducted without undue interruptions or disruptions. Finally, another important change was that clients receive the referrals soon after they request them and do not wait for the evaluation or assessment before graduation. All of these changes suggest that Lake County's psycho-educational trauma counseling may serve as a model for other counties as it continues to develop.

Based on the interviews with the developers of the program, one recommendation for change in the future would be to provide a greater number of trauma clients with referrals to the third providers' substance abuse treatment program. This recommendation is in keeping with the development of substance abuse programs that have integrated psycho-educational trauma counseling. For example, standardized curricula have been developed that integrate substance abuse treatment and trauma counseling. These standardized curricula may provide additional ideas for improving the current psycho-educational trauma counseling that is offered. Two such curricula are Helping Women Recover: A Program for Treating Addiction (HWR) and Beyond Trauma: A Healing Journey for Women (BTHJW) (Covington et al., 2008). Helping Women Recover (HWR) is a seventeen session curricular that has four modules, which are self, relationships, sexuality, and spiritually. The four modules represent areas that women offenders have identified as triggers for relapse (Covington et al., 2008). An increase of referrals to the third providers' substance abuse treatment programs may enhance the impact of the trauma psycho-educational counseling and the substance abuse treatment.

Chapter 5: Impact Evaluation

In Chapter 5, the trauma and control groups are first compared on demographic, social background, mental health, substance abuse, criminal history and court ordered probation conditions. This comparison determines how comparable the control and trauma groups are on these characteristics to rule out alternative explanations for any differences between the trauma and control groups on the outcome variables.

Comparison of Trauma and Control Groups: Comparable Samples?

It is necessary for the control and trauma groups to be comparable so that alternative explanations for differences between the trauma and control group on outcome measures can be eliminated. Where the groups were not comparable on a characteristic and the characteristic was related to an outcome, the effect of this characteristic is controlled in multivariate analyses. Statistically controlling for this difference provides more confidence that the outcome difference is due to the women's specialized services program; however, it is not foolproof.

Table 5.1 presents data in columns two and three a comparison of the combined trauma groups to the control groups on substance abuse characteristics. Columns four, five, and six presents data separately for the three different trauma providers. As shown in Table 5.1, the trauma groups and the control group do not differ for the substance use and abuse characteristics, except for current use of alcohol. The trauma group (59%) compared to the control group (26%) were more likely to be using alcohol in the last six months. Clients were defined as currently using alcohol or illicit drugs if they had a positive urine test, had admitted usage to or were detected by the probation officer or a therapist, or if recently placed on probation admitted current illicit drug or alcohol use on their intake form.

Table 5.1 Comparison of Control and Trauma Groups on Substance Use and Abuse with Non-Attendees Removed

Characteristics (Percentage with Characteristic indicated in the Row)

Substance Usage	*Trauma Group*	*Control Group*	*Trauma Group: First Provider*	*Trauma Group: Second Provider*	*Trauma Group: Third Provider*
Using Alcohol***[1]	59.2% ***[2]	25.8%	57.5%	50.0%	71.0%
Substance abuse Problem	74.8%	80.8%	76.7%	77.4%	71.0%
Prior Substance Abuse treatment	60.2%	60.7%	61.9%	46.7%	69.0%
Past use of Marijuana	82.1%	77.4%	81.4%	77.4%	86.7%
Past use of Cocaine, Heroin, or other stimulants	62.6%	57.3%	67.4%	54.8%	64.5%
Currently Taking Illicit Drugs	43.0%	28.8%	44.2%	32.3%	51.6%
Currently using Cocaine, Heroin, other Stimulants	69.2%	55.6%	78.9%	80.0%	57.1%
Currently using Marijuana	53.8%	63.9%	47.4%	70.0%	57.1%
Currently using Tranquilizers or Pain Killers	5.8%	2.8%	0%	10.0%	9.5%
Currently using Other Drugs	2.9%	3.2%	2.4%	3.2%	3.2%
Under the influence of drugs/alcohol time of the offense	53.5%	63.1%	56.1%	44.8%	58.6%

$^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$; p-values indicate that the difference between the two groups is statistically significant and therefore can be interpreted as a real difference with only a small chance of being wrong (e.g., .05 means a 5% chance that the difference is not real but due to random chance fluctuation).. [1] $\chi^2(3) = = 28.871$, $p < .001$; [2] $\chi^2(1) = 25.979$, $p < .001$.

Based on data from probation case files and event records, overall 35.2% are currently using illicit drugs. The majority of trauma (74.8%) and control clients (80.8%) have a substance abuse problem. Across the total combined control and trauma sample, 58.8% of the clients were under the influence at the time of their crime and 60.1% had prior substance abuse treatment.

Overall, 79.4% have used marijuana and 59.8% have used stimulants in the past. Thus, it is not surprising that 75.8% of the women were required by the court to seek substance abuse treatment as a condition of their probation (see table 7.5 for probation conditions).

Table 5.2 provides data on mental health characteristics for the trauma and control groups. Several differences in mental health status are statistically significant. Consistent with the criteria for inclusion into the trauma and control groups, in most clients' probation files there was information related to prior trauma from intimate partner violence, previous childhood physical or sexual violence, witnessing domestic violence as a child, or adult sexual violence. For the remainder of the cases, this information was not found in the files, but probation officers indicated that the control or trauma clients had prior traumatic experiences. Overall, 55.7% of clients in the trauma and control groups had prior mental health treatment, and 39.1% of the clients satisfactorily completed some mental health treatment (not counting the psycho-educational trauma counseling). The percentage of women who are currently in a relationship where their intimate partner is physically violent toward them is 32.9%; this information was based on data from their intake interviews and supplement with information from their records of communications with probation officers. This percentage is consistent with data from large randomly selected samples of adults in the U.S., which estimates about one-third of the population has experienced domestic violence (see LaViolette & Barnett, 2000). According to the first national survey of probationers, conducted in 1995, 41% of women on probation experienced either physical or sexual abuse, and almost 20% experienced both (Greenfeld & Snell, 1999). However, the finding that one-third of probationers are currently experiencing

Table 5.2 Comparison of Control and Trauma Groups

On Mental Health Characteristics with Non-Attendees Removed

Characteristics	*Control Group*	*Trauma Group*	*Trauma Group: 1st Provider*	*Trauma Group: 2nd Provider*	*Trauma Group: 3rd Provider*
Victim of Domestic Violence in the Last Six Months	28.6%	31.7%	36.6%	38.7%	38.7%
Witness Physical or Sexual Abuse between Parents** [1]	27.7%	37.6%	47.1%	50.0%	17.2%
Previously Diagnosed Post-Traumatic Stress Disorder	19.4%	33.7%*[2]	31.7%	32.3%	36.7%
Suffered from Prior Trauma*[3]	83.2%	93.5%*[4]	100%	93.5%	90.3%
Prior Mental Health Counseling or Treatment*[5]	53.6%	58.1%	47.6%	51.6%	80.0%
Currently Depressed	53.6%	64.5%	67.4%	67.7%	61.3%
Currently Taking any Medications for Depression*[6]	39.4%	51.1%	71.0%	39.3%	44.8%
Discontinued Treatment before Completion**[7]	17.3%	27.6%	52.9%	20.0%	13.3%
Completed any Mental Health Treatment	44.6%	31.9%	29.2%	35.7%	31.2%

* $p < .05$; ** $p < .01$; *** $p < .001$; p-values indicate that the difference between the two groups is statistically significant and therefore can be interpreted as a real difference with only a small chance of being wrong. [1] χ^2 (3) = 11.258, $p < .01$; [2] χ^2 (3) = 6.029, $p < .014$; [3] χ^2 (3) = 10.056, $p < .018$; [4] χ^2 (3) = 5.716, $p < .017$; [5] χ^2 (3) = 8.724, $p < .033$; [6] χ^2 (3) = 10.040, $p < .018$; [7] χ^2 (3) = 11.341, $p < .01$.

violent attacks from their intimate partners may be an underestimate; some women offenders may fail to report their violent victimizations due to shame or due to memory issues such as thinking it happened longer ago than it actually did occur.

There are some statistically significant differences between the trauma and control groups on mental health characteristics, but these differences may be due to better assessments on the trauma clients than the control clients. As children, a little over one-quarter of the control and

37.6% of the trauma clients reported witnessing physical or sexual abuse between their parents. Over half of the control clients and nearly two-thirds of the trauma clients are currently depressed, and 39.4% of the control clients and 51.1% of the trauma clients are currently taking depression medication.

The trauma groups were significantly more likely to have been previously diagnosed with Post Traumatic Stress Disorder than the control group; many individuals did not have mental health evaluations and therefore data on diagnosis of PTSD is incomplete. The percentages with PTSD should not be interpreted as the percentage of women on probation or in trauma counseling with PTSD due to the incomplete data; the reported percentages provide low bound estimates and the percentage in the population is much higher as is evident from the multiple traumas and kinds of traumas that the women experienced. In the first provider group, there were significantly higher differences for those currently taking medication for depression as well as were significantly higher to discontinue treatment or counseling prior to completion. The differences in PTSD and mental health characteristics may be due to the better data quality for the trauma group than the control group.

Table 5.3 presents a comparison of the control and trauma group on measures of prior criminal history. There was only one significant difference on criminal history measures: A greater percent of the control group (41.7%) compared to the trauma group (28%) had a prior arrest for driving under the influence. Across the three providers, there were no significant differences on criminal history measures, suggesting that the groups were comparable. Given no significant differences, the criminal history of the total combined control and trauma sample is described. Approximately half of the sample had an arrest for violent and property crimes. Prior driving offenses were also high with the control and trauma groups. Approximately 30% had an

arrest for possession of drugs, but drug selling was relatively low across the sample. The trauma and control groups show that over half of the offenders committed prior misdemeanors or other crimes.

Table 5.3 Comparison of Control and Trauma Group on Prior Criminal History
With Non-Attendees Removed

Priors:	*Control Group*	*Trauma Group*	*Trauma Group: 1st Provider*	*Trauma Group: 2nd Provider*	*Trauma Group: 3rd Provider*
Violent Crimes	51.8%	47.3%	50.0%	48.4%	39.1%
Property Crimes	48.7%	59.1%	65.8%	48.4%	65.2%
Domestic Violence	28.6%	37.1%	36.6%	38.7%	32.9%
Drug Selling	6.1%	9.7%	10.5%	12.9%	4.3%
Drug Possession	24.3%	32.3%	23.7%	32.3%	43.5%
Driving Under the Influence	41.7%	28.0%*[1]	39.5%	19.4%	21.7%
Driving Offenses	40.9%	33.3%	42.1%	22.6%	34. 8%
Prostitution	3.5%	7.5%	7.9%	3.2%	13.0%
Misdemeanor and Other Crimes	51.3%	54.8%	47.4%	51.6%	69.6%

*$p < .05$; p-values indicate that the difference between the two groups is statistically significant and therefore can be interpreted as a real difference with only a small chance of being wrong.
[1]$\chi^2(1) = 4.261$, $p < .039$.

Table 5.4 presents a comparison of the control and trauma groups on social background characteristics. The trauma and control groups were significantly different on whether clients were employed less than 50% of the time during the last 12 months. For all other characteristics presented in Table 4.4 except for whether clients worried about income and sporadic employment, the trauma and control groups were comparable. At the time of probation intake, 59.4% of the trauma group and 48.0% of the control group were unemployed, and 12.3% of the trauma group and 28.8% of the control group were employed full-time. The trauma group was significantly higher with sporadic employment (65.0%) than the control group (49.2%), $p < .01$. Sporadic employment was defined as being employed for less than 50% of the time in the past year. The trauma groups were significantly more likely to be worried about having sufficient income to meet basic life needs (57.3%) than were the control group (43.1%), $p < .05$.

For the other characteristics where trauma and control clients did not significantly differ, the entire sample is described. Across the entire sample, the typical woman client had completed a high school degree (38.4%), had children (74.8%), and had intimate partners who abused alcohol or drugs (31.3%) and had partners who were involved in prior criminal activity (37.0%). About 37% of the sample were never married, one quarter were divorced or separated and about 15% were currently married. Of the entire sample, 49.3% worried about having sufficient income to meet basic life needs such as food and shelter, 49.3% were receiving public aid or food stamps and 65.6% had a stable residence. On the intake form, 45.4% of the clients indicated that their parents did not use alcohol, drugs, or have any criminal arrests, 28.6% of the clients' parents used only alcohol, and 4.6% of their parents had been arrested for a crime.

Table 5.4 Comparison of Control and Trauma Group on Social Background Characteristics with Non Attendees Removed

Agency	*Trauma Group*	*Control Group*	*Trauma Group: First Provider*	*Trauma Group: Second Provider*	*Trauma Group: Third Provider*
Education Level:					
High School not Completed	34.6%	31.2%	25.6%	48.4%	32.3%
High School Graduate without further Job or College Training	65.4%	68.8%	74.4%	51.6%	65.5%
Income and Residence Status:					
Receiving Welfare, WIC or Food Stamps	54.7%	45.1%	52.4%	48.4%	64.5%
Worried About Income	57.3%*[1]	43.1%	61.9%	44.8%	60.0%
Has a Stable Residence	61.4%	68.8%	56.8%	58.1%	71.0%
Employment					
Unemployed at Intake	59.6%	48.0%	63.3%	69.4	54.3%
Employed Less than 50% of the time in last 12 months	69.4%*[2]	49.2%	69.0%	67.7%	55.2%
Marital and Family Status					
Currently Married	11.3%	20.0%	4.7%	12.9%	16.7%
Divorced, Separated, or Widowed	23.6%	23.2%	39.5%	25.8%	13.3%
Never Married	36.8%	40.0%	34.9%	41.9%	36.7%
Any Children	80.4%	69.6%	76.7%	83.9%	83.9%
Intimate Partner has History of Criminal Activity	42.1%	32.0%	44.2%	38.7%	45.2%
Intimate Partner has History of Substance Abuse	20.6%	28.0%	32.6%	38.7%	35.5%
Friends/Partners Involved in Crime	65.5%	52.8%	65.4%5	74.1%	58.6%
Parents of Offender have no History of Substance Usage	41.2%	49.1%	35.5%	39.3%	48.0%

$^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$; p-values indicate that the difference between the two groups is statistically significant and therefore can be interpreted as a real difference with only a small chance of being wrong. . [1] $\chi^2(1) = 4.387$, $p < .036$; [2] $\chi^2(1) = 5.75$, $p < .01$.

Table 5.5 presents a comparison of the control and trauma groups on conditions of probation and referrals to the Lake County Adult Probation's Cognitive Orientation Group

(COG). Most of the data in Table 5.5 was obtained from the court-order sentencing petition and therefore reflects the judges' or probation officers' discretionary decisions. As shown in Table 5.5, the control and trauma group were significantly different on referrals to COG, community service, substance abuse treatment and mental health assessment. These differences are not surprising because the women's specialized services program is designed to refer women to other programs that will address their needs. A greater percentage of the trauma group (41.5%) than the control group (21.8%) was referred to COG, $p < .001$. Also, women in the third provider group were significantly less likely to be referred to COG (23.3%) than the first provider (48.8%) and second provider (51.6%), $p < .001$. This finding however may be due in part to less time for the third providers groups to be referred to COG, which occurs after completion of trauma counseling.

Most women in both the trauma group (93.4%) and the control group (99.2%) had court-ordered open mandates. An open mandate directive means that the court supports the treatments and services that probation officers order. Clients in the trauma groups were also significantly more likely to be ordered to community service and mental health treatment, but were significantly less likely than the control to be referred by the court to attend substance abuse treatment. Also, women in the second provider group were referred to mental health treatment and assessment significantly more than the other two providers, but were less frequently ordered to perform community service.

Almost all of the women in both groups had to pay probation fees, had to pay court costs or fines, and were ordered to submit to random urine tests for drugs and alcohol to insure that they were complying with the courts' order to abstain from alcohol and drugs. For the entire sample, 26.5% were given some time in jail. The trauma and control groups did not differ on the

amount required to pay for probation fees (average = $426.67 control; $476.51 trauma) or court costs and fines (average = $1,159.87 control; $1,606.49 trauma). The trauma groups, on average, spent 50.81 days in jail and the control group spent 28.62 days in jail.

Table 5.5 Comparison of Control and Trauma Group on Court-Ordered Conditions of Probation With Non Attendees Removed

Agency	*Trauma Group*	*Control Group*	*Trauma Group: First Provider*	*Trauma Group: Second Provider*	*Trauma Group: Third Provider*
Referred to COG***[1]	41.5%***[2]	21.8%	48.8%	51.6%	23.3%
Open Mandate	93.4%	99.2%	97.7%	93.5%	86.7%
Pay Probation Fees	95.2%	95.0%	95.2	93.5	96.7%
Pay Court Costs or Fines	100%	96.8%	100%	100%	100%
Community Service*[2]	73.6%**[3]	56.0%	78.6%	67.7%	71.0%
Jail Time	29.2%	26.6%	32.6%	20.0%	35.5%
Substance Abuse Treatment	69.8%*[4]	82.3%	72.1%	74.2%	63.3%
Work Release/Periodic Imprisonment	19.4%	16.9%	20.0%	19.4%	20.0%
Random Urine Test	93.4%	96.8%	90.7%	96.8%	93.3%
Mental Health Assessment/Treatment***[5]	42.5%***[6]	28.0%	39.5%	61.3%	30.0%

* $p < .05$; ** $p < .01$; *** $p < .001$; p-values indicate that the difference between the two groups is statistically significant and therefore can be interpreted as a real difference with only a small chance of being wrong [1] $\chi^2(3) = 18.265$, $p < .001$, [2] $\chi^2(1) = 10.430$, $p < .001$; [2] $\chi^2(3) = 8.154$, $p < .05$; [3] $\chi^2(1) = 7.705$, $p < .01$; [4] $\chi^2(1) = 4.928$, $p < .026$; [5] $\chi^2(9) = 46.669$, $p < .001$ [6] $\chi^2(3) = 35.833$, $p < .001$.

In summary, based on the data from the probation files, the control group was a comparable sample to the trauma group. There were few statistical differences between the trauma and control group. The most substantial difference between the trauma and control group was that a greater proportion of the trauma group was currently using alcohol. Only 25.8% of

the control compared to 59.2% of the total trauma group (and 71% of the third provider trauma group) reported at their probation intake that they were currently using alcohol.

The trauma and control groups did not differ on prior arrests, convictions, probation sentences, or previous incarcerations and past or current use of illicit drugs or prior substance abuse treatment. The differences that occurred between trauma and control group on mental health characteristics may be due to better recorded data for the trauma clients. Trauma clients were more likely to indicate that they suffered from prior trauma and were on depression medication. Two differences are due to the structural design of the women's specialized services program: About 40% of the trauma group and only 21.8% of the control group participated in COG and 42.5% of the trauma group compared to 28% of the control group had a mental health assessment. Trauma clients also were more likely to be unemployed or have sporadic employment over the last twelve months and less likely to be employed full-time than control client. The differences in employment are a direct result of how the sample was drawn with the control sample having similar trauma backgrounds, but having logistical reasons such as a full-time job or the location of their residence as the reasons why they could not attend the trauma counseling.

Referrals to Agencies

An intermediate impact goal of trauma counseling is to increase clients' willingness to participate in the referred programs. Table 5.6 presents the data on whether women probationers in the trauma groups received a greater number of referrals than women in the control group. Overall, compared to the control group, as reported in the first report (Stalans, Lurigio, & Seng, 2008), the second provider of psycho-educational trauma treatment gave significantly greater

number of total referrals, and was more likely to provide referrals to job or educational training and mental health assessment and treatment.

Table 5.6 provides a comparison of the trauma and control groups in the second and third columns. When controlling for unemployment, the provider groups had a significantly higher percentage of referrals to employment services than the control group, $p < .001$. The trauma group clients as a whole were more likely to receive mental health services than the control group. A further analysis of referral data indicated that 23% of the trauma clients were referred for psychological counseling to the Lake County Psychological Services Division compared to only 2.5% of the control group, $p < .001$. This difference occurs for the second and third year of the implementation of the program (the second and third provider agencies). One-third of clients in the second provider group and 38.7% of clients in the third provider group compared to none of the clients in the first provider group and only 2.5% of the control group received referrals to the psychologist associated with the Lake County Court Psychological Services Division. Rates of referrals to the Lake County Mental Health (LCMH) Department were similar, with 23% of the clients in the control group and 32% of the trauma group, $p < .14$. The rates did not vary across trauma providers, with 29% of the clients in the third provider group receiving a referral to LCMH Department.

Table 5.6 shows that the third provider compared to the control group provided a significantly higher percentage of clients with referrals for mental health counseling (86.7%) than the control group (64.9%). The third provided also provided a significantly higher number of referrals for employment services (35.3%) than the control group (5.0%). The clients in the third provider group compared to the clients in first and second provider group also was significantly more likely to be referred to only one or two substance abuse treatment services and

Table 5.6 Comparison of Control and Trauma Group on Referrals given to Offenders

With Non-Attendees Removed

Referrals to:	*Trauma Group*	*Control Group*	*Trauma Group: First Provider*	*Trauma Group: Second Provider*	*Trauma Group: Third Provider*
One or Two Referrals to Substance Abuse Treatment*[1]	51.5%	37.0%	46.3%	51.7%	60.7%
Three or More Referrals to Substance Abuse Treatment*[2]	33.3%	51.3%	39.0%	37.9%	17.9%
Welfare or Public Aid	23.8%	21.7%	24.0%	33.3%	11.8%
Affordable Childcare if Women have Children	4.7%	4.6%	6.1%	7.7%	0.0%
Parenting Classes	14.8%	17.2%	21.4%	19.2%	3.8%
Mental Health Treatment***[3]	77.7%*[4]	64.9%	57.5%	93.5%	86.7%
Domestic Violence Services (victims of domestic violence in past 6 months)	17.8%	20.0%	9.3%	22.6%	25.8%
Sexual Assault Services And Programs	4.9%	2.4%	7.7%	6.5%	0.0%
Employment Services**[4]	30.6%***[5]	5.0%	29.2%	28.6%	35.3%
Job or Educational Training**[6]	22.2%	11.7%	16.0%	42.9%	5.9%

* $p < .05$; ** $p < .01$; *** $p < .001$; p-values indicate that the difference between the two groups is statistically significant and therefore can be interpreted as a real difference with only a small chance of being wrong. [1] $\chi^2 (6) = 12.47$, $p < .05$; [2] $\chi^2 (2) = 7.11$, $p < .02$; [3] $\chi^2 (3) = 16.712$, $p < .001$; [4] $\chi^2 (1) = 4.274$, $p < .027$; [5] $\chi^2 (3) = 13.912$, $p < .003$; [6] $\chi^2 (1) = 13.567$, $p < .001$; [7] $\chi^2 (3) = 12.624$, $p < .006$.

less likely to be referred to three or more substance abuse treatments. Interestingly, 47.9% of the women in the control sample compared to 33.3% of the women in the trauma samples were

referred to the substance abuse agency that is contracted to conduct the trauma group services for Lake County (third provider), $p < .001$. Moreover, since the third provider received the contract, they have referred only 9.7% of the clients in the trauma group to substance abuse treatment at their agency, which is a significant decline compared to the 41.2% of the clients of the second provider group and the 47% of the clients of the first provider group, $p < .001$.

In examining referrals to welfare and public aid, the analyses were conducted separately for those who were unemployed and those who were employed. Irrespective of how the analyses were conducted, the control and trauma groups did not differ on referrals to welfare and public aid. Examining only clients who were caring for children, the analysis suggests that there were no significant differences for those referred to affordable childcare or parenting classes. Also, the trauma and control groups did not differ on referrals to agencies dealing with domestic violence. Analyses for domestic violence referrals were conducted across the entire sample as well as separately for women who were identified as victims of domestic violence.

Table 5.7 provides information on the percentage of referred clients who actually went to the agencies and participated in the program. The first observation readers should infer from Table 5.7 is that a high percentage of women, both in the control and trauma group, participated when given referrals for mental health, domestic violence, welfare, child care, substance abuse, employment services, and other types of referrals. The majority of probationers participated in mental health referrals, employment services, and substance abuse.

The control and trauma groups did not differ on the percentage of women who participated in other types of referrals. Of the clients who were referred to substance abuse treatment, there was no significant difference between the control and trauma groups participating in substance abuse treatment programs.

Table 5.7 Comparison of Control and Trauma Group on Percentage that began Services after Receiving a Referral with Non-Attendees Removed

Type of Referrals:	*Trauma Group*	*Control Group*
% of clients who participated in all Substance Abuse (SA) referrals	44.9% (107)	52.6% (76)
% of clients who participated in less than 40% of the referrals to SA	15.9% (107)	21.0% (76)
Mental Health	84.7% (72)	89.7% (61)
Domestic Violence	48.0% (25)	42.9% (14)
Sexual Assault	0.0% (1)	75.0% (4)
Welfare/Public Aid	73.9% (23)	100% (16)
Child Care	100% (1)	50.0% (2)
Parenting classes	17.2% (16)	15.0% (13)
Employment Services	100.0% (12)	84.6% (13)
Other referral type	73.5% (49)	67.6% (34)
Improved education	20.0% (125)	15.0% (100)

Note: Referral types with superscripts indicate that the control and trauma group are significantly different in the percentage of clients who followed up on their referral and went to the agency for help or in the case of employment status, improved their employment status from what it was at intake.

Intermediate Goals

The trauma and control groups were compared on the following intermediate outcomes in Table 5.8: (a) mean number of months in treatment; (b) whether had a positive test for illicit drugs; (c) whether an administrative sanction was given for noncompliance to rules; and (d) whether the probation officer filed a violation of probation petition with the court, and (e) percentage with at least one noncompliance with treatment (not trauma counseling). The trauma

and control groups did not differ on the likelihood of receiving an administrative sanction, satisfactorily completing any mental health treatment, failed a drug test at least once, attended a substance abuse support group like AA, missed mental health treatment visits, and whether clients were noncompliant with treatment.

Table 5.8. Comparison of Control and Trauma Group on Compliance with Probation Conditions and Completion of Treatment with Non Attendees Removed

Outcomes	*Trauma Group*	*Control Group*	*Trauma Group: 1st Provider*	*Trauma Group: 2nd Provider*	*Trauma Group: 3rd Provider*
Received an Administrative Sanction	40.2%	48.8%	34.9%	54.8%	35.5%
Revoked*[1]	29.2%	33.1%	44.2%	30.0%	10.0%
Completed any Mental Health Treatment	31.9%	44.6%	29.2%	35.7%	31.2%
Had Violation of Probation Petition Filed**[2]	61.0%	61.6%	81.0%	54.8%	43.3%
Failed a Drug Tests at least Once	42.9%	55.0%	44.2%	35.5%	52.2%
Whether Non Compliant with any Treatment	53.0%	52.1%	51.4%	50.0%	58.3%
Completed a Substance Abuse Treatment	65.3%	72.4%	76.7%	56.5%	57.1%
Attended AA or substance abuse support group	49.4%	57.7%	58.1%	50.0%	31.6%
Missed Mental Health Treatment Visits at least once	39.6%	21.3%	40.0%	40.9%	36.4%

$^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$; p-values indicate that the difference between the two groups is statistically significant and therefore can be interpreted as a real difference with only a small chance of being wrong (e.g., .05 means a 5% chance that the difference is not real but due to random chance fluctuation).). $^{1}\chi^2$ (3) = 18.20, p < .017; $^{2}\chi^2$ (3) = 10.73, p < .013; $^{3}\chi^2$ (2) = 7.68, p < .021; ^{4} χ^2 (6) = 20.90, p < .002; $^{5}\chi^2$ (6) = 16.44, p < .012; $^{6}\chi^2$ (3) = 7.20, p < .027; $^{7}\chi^2$ (3) = 15.277, p < .002.

As shown in Table 5.8, the third trauma provider group was significantly less likely (43.3%) than the control group (61.6%) to have a violation of probation petition filed, and only 10% of the third trauma provider group compared to 33.1% of the control group had their probation revoked, $p < .01$. These findings may suggest that the probation officers have accepted the women's specialized services probation program and provide more informal sanctions for noncompliance. Another possibility is that the third trauma provider group had less time in which to be noncompliant and have their probation revoked. However, this explanation does not explain why the 2nd trauma group had a 30% revocation rate and the third trauma group had only a 10% revocation rate even though both groups had served about 1.5 years on probation at the time data were collected. It is clear that the third trauma group had similar rates of failed drug tests and noncompliance with treatment, but that officers were less willing to file a violation of probation petition with the court. There was no significant difference between the control and trauma groups on the percentage of offenders who completed substance abuse treatment programs.

Table 5.9 presents a comparison of the trauma groups and control group on changes in social support, education, and employment. Clients in the third provider group and the control group were similar in the changes in social support that occurred throughout their probation sentence with both groups having about 10% of clients improving their social support and a little over 20% of clients experiencing decreases in social support or support primarily from other adults who have criminal histories. By contrast, the first provider group compared to the control group and other providers had a significantly higher proportion of clients that experienced a positive change in social support (45%) and a lower percentage who experienced negative

changes in social support (10%), $p < .01$. The third provider group and the control group did not differ on changes in employment status or educational achievement.

Table 5.9. Comparison of Trauma and Control Groups on Changes in Social, Educational, and Employment Status

Outcomes	*Trauma Group*	*Control Group*	*Trauma Group: 1st Provider*	*Trauma Group: 2nd Provider*	*Trauma Group: 3rd Provider*
Change in Intimate Partner Relationship					
Became more committed**[3]	25.2%*[4]	11.5%	41.5%	19.4%	9.7%
Disengaged from intimate Relationship**[3]	15.5%	22.1%	9.8%	19.4%	25.8%
Increase in Employment Status* [5]	28.2%*[6]	14.0%	29.3%	38.7%	16.7%
Change from Employed to Unemployed	10.7%	9.9%	14.6%	0%	16.7%
Referred to Educational or Job Training**[7]	16.3%	8.8%	14.3%	32.3%	3.3%
Gained Additional Educational or Job Training while on Probation	21.9%	27.2%	20.9%	29.0%	16.7%

* $p < .05$; ** $p < .01$; *** $p < .001$; p-values indicate that the difference between the two groups is statistically significant and therefore can be interpreted as a real difference with only a small chance of being wrong (e.g., .05 means a 5% chance that the difference is not real but due to random chance fluctuation).). [3] $\chi^2 (2) = 7.68$, $p < .021$; [4] $\chi^2 (6) = 20.90$, $p < .002$; [5] $\chi^2 (6) = 16.44$, $p < .012$; [6] $\chi^2 (3) = 7.20$, $p < .027$; [7] $\chi^2 (3) = 15.277$, $p < .002$.

Impact on Recidivism

Table 5.10 presents a comparison of the trauma groups and control groups on recidivism measures. The recidivism measures are whether women clients were arrested for a crime during the time between the start of probation and when the rap sheets were pulled for coding. The service providers for trauma groups did not differ from the control group or each other on: general recidivism for any crime, property recidivism, misdemeanor or drug crime recidivism.

The average amount of time at risk for a new crime was 36 months (median number of months was 34). Given that the samples were collected at different time periods, it was expected that the third service provider trauma groups would have a shorter time at risk for committing a new crime. The third provider trauma group had a significantly lower mean number of months at risk of committing a new crime (M = 20.67) than the control group (M = 36.8), the trauma group of the first provider (M = 51.2) and the trauma group of the second provider (M = 35.5), F (3,225) = 49.9, $p < .001$, $eta^2 = .40$).

Table 5.10 Comparison of Control and Trauma Groups on New Arrest Measures with Non-Attendees Removed

Whether had a new arrest for:	Trauma Group	Control Group	Trauma Group: 1st Provider	*Trauma Group: 2nd Provider*	*Trauma Group: 3rd Provider*
Any Crime	50.5%	44.3%	52.6%	61.3%	34.8%
Violent Crimes	21.7%*[1]	11.3%	21.6%	22.6%	21.7%
Property Crimes	20.4%	20.0%	15.8%	29.0%	17.4%
Drug Selling	2.2%	0.9%	0%	6.5%	0%
Drug Possession	11.8%	9.6%	7.9%	19.4%	8.7%
DUI	12.9%	7.8%	21.1%	6.5%	8.7%
Misdemeanor	21.5%	26.1%	28.9%	22.6%	8.7%
Drug Crime or DUI	23.7%	17.4%	28.9%	25.8%	13.0%

* $p < .05$; ** $p < .01$; *** $p < .001$; p-values indicate that the difference between the two groups is statistically significant and therefore can be interpreted as a real difference with only a small chance of being wrong (e.g., .05 means a 5% chance that the difference is not real but due to random chance fluctuation). [1] $\chi^2 (1) = = 4.153$, $p < .042$.

Thus, Table 5.10 does not adjust for amount of time at risk to commit a new crime, prior criminal history, or other characteristics related to recidivism. A Cox regression survival analysis was conducted to assess whether the trauma groups were significantly different from the

control groups on number of months until first arrest and the estimates of recidivism. To attempt to control in part to the differences in time at risk, the survival analysis was conducted for the first 29 months from the start of probation for all groups. The effects of the total number of prior arrests, the number of scheduled probation office visited that were missed, and the amount of opportunity time were removed before estimating the effect of type of group on any recidivism.

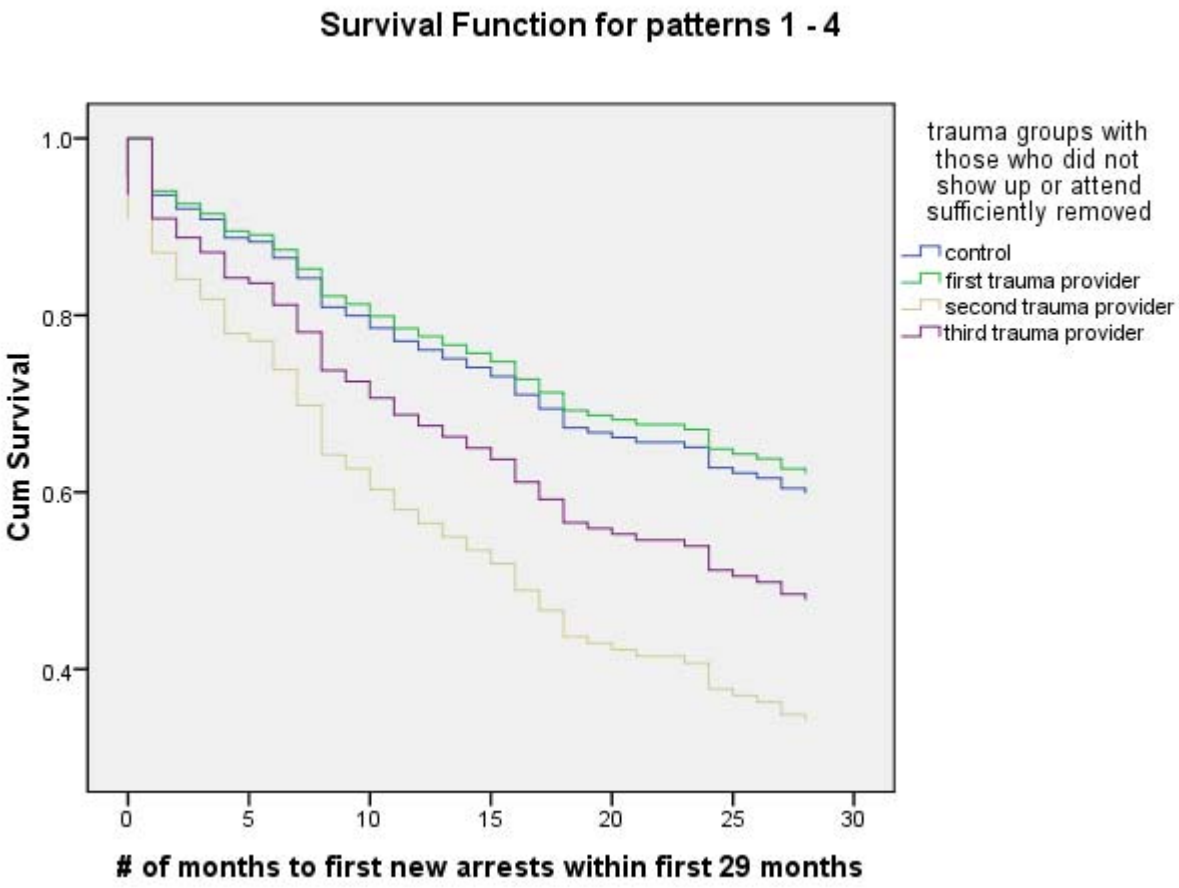
The Cox survival analysis found that individuals with longer times at risk (odds = 1.02, $p < .01$), with a greater number of prior arrests (odds = 1.04, $p < .006$), and with greater number of months of missed scheduled probation appointments (odds = 1.05, $p < .001$) were significantly more likely to be arrested during the 29 months. After controlling for these effects, the second trauma group had a lower survival rate (higher recidivism rate) than the control group, odds = 2.09, $p < .01$. The other two trauma groups did not differ significantly from the control group on survival. Table 5.11 presents the estimated rates of recidivism from the survival analysis for the control and trauma groups at 10 months and 20 months. As shown in Table 5.11, the control group and the trauma group for the third service provider have very similar arrest rates for any crime. The trauma group of the second provider, however, has significantly higher arrest rate for any new crime of 54.8% at 20 months compared to the control group's rate of 33.6%.

Table 5.11. Estimates of Recidivism at 10 months and 20 months for Control and Trauma Groups

Months	Control group	Trauma group of 1st service provider	Trauma group of 2nd service provider	Trauma group of 3rd service provider
Arrest rates at 10 months	23.0%	27.0%	38.7%	25.0%
Arrest rates at 20 months	33.6%	48.6%	54.8%	33.3%
Sample size	113	37	31	24

Figure 1 presents the plot of the estimate of survival for each of the trauma groups and the control group from the Cox Proportional Survival Regression analysis. Figure 1 shows that the trauma group of the 2nd provider has a steeper decline than the control group, suggesting that the amount of time to first arrest was significantly shorter.

Figure 1. Estimates of Any Recidivism Across Time for Control and Trauma Groups



Conclusions

The impact evaluation found that the control group and trauma group were comparable samples except that the trauma group had a higher rate of sporadic or unemployment, and a higher rate of admitted alcohol use. The trauma group of the third provider compared to the control group was more likely to receive referrals to employment services and mental health counseling. Trauma clients of the third provider, however, were less likely to receive three or four referrals to substance abuse treatment agencies than were trauma clients of the first and second provider. Moreover, compared to the rate of referrals that control clients and trauma clients of the first and second provider received to the third providers' substance abuse treatment, the third provider substantially decreased their referrals to their own agency for substance abuse treatment. Interviews with the developers of the women's specialized probation program revealed that the developers desired an increase in the referrals to the third providers' substance abuse treatment; the empirical data support this recommendation and suggest that current practice have significantly lower the rate of referrals for trauma clients.

Although trauma clients have received a higher rate of referrals to employment services and mental health treatment, this greater access to help has not translated into many changes in their social lives, employment status, or mental health status. The trauma and control groups did not differ on positive urine tests, changes in social support or residential stability, changes in educational achievement or employment status, and satisfactory completion of mental health treatment or substance abuse treatment. The overall trauma group and the control group had similar rates of recidivism. However, after controlling for the amount of time at risk, the trauma group of the second provider had a significantly higher rate of recidivism at 10 months and at 20 months than did the control group, and were significantly more likely to be arrested sooner than

the control group. This finding may be due to initial relapse while in mental health and substance abuse treatment or differences between the 2nd provider trauma group and control group on dual diagnoses of mental illnesses or other unmeasured characteristics. In assessments of the impact on recidivism in the first 29 months during supervision, the trauma group does not show any significant reduction in recidivism. However, future research will need to assess whether the trauma group shows any positive impact on recidivism. It is quite possible that the program has a greater impact for certain groups of offenders, and will show an impact on recidivism after clients' complete their needed services and treatment. The small sample sizes for each provider, unfortunately, do not allow examination within different groups, and examinations for the total trauma group are less informative when each year the trauma counseling was changed in ways that improved the quality of the specialized women's probation program. Future research will need to examine whether the program has differential impact for depressed clients, stimulant users, those who receive jail, those who have stable compared to unstable residences, and those who are caring for children.

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