AND SO I BEGAN TO LISTEN TO THEIR STORIES . . .

WORKING WITH WOMEN IN THE CRIMINAL JUSTICE SYSTEM

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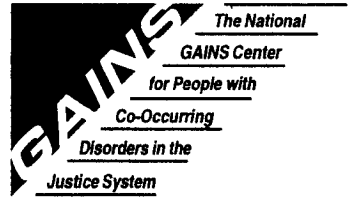
With Support From



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Introduction

In the Winter of 1993 I had the opportunity to visit the Women's Annex of the Minimum Security Prison at Lorton in Lorton, Virginia. This complex houses women from Washington, D.C. who have committed crimes with a sentence of less than two years and women who are serving out the last two years of their sentence. My trip to Lorton was sparked by my longstanding relationship with a colleague who is a national leader and advocate for women in prison and my own years of advocacy on behalf of women with alcoholism, drug addiction, and histories of abuse and trauma. I wanted to learn more about the women, their lives, and their prospects for getting and staying out.

I was nervous as I rode in the car for the 15-mile trip from Washington, D.C. to the countryside of Northern Virginia where the Lorton complex is located. I didn't know what to expect. I was filled with all of the typical fears about prisons and the dangerous people they keep locked away from society. It was a grey, cold day and as we approached the prison, I saw low, cinder block buildings surrounded by barbed wire. The place looked desolate. It was in the middle of nowhere. It seemed attached to nothing — a set of ugly buildings dropped down in the middle of a cow pasture.

I accompanied my friend through the security checks and we finally reached our destination — a trailer filled with 30 women who were there for the weekly Empowerment Group. The topic for the group was "disciplinary actions," how to avoid them, and what to do if you get one. The group came alive as the women acted out different role plays — some playing correctional officers and others playing women who had been written up. Within minutes I forgot where I was — in a prison. I felt like I was back in the halfway house for alcohol and drug dependent women where I began my career in the mid-1970s. These were the same women with the same life experiences — lousy childhoods, multiple relationships with abusive men, histories of sexual and physical abuse, drug addiction and alcoholism, and serious mental illnesses. The difference was that in 1993, they were in prison not treatment.

. . . these are the women who need more resources, not less, and here they are living in the most desolate environment with almost no support to change and put their lives together.

I left wanting to know and do more. I shared my strongest impression with my friend — these are the women who need more resources, not less, and here they are living in the most desolate environment with almost no support to change and put their lives together. I continued to go back to Lorton for the next 18 months where I worked in small groups with women who were preparing for their release. The groups focused on building the internal and external resources to stay clean and sober after leaving prison. The women were in different stages in facing their histories and illnesses — some stayed out while others returned to prison after only a short time back in the community. The women talked about the group and what was helpful. They found the greatest value of the groups was the quiet space — without harassment — where they could talk about their lives. It was something many of them had never experienced.

Two years later, I had the opportunity to facilitate a meeting on Women with Co-Occurring Disorders in the Justice System that was convened by the National GAINS Center.[1] The meeting brought together leaders from across the country, many with decades of experience working with women. The participants included women who have been through the criminal justice system and are in recovery, professionals in substance abuse and mental health treatment, experts in corrections, and researchers. The focus of the meeting was to talk about "promising practices" in working with women in the criminal justice system who have mental illness and substance abuse

[1] The National GAINS Center for People with Co-Occurring Disorders in the Justice System was established to improve services for people in the criminal justice system with the co-occurring disorders of mental illness and substance abuse. The Center is funded by the Naitonal Institute of Corrections, the Center for Mental Health Services, and the Center for Substance Abuse Treatment.

problems and to document what works in helping women. The meeting was one response to grapple with the dramatic increase in the number of women with these problems who are landing in the criminal justice system and the difficulties these systems are having coping with their complex problems.

Nobody disputed that these women had committed crimes. They just noted that these crimes were directly related to each woman's mental illness or drug addiction and challenged the notion that incarceration would accomplish anything.

The participants had a lot to say. To begin, there was a great deal of discussion about the advances over the past three decades in understanding the lives of women with mental illness and addiction and the major role of early childhood sexual abuse and trauma in their lives. Participants commented that the criminal justice system was becoming the institution of last resort — the place were many women with histories of trauma, mental illness, and substance abuse end up because there is no place else for them to go. They also talked about the disproportionate number of women of color in the criminal justice system — calling for an end to racial disparities in sentencing practices and the implementation of culturally appropriate interventions. There was also discussion about the criminal justice system being ill prepared to deal with the complexity of needs and issues many women have when they end up in these institutions. Nobody disputed that these women had committed crimes. They just noted that these crimes were directly related to each woman's mental illness or drug addiction and challenged the notion that incarceration would accomplish anything.

Participants talked at length about the need to humanize these systems — the futility of punishment without treatment or rehabilitation — so that women can have some control and responsibility for their lives and futures. There was a general cry for improving the physical conditions and services throughout all parts of the system.

> Women who have mental illnesses, substance abuse problems, and criminal justice histories often feel too badly about themselves and their histories to seek recovery services.

Also a great deal of discussion focused on stigma. Women who have mental illnesses, substance abuse problems, and criminal justice histories often feel too badly about themselves and their histories to seek recovery services. Their feelings are reinforced by society with harsh and judgmental treatment. Participants concluded that reducing stigma, making systems more humane, and adding basic health care and treatment services were critical steps to reduce the number of women in the criminal justice system and to improve the prospects for their futures.

As a follow-up to the meeting, I was asked to write a Guide on working with women in the criminal justice system who have mental illness and substance abuse problems. At first, this Guide was planned as a review of the literature and summary of the handful of promising criminal justice-based programs that have sprung up across the country. As I thought about the meeting and reviewed the literature I felt convinced it would be far more valuable to ask some women directly what in their experiences had hurt and helped them. Their voices have been absent from the literature. It seemed to make sense to solicit their participation and guidance in developing interventions and policies. After all, they are the individuals who are living and breathing these experiences.

I purposefully set out to interview women who are living successfully in the community. I wanted to underscore that this is not a hopeless group of women as is often depicted by the stereotypes. I also wanted to hear from women whose successes would offer perspective on what had worked and what had not. One of the women persuaded me to interview a woman who is still incarcerated. She felt strongly, and was right, that the story would be incomplete without her perspective.

I also interviewed people who are considered leaders and innovators in systems that work with women. I was interested in their perspectives on what helps and hurts and how "expert" opinions would compare with those of the women. Ultimately, this approach garnered a rich amount of information and some important insights on where we go from here.

The result of my work is presented here. This is a book about women in the criminal justice system, their children, what hurt, what helped, and where we go from here. This is not a research study. It is not a book of statistics.[2] It is a look into the lives and experiences of 20 individuals who have a vast amount of experience and information to share with practitioners, policy makers, researchers, women, and their families. There was no effort to validate the facts of these stories — they are presented as told and recorded. The words expressed here are my own and those of the individuals I interviewed. They are not the words of the National Institute of Corrections, the Center for Mental Health Services, or the Center for Substance Abuse Treatment. The interviews were rich with information, insights, and recommendations. They are offered in that spirit. [3]

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[2] The Center for Substance Abuse Treatment (CSAT) has published a complete **Guide to Promising Practices — Substance Abuse Treatment for Incarcerated Women Offenders.** This publication provides an excellent and complete summary of statistics on the number of women entering the criminal justice system today, their histories, and their crimes. It also provides guidance on developing and implementing programs for women offenders and some summaries of programs that have been funded through CSAT.

[3] The 20 interviews were recorded and transcribed. Approximately 50 hours of interview material was transcribed. Excerpts were taken directly from the interviews. The excerpts appear as they were spoken. Some words were omitted if they were not essential to the meaning of the statement and would be distracting to the reader. The author's words are italicized. Each person was given a list of questions before the interview (the survey instruments are attached in the Appendix). Most of the women asked to be identified with a pseudonym. Joy, Linda, and Mary Ann asked that their real names be used. All of the individuals interviewed were given an opportunity to review their words to make sure that the integrity of their interview was preserved.

In summary, this book asks and attempts to answer one important question — what can we as a society do to help women with histories of trauma, mental illness, and substance abuse stay out of the criminal justice system and re-integrate back into the community? It assumes that we live in a humane and just society where there is an interest and commitment to improve the conditions of women's lives. It assumes that we do not view incarceration merely as a deterrent aimed at reducing the crimes committed by women who have mental illness, drug addiction, and histories of trauma. Rather, people have been asked to share their perspectives. My hope and their hope is that the reader will be open to the possibility that the women who have told their stories here know far better than anyone — what worked, what helped them to feel human, what made them feel hope, and what made a difference.

Chapter I

The Individuals Who Were Interviewed - Biographies

Twenty individuals were interviewed for this book — 10 women who have been in the criminal justice system and 10 experts who are known as leaders and innovators in working with women who are in the criminal justice system. Nine of the women interviewed were living in the community. One woman was still incarcerated in a maximum security prison. The women ranged in age from 32 years old to mid-60s. Eight of the 10 women are mothers and one is a grandmother. Five of the 10 women are married. Eight of the 10 women are either working for an outside employer or independently. Four of the women interviewed are African American, one is a Latina, and five are white.

The experts have worked in many different institutions including prisons, jails, community corrections, substance abuse treatment, and mental health programs. They have run state departments of corrections, county jails, treatment programs, and presided over busy urban courts. As you will see from the biographical sketches below, some of the women are now experts and professionals working in the fields of mental health, substance abuse, and corrections. Some of the professionals disclosed their own histories of mental illness, substance abuse, and criminal justice involvement. Here are brief descriptions of the individuals who were interviewed.

Allen Ault, Ed.D.

Dr. Ault is the Director of the Training Academy for the National Institute of Corrections. He has served as the Commissioner of Corrections for the states of Georgia, Mississippi, and Colorado. Dr. Ault has a doctorate degree in rehabilitation counseling.

Barbara

Barbara, 38, has been incarcerated at Bedford Hills Correctional Facility in New York for the past 18 years on murder charges. Barbara's mother was schizophrenic and her uncles were both alcoholics. Barbara spent years in foster care where she was sexually abused by her foster father and

foster brother. She was unable to speak for long periods of time as a result of the trauma. She lived with a series of violent men and has a long history of being abused and battered. Her last intimate relationship was with a professional hit man. She witnessed him kill people on two different occasions, but felt trapped because he threatened her if she tried to tell anyone what had happened or to leave him. Barbara hid in a closet during the second shoot out and then fired a gun to make sure nobody would hurt her before coming out into the open. She was convicted of firing a fatal shot into one of the men that died.

Barbara has two sons. One is currently in prison and the other is living with friends. Also, Barbara is a leader in running groups on domestic violence at Bedford. She is especially committed to working with adolescent women.

Bonita Veysey, Ph.D.

Dr. Veysey has a doctorate degree in sociology and is a Senior Research Associate at Policy Research Associates. She directed their Women's Program within the National GAINS Center for People with Co-occurring Disorders in the Justice System. She has directed multi-site national research projects in the area of jail mental health services and was the principle staff member for the Center for Mental Health Services Report to Congress, "Double Jeopardy: Persons with Mental Illnesses in the Criminal Justice System." Dr. Veysey has written numerous articles on the needs of women in the criminal justice system who have mental illnesses and substance abuse problems and has consulted with correctional facilities throughout the country.

Brenda

Brenda is a journey-level carpenter and the director of a work skills training program for a national organization in Washington, D.C. She conducts skills classes to introduce nontraditional occupations to low-income women and women on welfare. She provides technical assistance to employers and unions on integrating women in the trades and has produced videos to recruit and train women in nontraditional jobs.

Brenda works on many issues affecting incarcerated women including recovery, job training, and housing. She was a trainer for the National Network of Women in Prison's first Leadership Development Institute designed to empower formerly incarcerated women to become effective advocates. She is a board member of the D.C. Prisoners' Legal Services Project and the National Network for Women in Prison. She is on the advisory council for the N Street Village, a continuum of care for homeless women.

Brenda has been clean and sober for over five years. She was sexually and physically abused as a child. She served a two-year prison term at Lorton Prison for crimes related to her drug addiction. Brenda has two grown children — a daughter who is in law school and a son who is serving a life sentence for murdering his aunt, Brenda's sister.

Brenda Lyles, Ph.D.

Dr. Brenda Lyles has a doctorate degree in psychology from the University of Texas at Austin. She is currently the treatment director for the Alcohol and Drug Abuse Services Division of Broward County in Florida. Dr. Lyles has worked in mental health and substance abuse treatment and with persons with developmental disabilities for the past 22 years. She has directed both mental health and substance abuse treatment programs and worked closely with local jails, probation departments, and courts.

Dr. Lyles has a son who has struggled with his own mental illness and who has been incarcerated. She is a nationally known advocate and a treatment expert for individuals and families with mental illness and substance abuse problems and has served on the board of directors of the National Alliance of the Mentally Ill (NAMI).

Cassandra Newkirk, M.D.

Dr. Newkirk is a forensic psychiatrist who currently lives in Caldwell, New Jersey. She has worked in correctional settings for the last 14 years treating offenders with mental illness. She was the Director of Psychiatric

Services and Deputy Commissioner of Offender Services for the Georgia State Department of Corrections. She has had faculty appointments at Morehouse and Emory Schools of Medicine in Atlanta.

Dr. Newkirk is currently a private consultant in correctional settings throughout the United States with special interests in women and adolescents. She is currently a member of the Women's Advisory Committee for the Substance Abuse and Mental Health Services Administration. She has also served in several elected and appointed positions with the American and Georgia Psychiatric Associations.

Sister Elaine Roulet

Sister Elaine Roulet is a leader, educator, and humanitarian. She has worked at Bedford Hills Correctional Facility for the past 29 years where she has established and led the nation's most innovative programs for women who are incarcerated and their children. Programs under her leadership are run by inmates and include a nursery, parenting programs, and a summer program.

Sister Elaine is also the founder of Hour Children, Inc., an organization dedicated to assisting the children of inmates in prison systems and to establishing nurseries in prisons throughout the United States.

Joy Parker

Joy Parker, 42, is currently the Program Manager of Center Point's Pregnant and Postpartum Women and Children's Program. Referred to Center Point in 1991 by the United States Court, Joy exemplifies persistence and determination by not allowing her history of incarceration (13 years) and substance abuse (20 years) to debilitate her. She champions other women to become productive citizens. Her compassion and courage are matched by her commitment and dedication to helping others just as she has been helped.

Joy is the Program Manager for Center Point's Women and Children's Program, a residential program for substance abuse and mental health treatment for women and children. She completed her master's degree in psychology in 1996 and she has specialized training in psychodrama and group techniques. Ms. Parker has testified before the U.S. Congress on appropriations for drug and alcohol treatment.

Judge Gladys Kessler

Judge Gladys Kessler has over 20 years of experience as a judge in Washington, D.C. She has been a federal judge for the past three years. Before this appointment, she served in the D.C. Superior Court for 17 years presiding over cases in the Family Division, the Criminal Division, and the Civil Division. In Family Court, Judge Kessler presided over a variety of cases including juvenile delinquency, abuse and neglect, adoption, divorce, child support, and mental health and mental retardation. In the Criminal Division she saw many drug-related cases. Judge Kessler has done extensive writing, speaking and public policy work on domestic violence, child support, dispute resolution, and medical ethics. She is a graduate of Harvard Law School.

Kate DeCou, M.S.W.

Ms. DeCou directs the Women's Jail for the Hampden County Department of Corrections in Western Massachusetts. She was one of the chief architects of the programs at that facility where she has implemented some of the nation's most innovative jail-based services for trauma survivors. Ms. DeCou has extensive experience developing and providing services to women with severe abuse histories, mental illnesses, and substance abuse problems. She has a master's degree in social work from the University of Chicago and is in the process of completing her doctorate degree at the State University of New York at Albany.

Laura Prescott

Ms. Prescott is a private consultant who works on mental health and trauma issues. She served as a Human Rights Coordinator for the Department of Mental Health in Western Massachusetts. She helped to produce the ground breaking report and recommendations — **Final Report of the Task Force on the Restraint and Seclusion of Persons who have been Physically and Sexually Abused**. She is an Advisory Board member of Mental Disabilities Rights International, National Association of Rights Protection

and Advocacy. She served as a member of the Technical Expert Group on Women, Violence and Mental Health for the National Women's Resource Center. Ms. Prescott has lectured nationally on topics such as self-inflicted violence, lawyering for discredited women, and retraumatization of abuse survivors in the psychiatric system. She has served as a consultant to the Office of Mental Health in New York and the Department of Mental Health and Mental Retardation in Maine.

Ms. Prescott graduated as an Ada Comstock Scholar from Smith College. She is a survivor of abuse and the psychiatric system.

Linda Powell

Ms. Powell is married and has one son. In 1989, Ms. Powell was found guilty of embezzling $15,000 from her boss who was a Virginia state senator. She was in a manic episode when she committed the crime and has no memory of taking the money. She received 10 years of probation. Shortly after she was arrested and released on bail, Ms. Powell was diagnosed with bipolar disorder. Her son has since been diagnosed with bipolar disorder.

Ms. Powell is currently the Executive Director of the Virginia Mental Health Consumers Association. She and her members advocate for improved funding for mental health treatment and the preservation of human rights for individuals with mental illnesses.

Marta

Marta, 32, is the mother of seven children. Five of her children are being cared for by relatives in the United States and in Puerto Rico. One of her children has been adopted by another family. She is trying to gain custody of her 9-year-old daughter.

Marta has been clean and sober for over two years. She was sexually abused by her stepfather. When interviewed, she was within months of completing treatment in a long-term residential program for women with alcoholism and drug addiction. She was also being treated for manic-depression. In 1993, Marta was diagnosed with HIV. She is currently asymptomatic.

Marta served 18 months of a two-year sentence in Framingham Correctional Facility in Framingham, Massachusetts. She was convicted of assault and battery of a police officer. She stated that she was high when she committed the crime.

Mary Ann Beall

Ms. Beall is in her mid-50s. She is married and has two grown daughters. Ms. Beall has a long history of mental illness and trauma and has been diagnosed with obsessive compulsive disorder (OCD), severe anxiety, and major depression. She has been incarcerated for crimes related to political activism and as a result of her psychiatric disabilities.

Ms. Beall is an advocate for people with mental illness. She serves on many distinguished state and national committees working on issues relevant to individuals with mental illness and trauma. She is a potter, glassworker, and jeweler by profession.

Michelle Petrino, R.N.

Ms. Petrino is the Forensic Unit Chief for Mental Health Services at Bedford Hills Correctional Facility. She has worked for the New York State Department Office of Mental Health for the past 24 years. Before coming to Bedford Hills, Ms. Petrino worked as a clinical nurse in a state psychiatric center.

Ms. Petrino developed services for women in the Special Housing Unit at Bedford Hills where she provided direct services to some of the institution's most difficult to manage and treat inmates.

Niyyah

Niyyah is a mother and grandmother. Niyyah has a lifetime history of trauma and mental illness. She was homeless for about 10 years and lived on the streets in Washington, D.C. Niyyah was jailed repeatedly for episodes related to her mental illness.

Niyyah is currently caring for three of her grandchildren while their mother is incarcerated. She describes herself as a "kitchen table" advocate. She is dedicated to improving the conditions for women in prison who have mental illnesses and the lives of the children who are left behind. Niyyah is also devoted to increasing the participation of consumer survivors in the development of public policy. She serves on numerous national and state committees where she provides a critical voice for consumers.

Pat

Pat is 37 and she is married. Her mother was schizophrenic and committed suicide shortly after she was born. Pat's father is an actively drinking alcoholic. Pat and her sisters were sexually abused by their father as children. Pat attempted suicide three times when she was as an adolescent.

In 1985, when she was 25, Pat was arrested for embezzling money from the bank where she worked. She has since been diagnosed with a schizoaffective disorder. She has no memory of the incident and reported that she was in a hypomanic state when it occurred. Pat was sent to the Federal Prison at Lexington, Kentucky where she was under observation for 18 months. When Pat left Lexington, she went back to her community, where she served five years of probation. Pat is currently working as an advocate in the mental health field.

Sharon Smolick

Ms. Smolick has been working on criminal justice issues since 1974. She was the Program Coordinator for the Family Violence Program at Bedford Hills Correctional Facility. She is currently a Substance Abuse Counselor at the Grace Smith House, a program for battered women in New York State.

Ms. Smolick served two prison terms in the state of Florida. She has a history of drug abuse and trauma.

Sushma Deva Taylor, Ph.D.

Dr. Taylor is the Executive Director of Center Point, Inc., a position she has held since 1981. Since 1972, she has held clinical and administrative positions specializing in providing substance abuse treatment and prevention services to youth, families, women, dually diagnosed, ethnic minority, and criminal justice populations. Dr. Taylor is the former Director of Marin Treatment Alternatives to Street Crime (TASC), Sonoma TASC, and Insight, Inc. She directed the Phoenix Project at San Quentin Prison, served on the Marin County Criminal Justice Commission for eight years, and served as a special consultant to the National Council of Juvenile and Family Court Judges.

Dr. Taylor has a master's degree in public administration, a doctorate degree in clinical psychology, and is licensed as a marriage, family and child counselor and a certified practitioner of psychodrama and group sociometry. She is a board member of Therapeutic Communities of America and chairs the California Therapeutic Communities Association.

Tanya

Tanya is in her 40s and has been clean and sober for over five years. She spent 20 years of her life in and out of jails and federal and state prisons for crimes related to her addiction -- selling drugs, prostitution, theft, and forgery.

Tanya is married. She has established a strong relationship with her son, who was raised by her sister during her long periods of incarceration. She is the guardian for her niece, whose mother is incarcerated. For the past four and one-half years, Tanya has been employed as an administrative assistant for a national organization. She serves on the board of directors of a community-based program that serves women with drug addiction and mental health problems and have histories of incarceration.

The Author — Susan Galbraith

Ms. Galbraith is an advocate for alcohol and drug dependent women and their children. She is currently an independent consultant on alcohol and drug issues and a patient advocate at the Washington Free Clinic. Previously,

Ms. Galbraith worked in the Washington, D.C. office of the Legal Action Center, a not-for-profit law and policy organization specializing in drug and alcohol problems and HIV/AIDS. She was the Director for Community Development and the Co-Director for National Policy. Ms. Galbraith was a founder and the chairperson of the Coalition on Alcohol and Drug Dependent Women and Their Children. She also served as the associate director for Public Policy for the National Council on Alcoholism and Drug Dependence.

Ms. Galbraith has directed treatment programs for women and their children and provided clinical services. She co-led a women's recovery support group at the Minimum Security Unit at Lorton Prison. She has served as a board member for the Health Care for the Homeless Project in Washington, D.C., on the Governing Council of the American Public Health Association, and on the Executive Committee of Women and Health Roundtable.

Ms. Galbraith has a master's degree in social work from Catholic University with a specialty in communities and organizations. She has dealt with alcoholism and trauma issues in her own life.

Chapter II

How We Got Here

Who are the women in the criminal justice system in the United States today?

The number of women in the criminal justice system in the United States has increased dramatically. Between 1983 and 1994, the number of sentenced women prisoners under state and federal jurisdiction rose by 230 percent, compared to 134 percent for men. In 1994, there were 48,900 women in U.S. jails and 69,028 women in U.S. prisons. Eight in 10 of these women were mothers. Most had been sexually or physically abused at some time in their lives. Most had serious substance abuse problems and many had serious mental illnesses. Most of the women were poor. And, the women were disproportionately women of color.

These women are in jails or prisons today because of changes in public policy, especially the implementation of mandatory minimum sentences, and the lack of treatment and alternative community sanctions. They have significant needs for treatment and rehabilitation. Most are getting neither.

This is some of what we know about the women who are in our jails and prisons:

- More than half of women test positive for illicit drugs at the time of their arrests and in some cities this number is more than three-quarters of women arrestees.[1]
- In 1993, nearly 72 percent of women inmates were serving sentences for drug and property offenses.[2]
- In Massachusetts, 90 percent of women prisoners are estimated to have alcohol or drug problems.[3]

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[1] NIJ Research in Brief. *Drug-Abusing Women Offenders: Results of a National Survey*. Washington, D.C.: National Institute of Justice, October 1994.
[2] Ibid, op. cite.
[3] Massachusetts Committee on Criminal Justice, 1993.

- In California, nearly 72 percent of women inmates are serving sentences for drug or property offenses.[4]
- More than 80 percent of female jail detainees suffer from one or more lifetime psychiatric illnesses according to a random study of nearly 1,300 detainees awaiting trial at the Cook County jail between 1991 and 1993.[5]
- Imprisoned women are mostly young, single heads of households, and mothers. Eighty percent have children.[6]
- The Michigan Women's Commission found that 50 percent of jail detainees had been victims of physical or sexual abuse at some point in their lives.[7]

The 10 women and 10 experts who were interviewed for this book bring these grim statistics to life. The women whose stories follow committed a number of different crimes and received and served varied sentences. Some were convicted of crimes they committed to get money for drugs, others were convicted of drug dealing, and still others were seriously mentally ill when they committed their crimes and have no memory of what actually happened. While the women differed in many ways, there were specific themes that were common in their histories. Most grew up in families where either one or both parents had a mental illness, alcoholism or drug addiction. Eight of the 10 women described experiences of early childhood sexual abuse by fathers or stepfathers or in foster care. Most of the women had early signs of mental illness or substance abuse problems and

[4] Austin, J.; Bloom, B.; and Donahue, T. *Female offenders in the community: An analysis of innovative strategies and programs*. Washington, DC: National Institute of Corrections, 1992.
[5] Teplin, L.A.; Abram, K.M., and McClelland, G.M. Prevalence of psychiatric disorders among incarcerated women. *Archives of General Psychiatry* 53 (6): 05-512, 1996.
[6] Owen, B. and Bloom, B. Profiling women prisoners: Findings from national surveys and a California sample. *The Prison Journal* 75 (2): 165-185, 1995.
[7] Holden, P.; Ran, J., and Van Drasek, L.: *Unheard voices: a report on women in Michigan county jails*. Lansing, Michigan: Michigan Women's Commission, 1993.

three of the women mentioned that they had attempted suicide in adolescence. Almost all of the women talked about being sexually and physically abused by men through childhood, adolescence, and adulthood. These themes were corroborated by many of the experts.

Kate DeCou poignantly described the characteristics of the women in a typical correctional setting — jail, prison, or community corrections — in the United States today.

The female offenders are an exceptionally injured group of individuals. The massive amount of early childhood trauma and dysfunction that they are raised with is so clear.

I would say that about 90 percent of the women that come through are substance abusers. I would say 40 percent of them might be dually diagnosed with a serious mental illness and substance abuse problem. I've seen a statistic that says about 75 percent of the women in corrections are incest survivors. I would think that somewhere between 60 and 70 percent makes sense from my personal experience of self-disclosure with them. On top of that almost all of them come from dysfunctional substance abusing environments where there's been a lot of physical violence. So many of the women don't seem to have a clue about what respectful treatment is, especially at the hands of a male.

Themes

- Family histories of mental illness or substance abuse
- Childhood sexual abuse by fathers, stepfathers, and in foster care
- Early onset of drinking and drug use
- Childhood symptoms of mental illness and early suicide attempts
- Victimization by men
- Misdiagnosis

Family Histories of Violence, Mental Illness and Substance Abuse

Niyyah described her illness as an intergenerational problem.

I really view my situation as an intergenerational problem. My family problem didn't start with my illness, it started with my biological father who was also the person who started the abuse and violence in my family. And then we go to my daughter, and then we go to my grandchildren. So you see we have at least four generations that we've seen, you know, all of these problems that have happened to us.

> So, I came into this world...if I wasn't scarred by him, by the genetics of him, I was certainly scarred by the world that he created – both in my family and in my surrounding community.
>
> **– Niyyah**

Niyyah's father was violent and abused her beginning in infancy.

I don't have a lot of information on his in and out of prison. There is some newspaper article that I have seen — that he took me as a baby to people's houses and knocked on their door and asked for help for me. So that even as a child, I was in the newspaper as like "baby bandit" or something. And then he robbed and raped and attempted to kill people. So that people have a lot of feelings about me that I don't even know.

So, I came into this world ... if I wasn't scarred by him, by the genetics of him, I was certainly scarred by the world that he created — both in my family and in my surrounding community. Which, I guess, has a lot to do with my own condition.

Barbara's mother was schizophrenic. She never knew her father. She grew up in an environment surrounded by family who were drinking and using drugs.

To begin with, I come from a mother who is schizophrenic, who was diagnosed much later in my older years. Maybe when I was about 14 years old, I finally learned that this is what was wrong with her. I come from an alcoholic family as well as drug abusers. And, throughout the entire house I can say there was only one person that didn't use some sort of drug or drink.

Pat's mother was schizophrenic. Her father was an alcoholic. She learned of her mother's illness and suicide when she was under observation at the Forensic Unit at the Federal Prison at Lexington, Kentucky.

A wonderful doctor there probably saved my life. I was 25. I had no idea what the disposition of my case would be. He called my dad. I had thought for 25 years that my mother had been murdered. I found out that she had actually been in and out of state hospitals — including the time she was pregnant with me — had schizophrenia, and killed herself.

Joy's parents divorced just after she turned 1. When Joy was 4, her mother remarried a man who was an alcoholic.

She remarried when I was approximately 4 years old, just before I entered kindergarten. That relationship, initially with my stepfather, was great. I was a tomboy. We went to baseball games and it was a healthy, male role model in my life. He definitely had an alcohol problem, and as years progressed, turned into an abusive alcoholic. He wasn't the kind of alcoholic that drank every day, but when he drank he was a definite Jekyll and Hyde.

Tanya's parents were alcoholics who had terrible fights. Her mother died when she was 11.

Both of my parents were alcoholics. My father's was a very, very functional alcoholic. And when I say functional, I say that because he worked six days a week, every single week of his life that I can remember until he retired. My mother, on the other hand, was always a housewife. She

never worked. They drank a lot. I remember my parents — and my father was a pretty introverted guy, but my mother had a way of provoking him — and I remember my parents fighting terrible.

Dr. Sushma Taylor described the life histories of many of the women she treats at Center Point, a therapeutic community in Northern California. The women she sees have often been incarcerated before they enter treatment.

And they run away from home because they were misunderstood. They were not given what they feel they need. They may be physically abused, sexually abused, come from unfunctional families, because dysfunctional assumes they were functional at some point. Families that are not intact.

> I thought I was bought and my mother didn't want me, my family didn't want me. I was garbage.
>
> **– Barbara**

Childhood Sexual Abuse By Fathers, Stepfathers, and Foster Care Families

Barbara was sexually abused while in foster care.

From the time I arrived, it was the grandson. He owned me. I was property. I belonged to him. He was like 16, telling me he could do what he wanted to and I belonged to him. They had bought me was what he said and I believed him. I didn't know. I thought I was bought and my mother didn't want me, my family didn't want me. I was garbage. And they were good enough to take me in and whatever he wanted to do, he could do.

Joy was sexually abused by her stepfather.

As I got older, the healthy relationship turned to an unhealthy attraction, and in fact, there was some physical and sexual abuse that for many years I allowed to justify my addiction — or it helped me to justify my addiction (*alcohol and drugs*).

Marta was sexually abused by her stepfather.

Yeah, since the age of 12 to 15. And it really bothered me, and I started hating men, and I wasn't in love with my husband. The only reason I married him was because of my childhood.

Dr. Cassandra Newkirk was surprised by the number of women she saw in the Georgia correctional system with psychiatric conditions secondary to childhood trauma, especially sexual abuse.

Even though I had worked with women in private practice for years and I had worked with male offenders, I still wasn't prepared to work with female offenders, which was sort of a surprise to me. It was an eye opener because I probably saw more psychiatric conditions secondary to childhood traumas.

Let me give you an example. In my private practice I had seen one woman where we made a definitive diagnosis of having a multiple personality. In contrast, in the first three months of working with the women in the prison system, I probably saw 10.

Early Onset of Drinking and Drug Use

Joy started drinking at age 10. Her drinking escalated when her stepfather started sexually abusing her. She told her mother about the sexual abuse, but her mother didn't believe her.

And my behavior in school started to really change a lot — which is in many cases where these kinds of problems manifest themselves — in school. I started to get referred to school counselors and psychologists and they told my mom that there was some underlying thing that was bothering me. They encouraged me to talk about it. My mom kept on saying, "Whatever it is, it's OK."

And when I finally brought this information out after about a year — and it had probably been going on for several years — nobody believed me.

Their denial, their emotional state, could not allow them to accept it at the time, and nobody believed me. Therefore, it was like well, I don't ever need to trust anybody again in my life.

And from that point, I made a conscious effort to behave in a way that — while I certainly didn't have the full capacity of understanding what I was doing — certainly allowed me to get emotional revenge to those around me. It's easy for me to say now, at the time I certainly didn't recognize it.

It kind of allowed me to justify my addiction and my behavior and my criminal behavior. I'll say probably at 14 was when I made a real conscious decision that — OK, fuck you — if you don't believe me, then let me act like this. And that included leaving school and starting to drink alcohol on a daily basis. But, like I said, I was drinking at 10 — sometimes when I babysat. So, I can't say that the sexual abuse in itself made me use. It's not that simple. But it certainly was a conscious decision, it was a turning point in my life.

Tanya described her early drinking and drug use.

I guess around the age of 13 — simply because of peer pressure, because that's what everyone else was doing — I would go to these house parties in the neighborhood and be drinking. And we just thought it was a cool thing to do at the time. We were so very young. None of us could even purchase alcohol. We'd have to catch somebody going into a liquor store and buy them something for them to buy us Bacardi — rum and coke. Then we'd go sit on the school steps and proceed to get drunk. I mean, rip-roaring drunk. And that was my introduction to alcohol and chemicals.

By the time I was 16 years old, I had started to experiment with drugs — marijuana, heroin, cocaine. I think when I started doing it again it was just because it was cool. And my peers were doing it. And, of course, I hung around with the wrong people. I hung around with the wrong people simply because I was in a one-parent home. My dad worked six days a week.

So I was pretty much left to my own resources, and I did whatever I wanted to do.

> No one ever questioned why a 12-year-old was drinking heavily.
>
> **– Sharon**

Marta started using crack cocaine at 16.

My drug of choice was crack cocaine.
I started at the age of 16, my first sniff — I was sniffing it. I got into a relationship with a man. He was a drug dealer. I had my first child at 17 years old.

He was the father of my child, and I constantly had drugs with me, so it made the ability for me to have whatever I wanted to and that's why I got addicted. And then my second child came along.

Sharon was drinking and in trouble by the time she was 12.

I hit the streets when I was about 12 years old. I was drinking and clearly in trouble. I used to come to school with black and blue marks all over me and no one ever questioned that. When I got angry in school or acted out of course then I got JD (juvenile delinquent) cards.

In those days nobody ever questioned any of that. No one ever questioned why a 12-year-old was drinking heavily. I'm talking about 1956, '55, and they started labeling me a conduct-disordered child.

Childhood Symptoms of Mental Illness and Early Suicide Attempts

Niyyah was hospitalized at age 9 for symptoms related to her early childhood trauma and abuse.

I was in a mental hospital. I was even in hospitals when I was a child. They treated me for stomach disorders, for things that now — if you get a 9-year-old that is having kinds of bulimia and anorexia — that somebody's abusing her. But they didn't know that then, or they didn't talk about it.

So very early, I was institutionalized. I was the only child of color in that hospital. So the things detracted on why I was there, what I was doing there. And then the race factor was really horrible in the hospital.

> And even though I had, at age 21, a suicide attempt, everybody just seemed to ignore it.
>
> **– Linda**

I couldn't walk. Now nobody's ever been able to really convince me as to why I didn't walk. I really think I didn't walk because of the trauma. I really thought if you couldn't walk, you couldn't go home. You couldn't be home, you couldn't be abused. I mean, I kind of figured that out.

Pat was hospitalized three times for suicide attempts.

I had three other hospitalizations, all involving suicide attempts. And, it wasn't until my incarceration that I was actually diagnosed. My suicide attempts were seen as family transitioning issues (her father was sexually abusing her).

Linda's father understood and described her illness at a very young age.

But my father, who was basically uneducated, had it figured out long ago. And this will date me. My father used to say that the world revolved at 33 and one-third and Linda was stuck on 78. And from an uneducated man that's a pretty good description of somebody in a hypomanic state.

And all my life I was really thin. I went through all kinds of testing — metabolic testing — and all of that. And my father used to say that I didn't stand still long enough for the fat to catch up with me. So I mean, people saw it back then. It wasn't something that happened overnight.

Linda made one suicide attempt but her manic depression was not diagnosed.

And even though I had, at age 21, a suicide attempt, everybody just seemed to ignore it.

Victimization by Men

Marta was constantly abused by her husband.

We had our fights, we had our argues. Our relationship wasn't a love relationship. It was more a hate relationship. It was abusive. He used to beat me, he shot me, he's broken my ribs. Yeah, I got a bullet wound in my leg. Anyhow, I just had a rough couple of years with him.

Judge Gladys Kessler saw many women in the D.C. Superior Court who were involved with abusive men and were pulled into criminal activity because of those relationships.

She's typically with an abusive partner. That partner uses drugs and she ends up using drugs. And it doesn't have to be physical abuse. It's a relationship that's not a healthy relationship or, let's face it, she wouldn't stay in the relationship with a drug-abusing person.

I've known people who are involved with drug-abusing people and painful as it might have been, they all ended those relationships because they were going nowhere. But you get a woman who is in one of those relationships and whether it's psychologically or emotionally abusive, that is how she often gets started on drugs. But often it is physically violent. In many of the criminal cases that came here it was clear that the woman was involved in a physically abusive relationship.

And, well, you saw low-level drug sellers come in or low-level participants in the drug distribution scheme. Sometimes they were users. Sometimes they weren't even users but they were doing it for their boyfriends. You see a lot of it in the Hispanic population, mostly either non-English speaking or women who spoke so little English that they were not functional in the United States. And they were being forced to serve as mules ... either carry drugs from city to city or what you see here as in many border states, the women are being used as mules to bring drugs into the United States.

Dr. Taylor described the victimization that many of the women she treats have experienced.

Men want something from them. It's either prostitution or it's just somebody to be an arm charm, but pretty soon they become an attachment or an appendage to a man. And they begin to follow what he does — they take care of him and they do what he tells them to. Or they're either left or abandoned, which is the same feeling they had when they were at home. Or they're beaten up because the man doesn't understand them. One way or another, they're victims. Although they can be emotional victims, they can also be psychological victims, and they certainly are physical victims.

Misdiagnosis

Mary Ann was not properly diagnosed until she was in her early 50s. She described what it was like to live for so many years without helpful treatment.

I had tried so many things. You know, it gets to be very, very hard to cope. Coping itself becomes a very painful process if nothing succeeds. I think mental health professionals meant well. I think they just had pitifully inadequate tools to deal with the picture that I presented to them. And I think they did their best.

On the other hand, there were some folks who kind of said — "well, you're not getting better. Are you sure you don't want to be sick? Nothing anyone has ever done has ever helped you, so maybe you're getting off on being the perpetual patient." And that's a terrifying thought. That there is some kind of thing lurking in the dark corners of your mind that's so powerful and perverse that you can lose yourself in the deep horrors. And that's very frightening.

And that time I truly gave up. I figured I'll have my symptoms. The hell with it. I'll have it. I mean the kinds of side effects I had from medications were so horrendous. I lost control of my bladder and bowels. I had rheumatic fever as a child. The tricyclic antidepressants are cardio-toxic and I

had these terrible blackouts. Believe me, I didn't want to pass out on the street. It's not one of those things that you particularly care to do. I couldn't see. I couldn't focus my eyes. I had trouble with my muscle control. I dropped pencils. It was like I was not just fighting the symptoms, but now I was kind of fighting my own body. And then the response of people — that the reason you're not getting better is because you want to be sick. Well, that really made me feel truly despairing. I mean truly despairing.

And you give up the hope of ever being like other people. I used to look out and think of the people who smiled and seemed to interact — people from my viewpoint kind of looked like golden people, the laughter, the closeness — were all things that I couldn't be, couldn't reach, couldn't do.

Dr. Taylor sees many women who were misdiagnosed or never diagnosed.

I also believe that a lot of mental illnesses are undetected and poorly diagnosed when these individuals are young. They are considered behavioral disorders rather than neurological disorders. And so they are undiagnosed and untreated.

So when they get a little older they self-medicate in order to alleviate the stress of the symptoms they're experiencing and the self-medication leads to illicit substances.

Dr. Newkirk found that many of the women with trauma histories appeared psychotic but were really dissociating.

The diagnostic process of deciding what I was looking at got to be a dilemma because as a psychiatrist I was trained that if someone was psychotic you were to give them psychotropic drugs. And in many cases, the women weren't psychotic, they were dissociating.

Chapter III

Children

Eight out of 10 women in the criminal justice system are mothers. When they are arrested their children are left behind and care arrangements are often made on an ad hoc basis. Many children are cared for by relatives — especially grandparents. Others are placed in temporary or permanent foster care. Little thought or attention has been given to the children of incarcerated mothers — by the judicial system, the criminal justice system, or the social services systems in the community.

Women are intensely concerned about the welfare of their children. This sentiment was probably best expressed by Sister Elaine Roulet who runs the Children's Programs at Bedford Hills Correctional Facility. She went to prison to teach reading and found that the women wanted her help to find their children.

Eight of the 10 women interviewed were mothers. They all talked about their children. They all expressed guilt and shame about how their crimes had affected their children. Some have reunited with their children, others have not. All of the women

Themes

- Children are deeply affected by their mother's incarceration and there are few resources to help them
- Women feel intense guilt and shame about their children and society's labeling of them as bad mothers
- Women who commit child-related crimes are especially stigmatized
- Reunification with children is a goal for most women
- Families often care for children while their mothers are incarcerated
- Women need resources and support to successfully reunite with their children

and many of the experts urged that we pay more attention to the children and improve resources to help them cope with their mother's incarceration, mental illness, and drug addiction.

Children with Mothers in the Criminal Justice System are Deeply Affected and Their Needs are Often Ignored

Mary Ann talked about her children.

One daughter did fairly well. The other is a very shy child and a child who was much needier when it came to social approval. And a couple of times I was in for political things. We lived in a very blue-collar neighborhood, probably my husband was the only college graduate. And my oldest girl — she got beaten up on the way home from school.

And that was very hard. I think that has affected her life very much. And I think in her relationship and my relationship there's always a sense on her part of abandonment, you know if you had wanted to be a better mother you would have been different.

And when my youngest daughter began to have seizures and was then misdiagnosed as having a psychiatric disability, my older daughter's position was well — you were the one who caused this. If you were good parents, none of this would have happened, things would not have worked out like they have. And that has been hard.

Hardest of all is to make sure to leave the doors open. I mean we have as much contact as we can with her. But it's always when she wants. We want to keep the doors open, but it's a long road.

On the other hand, what was miraculous was that we all hung together and we loved each other and we made it through. But I also think my husband and I both come from fragmented families and I think when we married we really made a commitment to each other.

Dr. Allen Ault discussed his concerns for children who have mothers in prison or jail. He was deeply concerned about their futures.

I'm concerned about how the children turn out. God knows that the solution to crime is not prisons. It's in preventative programs where how we treat those children could determine whether they're going to be future criminals or not. But, I'm not sure that what we're practicing in most states is corrective.

And what I saw was more and more women coming into the system and attention was not paid to their particular employment needs, to their vocational training needs, and certainly was not paid to their need to keep in touch with their children and families.

– Judge Gladys Kessler

Judge Gladys Kessler talked about the separation of children from their mothers when they are incarcerated.

And what I saw was more and more women coming into the system and attention was not paid to their particular employment needs, to their vocational training needs, and certainly was not paid to their need to keep in touch with their children and families. Quite the contrary. I think those needs are by and large ignored. And the sad irony is that whereas women were the caretakers in the community before they were incarcerated, nobody bothers to visit them or to bring those children to visit them. And while there are some outstanding examples of prison systems such as Bedford Hills making a real effort to deal with those issues, most of the prison systems don't. Very few do. Lorton makes some minimal, minimal attempt to work with families, but this is a very small jurisdiction.

But if you are talking about just states — forget about the federal system for a minute where you're talking about many thousands of miles that people may be removed from their families, but even in states, the long-term prisons could be a long way from their families — there are few programs designed to deal with those problems.

Women Feel Intense Guilt and Shame about the Impact of their Incarceration on their Children and are Viewed as Bad Mothers

Brenda described how she was treated by the women who were supervising a house where her daughter was living.

Well, they marched over to where I was in treatment and these very upper middle-class black women told me that I was a detriment to my daughter and that I should just let her go and not have anything to do with her. And I was devastated. I just didn't understand. What I told them was, "you act as if you discovered her. That she hasn't had any nurturing to this point that would make her the excellent student that she is." I mean she had gone to the Washington International School from kindergarten.

And I had put a lot of effort into recognizing her gift. I think that I was a gifted child and I think that it wasn't paid attention to or channeled or anything. When I was participating in school I would be an honor student, but nothing ever seemed to please anybody enough and I always got B's. And I didn't want that to happen to her so I put in a conscious effort. And they treated me like the stereotype of an addict.

Sister Elaine Roulet talked about what it is like to be a mother in prison.

Well, what happens is that they're wounded and they're hurt and they're embarrassed. They eat guilt burgers. The first thing they want to do is talk about their children. And society always says that she can't be a good mother and be in prison. We know that people can be terrible mothers and be out on the street and never break a law. But, I think it's important that women don't say that to themselves — that I'm a bad mother because I'm in prison. It's bad enough that society says that.

I think it's like reading in a way. When I was a principal I saw children coming to school in first grade and they could already read. And some in the third grade and some read even in the eighth grade. And I think

mothering is like that. I think some are not a born mother, some need to work on it and I think sometimes when people learn about parenting — and it's almost when you see people learning the computer, their face lights up and they say — oh, if only I had known that.

Women Who Commit Child-Related Crimes are Especially Stigmatized

Sharon talked about women who had committed crimes that involved their children.

One of the things that cued me in to it early was working with women with child-related cases. I started this group. I had no experience. There was nothing in the literature about working with women with child-related cases. They're pariahed in the system. I said what the hell, just do it.

And we'd brainstorm and then we'd start using these as topics to work each group. And about six months into the group I realized that none of the women ever used the name of the child that died. And I mentioned that. And they fell to pieces. And from that point on they began talking about what it is to be responsible for the death of your child. How you deny yourself the right to grieve. How everybody denied you your right to grieve. The stigmas attached to it. And in many of the cases, it's a moment, an insane moment in their lives that they truly, truly agonize with.

I don't know how many women have said to me, "they can lock me up for the rest of my life, they can never hurt me. Do you think that's any real piece of the real pain of this? I killed my child and I have to live with that my whole life. Do you think they can do anything to me?" I heard that so often.

You know one woman, she had five kids ... when she gave birth to the last child she said, I don't want this child, please take this child. She had been raped. And she said from the minute she looked at the baby's face the baby looked just like him. And she said every day I looked at that baby

and his face was in front of me. And I begged them. I left the hospital and left the baby in the hospital and they made me go and get it.

When the baby was 2 years old, she hit the baby and the baby fell down the stairs. The baby died. It's a terrible, terrible story. These are the stories that came out in the room.

> All they wanted to know about was their children. So I put my reading books away and I realized that I wasn't meant to teach reading. I'd come to work with women and their children.
>
> ***–Sister Elaine Roulet***

Reunification with Children is a Goal for Most Women

Sister Elaine went to prison to teach reading. She found women wanted her help to find their children.

And I was shocked when I went to prison. My whole motivation was reading. And I was, well I was shocked at one particular prison. It was July and the papers on the bulletin board were from January. I couldn't believe it. And then I re-observed the way reading was taught so I knew, then I was convinced that if I could teach reading in prison the crime would decrease, there would be no troubles in the world. That's what I believed. I thought that about the sex crimes, that people could read books and they wouldn't commit sex crimes. I thought that if people could read they would have no time to rob. It was a very simple thing. So I went in. There was a women's house of detention and I asked people to sign up for reading. Everyone signed up.

And as soon as I sat down the first question they asked me was — "can you find out where my children are? Can you find out?" I can honestly say I never taught reading for five minutes. All they wanted to know about was their children. So I put my reading books away and I realized that I wasn't meant to teach reading. I'd come to work with women and their children.

Most of the mothers at the Hampden County jail hope they will be reunited with their children when they are released. Ms. DeCou talked about the women and their children.

Most women want to be reunited with their children. My previous experience from working with them is that most of the women have had custody or partial custody. While they were substance abusing, many of the women consider themselves having been responsible by giving custody of their children to their mother or their sister. They perceived it as temporary until they could get their substance abuse problem in order. And in truth, I think that does show a fair amount of judgment that other people don't always see.

But whether they had kids with them or whether it was some farmed out arrangement like that, most of the women — once they get in jail, once they've been off drugs, once they begin learning about this, who they are, and reclaim their self-esteem — assume they're going to get custody of their kids back and want it.

Do most of them? I don't know what the numbers look like, but the guidelines in Massachusetts for permanency planning for the Department of Social Services have become shortened in the last seven years, so that adoption and permanency planning tends to start on a fast track earlier.

A lot of these women's lives are so complicated — their deficits are so big — that I think a lot of them end up losing their kids because there's not enough time for them. And I see that as very tragic. I worked in the child abuse arena. I supervised contracts of other agencies that provided these services of overseeing abuse and needing to kind of proceed with operations. I feel like it's our delivery network that is erring in the side of trying to be too efficient. Maybe it's doing it out of numbers and need but what I find is that a lot of these women — that recovery doesn't happen that quickly.

Recovery is possible for many of these women. Recovery is definitely possible. We're starting to see success stories. But often it's a little too late and I think that's tragic.

> . . . "I love you mom. I can forgive everything that you've done." We sat down and we talked about being in prison and why I was there. She wanted to know.
>
> **– Marta**

Marta is currently in a long-term residential program after serving 18 months in prison. She hopes to regain custody of her 9-year-old daughter.

My first visit was February 9th. It was a good visit. We got to know each other. Then we had another visit a month later. She started calling me mom and she wrote me a letter saying, "I love you mom. I can forgive everything that you've done." We sat down and we talked about being in prison and why I was there. She wanted to know.

I told her that my addiction brought me to the level of robbing and stealing. I've never sold my body. I've never gotten to that point. But, carrying a gun on me, which got me into trouble, and not paying attention to what my responsibilities were and just giving my children up.

I loved the drugs more than I loved the children. And now I've realized, after all these years of using, that it wasn't that. You know, I'm hurting. I'm hurting right now because I can have only one of my kids in my life. She's not adopted and the judge has given me a chance. Now I get phone calls with her. I have a visit with her every other week. And she's looking forward to having overnights with me.

That will come soon. I'm going to court July 24th and they're going to let me know. But as far as I see, she's still on the adoption list. But, I've done everything.

Sharon talked about helping women to realistically assess their relationships with their children. Sometimes the goal of this work is to help women regain custody of their children, in other cases, it is to help them to give up their children.

If it's a woman with children, you're going to start with housing, you're going to start with child care, you're going to start with training, you're going to start with some mental health, maybe for the kids and for her. You're going to help create continuity in her family. All of it.

Where that's not possible, you're going to help her with whatever she needs. And that's the other thing we don't face. I've worked with women who give their children up and I believe in that for a number of reasons. One of which is that she has so much work and so much she needs to do for herself. If she's ever going to have a chance, and the children are ever going to have a chance — they have to separate — and both have a right to a chance.

If you keep them together, there's too much that needs to be done that can't be done. If she's got 10 years she's going to be in prison, by the time she gets out, those kids will be almost grown, and we will have done nothing to help those kids.

I've worked with a woman to help give an open adoption so that she could stay in touch with the family and that was very nice. She liked the people who were adopting her daughter. They liked her. They brought the child to see her. You know, it's a wonderful way to do it. So they're not stripped of everything. But, sometimes you need to help them to let go. When you've had so many bad experiences in your life, you've got so much work to do. And women don't have to ... we're not ... we don't have to be mothers. And given some of the histories of the women, some of them shouldn't.

Judge Kessler discussed the impact of crack on the families she saw in court and the lack of treatment resources in the community to help them stabilize.

Many parents are losing children and using heroin, using PCP, certainly using marijuana. The mothers who are using cocaine are out of control. They are totally unable to be responsible in any other respect of their lives and they are doing terrible, terrible things to their children. A level of abuse that most of us have never seen. So the caseload was skyrocketing.

At the same time, I think that mothers who lose their children because of cocaine usage are more able to deal with their drug addiction than any other subgroup of the cocaine using population. And the reason I say that is because their motivation is so incredibly high to get their children back.

And so while it's terribly difficult, I firmly believe that there is a chance of rehabilitating many drug-addicted, cocaine-addicted mothers whose children are in the neglect and abuse system. Having said all of that, there is an incredible paucity of treatment facilities in the District of Columbia for addressing the needs of those mothers. So that's what I saw. And it was a terrible tragedy. You definitely were aware that there were mothers who could be salvaged, who could get reunited with their children, if there had been sufficient resources.

Families Often Care for Children While Their Mothers are Incarcerated

Tanya's sister raised her son.

My son would come to visit me. He must have been 3 or 4 years old. He would play with me and we talked and I thought he was OK. And I really didn't feel very sad because I could call home. They always accepted my collect calls and my sister sent me pictures of him. The thing that was really on my side, and fed into my denial, was that my family was always supportive.

I didn't have one of those families who said, "I'm not bringing this baby to prison to see you. If you wanted to be with him you should have stayed straight." They never treated me like that. This is your child. We'll bring him to see you. And it was always, "Give mommy a kiss. Tell mommy bye-bye."

They always made me still feel a part of — to the extent they could. And that kind of fed into my disease, my sick thinking. Because they said to me, my son is OK. He's still in my life. And so if you can do the time, then you can commit the crime. And I would go to jail and I'd do what I

had to do and it was OK and I'd see my son. And I'd come home and be in the halfway house and my sister would allow me to get him on weekends and keep him all day. For a long time that was enough.

Niyyah is taking care of her grandchildren. Her daughter is incarcerated in New York City but before that she was at Bedford Hills Correctional Facility. Niyyah described their commitment to working with families.

Bedford made it a family affair in a way we could accept. Bedford told us some of the things that we would have to do. To begin to act as if there would be a tomorrow. There would be a day she was out. That we had to raise the children. That we had a responsibility to the children. That it was right for us to believe that and the children to believe that. And to get the children and encourage the children to know her and stay close to her. All this came from Bedford.

Women Need Resources and Support to Successfully Reunite with their Children

Marta was paroled to a long-term residential drug treatment program.

I'm staying the whole year. I got paroled here. I did 18 months and the six months that I had left of the two years I did here. And everybody thought that I was going to leave because usually the women do. But I didn't. Because I don't think it was fair of me to open the doors for my daughter and then come to a program and just do six months and then leave out of her life and out of the program. I wouldn't have gained nothing out of that. The only thing I would have done was ruin my daughter's life even more. Because my daughter didn't ask to come back into my life. I asked my daughter if I could have her back in my life. And I got that opportunity and I'm glad. Because now I can see that my daughter is a lot of me. She means a lot.

Sister Elaine described how women in her programs at Bedford Hills support each other. She recounted a speech one woman gave at a recent graduation from a parenting class.

And one woman said — "last week when I called home my daughter answered the phone and she said, 'I hate it here. I hate living with grandma.' And I said to her, that's all you got. That's all you have so you better start liking it. And when I went to class the next day and I told them what happened in class they said, 'You could have said it differently.' And the next night I called her up again and I said, how are you? She said, 'I still hate it here.' I said to her, how can I tell this to grandma without breaking your trust in me? I promise you if things don't get better, I'll look for another place. And she said, I only would have learned that in the parenting class."

She learned to listen. And said grandma loves you. How can we work this out? And it was just so different from the first conversation saying — this is it, you better like it. So when you hear people, knowing that there are other ways of having a third ear, and if you feel what she is saying is — I'm a teenager, I'm miserable, and I miss you. And what she's really saying is not, I hate grandma. It's, I hate the fact you're in prison. I hate the fact that we're not living together. So it's interesting to sit down and you hear what people are saying.

Chapter IV

What Hurt

Women discussed experiences that hurt them while in the criminal justice system. Many of the experts confirmed that women are often treated in ways that are unnecessarily harmful.

A number of women talked about their experiences in institutions — primarily mental hospitals, jails, and prisons — as experiences where they felt they re-lived their early childhood trauma. Some had been brutalized by staff and sexually abused. Many women talked about force — how it is used to contain women when they are considered out of control — and how painful and alienating that treatment felt.

Women also talked about the lack of well trained staff and emphasized that improvements in gender specific training could make a remarkable difference. For example, when staff were sympathetic and knowledgeable about issues relevant to the women's lives, they were instrumental in helping them to change and begin to recover.

Women and experts identified problems throughout the criminal justice system — from courts to jails to prisons to community release programs. They offered specific examples of how these

Themes

- Dehumanizing and harmful medical and psychiatric interventions
- Unnecessary and arbitrary harassment
- Disruption of important medications
- Use of force, restraint, and isolation
- Dehumanizing living conditions and processing by the criminal justice system
- Sexual harassment and abuse
- Language barriers
- Stigma
- Lack of support for re-entry into the community

institutions often worked against them. They were realistic about the need to maintain order in criminal justice settings but critical about the methods that are often used.

Dehumanizing and Harmful Medical and Psychiatric Interventions

Mary Ann described some of the medical exams she experienced.

Very, very rarely did I have, for instance, women physicians and women guards. And I think that in terms of somebody who is scared, that makes a big difference. A lot of the staff that I interacted with seemed to be directly out of the military. These were people who had been doctors in the armed forces. And there really were a lot of distancing mechanisms that were used. I mean, a medical exam was not a safe situation.

Mary Ann continued . . .

I think it depends, one thing is on the way the people physically approach you and the context they put the experience in. Because I have been places where no explanation is given at all. You know, it's go into that room. You take off your clothes, and then you're given a kind of a paper gown and then you have to take that off. And it can be just very frightening. And it also depends on the skill of the person who is doing it. Rectal and various — it is a very intrusive kind of exam. And depending on who's doing it, it can be physically painful. And I think it foreshadows the institutional culture. How you are treated at that point often is reflected then down the line.

Mary Ann witnessed women being treated as hopeless by psychiatrists.

I can remember a woman who, as it turned out, had MS [Multiple Sclerosis], and was a substance abuser. She struggled with depression. I can remember her telling me she was in isolation and a psychiatrist came down to look at her and she was just kind of curled up in a fetal position in the corner of a

cell. And he walked over to her and he said, "you're not more than a vegetable are you?" And just shoved at her with his shoe. But she was enough there that she knew. And she heard.

Or the woman in the bed next to me who was told by the psychiatrist that she was really irredeemable. It was her third return to prison and she said, "what does this mean?" And he said, "well, it means I think you can't change." And you know, the person who said this was just a human being. These pronouncements are arbitrary, laws are arbitrary. They are made by human beings. But she was devastated. And sometimes, it's the small things like that that can determine the total outcome.

Brenda talked about medical care in the criminal justice system and how a routine check-up turned into a traumatic experience. She described a pelvic exam while she was being held in the city jail.

One of the first things you do when you go in is you go to the medical unit and you really just lay around and are really miserable and throw up and whatever you had to do. I was in withdrawal. I think that I got a Pap smear or something like that. It was the most uncomfortable — by this time I've had three children and I'm 37 years old. This pelvic examination that I got was brutal. I mean, you know, just kind of a pattern.

And so he kept telling me to relax, relax. So that it was my fault that I was all tensed up. And I felt the swab you know, much further. He stayed down there longer than I thought was necessary. And the activity around you is pretty demeaning, even in the state I was in.

Well, it's like this — up to six people milling around. In and out and talking. Having gloves on but signing papers and handling things in the middle of it. What could have been a 10- or 15- minute examination turned out to be 30 minutes because of all the interruptions. And even though it was a room, the room had so much activity in it, you know, and people, you're kind of laying there nonexistent while they're trying to carry on all kinds of other business.

Brenda described the medical care she received for a persistent physical problem.

I can't use the bathroom. I can't defecate anywhere. I need a familiar surrounding and I hesitate to go into that kind of stuff. It's just not in me to do that easily. And so when I went to prison — I was in jail — I was having a hard time digesting the food. And then I don't go to the bathroom easily if I'm not in familiar surroundings and this was a whole process to get used to that. And anyway, I hadn't been to the bathroom in more than a week. It was about 10 days. I was trying to say that I was having a really hard time. It was pretty much beyond constipation and one of the other inmates was trying to tell me I needed to get a different diet.

And so I was trying to go through those channels when I remember, I was on the top bunk. I got out of the bunk. I had this real heavy pressure and I felt like I was going to go to the bathroom. But, I woke up once more in a really cold sweat and the emergency medical team was there, which means that I was out for a while.

I was cold and sweaty on the floor when I came to and I had urinated on myself. And so when I got up to the medical unit what I said was I hadn't been to the bathroom in 10 days. The doctor told me that was impossible. That it would be coming out of me. That it would come out of my mouth if it didn't come out of that end in that amount of time.

I got an X-ray and the X-ray showed that I had a bunch of stuff all up in there. That it was pretty evident that I was full. The doctor told me that I was faking, trying to get a different diet and if they gave everybody a different diet around here you'd be out on the street barely eating and then you would want to come in here and get a vegetarian diet.

It actually hurt the process that I was in instead of helping. He accused me of being a complete and utter fake. That it was not possible for me to have not gone to the bathroom that long and not be sicker than I was.

Unnecessary and Arbitrary Harassment

Mary Ann described the unnecessary and dehumanizing treatment she experienced in a prison infirmary.

> And, it was just a demonstration that you had to do what you were told, when you were told . . .
>
> **– *Mary Ann***

Well, I know that at one point I was incarcerated at the old women's prison in the District and it struck me that one of the ways that the guards could keep a distance from us was how they played out the orders of the day. And small things would become enormous, whoever's in control.

You spend a couple of days in the infirmary before you are put into the jungle of corrections. And it's a really strange experience. The infirmary was a fairly large room with beds and mattresses. Every time someone would come in that was new, the mattresses would be stacked one on top of another so you might have been given a bed with three mattresses on it. So they would have to wake people up and take mattresses out from under them and then set up a new cot and put a mattress on. It was a strange experience. You could get up five times in the night. And, it was just a demonstration that you had to do what you were told, when you were told, and it was just, it was in the culture.

And I don't know that it was thought out to be harassment, but a lot of women who came in were frightened, disoriented. Some actually were ill. And I can remember one woman in that setting who had killed her child. She was clearly hallucinating, schizophrenic. She just sat in the corner of the room and tore her clothes to shreds and each little strip she would tie into a bow. And the guards would just keep ordering her back. She was clearly in very, very bad shape and probably didn't belong in a penal population. But it's things like that which really impress you and during that time when they do a kind of evaluation. The quality of the evaluation and how good it is — which is really important. And, how professional it is.

Disruption of Important Medications

Mary Ann talked about the harm done by taking women off medication during their initial assessment when they enter the criminal justice system.

If they have a real recurrence of their symptoms it's very, very difficult. Sometimes it's very difficult to know what the social cuing is anymore because you're in a frightening situation and you don't know what's going to happen to you. You've never been in this situation before. And there's also, for many of us, an acute sense of shame when we become severely symptomatic because we don't want to be this way in front of people anyway. And some of us may be severely enough affected that we don't know where that boundary is, a lot of us are aware but a lot of us are hyper-aware.

Use of Force, Restraint, and Isolation

Brenda described a typical intervention with a woman who was schizophrenic and in a psychotic episode.

I remember this woman who was schizophrenic and everybody knew her. She was in there pretty often and they called her "Mama Black." And, you know, they kind of cleared the whole tier when she went into her thing. Everybody would leave her alone. It was up to us to get out of her way. The guards would not do anything. And it was kind of funny. Everybody took it like it was just her going off.

She would become very loud and she would run to the stairs. She lived on the bottom tier and that was one of the things, they knew her and they put her on the bottom tier. Because putting her on the top tier would have been a different situation. So because that way everybody had someplace to go. And she would come to the center of the floor and she said, "Oh you motherfuckers. I'm going to get you all." And everybody knew that meant that they should stay out of her way. And they sometimes would close the cell doors because she would tear people's stuff up. I mean it was really up to you to get out of her way.

It would go on for an hour or so and nobody would come and try to calm her. They would threaten her. "You want us to call them down here?" These storm trooper types — I really only saw them come once for her. I've seen them come a number of times and it's a horrible thing to see. Twelve or 15 strong come in and just ...

Men in riot gear, the boots, and they just come in and take her. And she's tussling with them. It's about six of them on top of her. We're all locked down. Only a few people can actually see what's going on and they tell everybody else. And the compassion that the women feel for her would be the way it was reported. It was like, "Stop, stop. Please, you don't have to hit her that much." You know, things like that.

Brenda described what happened after the woman was taken away.

The usual — they come out of the cells, but actually you're locked down for a bit. You may stay locked down, depending on what time of day it was, until dinner. You may stay past that. You might get your meal in there.

And for me, what that seemed to do was build a resentment against her. And there were some people who would — some blame had to be placed. "Why don't they put her in a nut house and stop putting her in here with us? And we have to be locked down like this."

Pat spent a lot of time in lock down and restraint.

I would be in restraints and seclusion until I would promise not to hurt myself. A couple of days I could be in lock down and then probably 24 hours in restraints. Meals would be served to me in lock down. And there was a toilet in that area. As far as eating with restraints, they would feed me. I would stay in restraints for the bathroom and for food. None of the other inmates were permitted to talk to me during that time — so here I was depressed and even further cut off. It was not necessarily the best kind of intervention for somebody who was in need of some connection.

And this is what I would consider a very good, caring facility. But from a staffing perspective, when you have a psychiatrist that's not there 24 hours, you have no social workers, you have guards, what do you do if somebody is suicidal after hours? You can't have them kill themselves. That's a liability. So from the staffing perspective I understand it.

> She said she couldn't stand it in the locked room because she was abused in a closet. But because she shared that with me it then made perfect sense to me as to what had happened.
>
> ***–Dr. Cassandra Newkirk***

Dr. Cassandra Newkirk talked about the harm done by unnecessary restraint and seclusion.

This issue of seclusion and restraint is a very big one for me because if you have someone who's agitated, the traditional thing and the way I was taught is, you seclude them and evaluate whether they need medication. You usually give them an injection and then you would seclude them and/or restrain them.

But I was sensitized listening to the women talk about how that could be retraumatizing. If you really haven't been taught trauma issues and you've never been traumatized, it really doesn't even cross your mind.

For instance, I had a woman who came in to the prison system. She was in the diagnostic process and told a counselor that she sometimes felt like she wanted to hurt herself. The policy in this institution was if someone even said that, you locked them down until they could be seen by a psychiatrist. That was just the policy.

I went to talk to this woman and I did my evaluation. One of the first things she said was, "you've got to get me out of here because they've made it worse. I didn't want to kill myself then." She was just giving a history. She said she couldn't stand it in the locked room because she was abused in a closet. But because she shared that with me it then made perfect sense to me as to what had happened.

They didn't even get her history. They were so frightened that instead of getting the history and really listening to her when she was talking — they asked a simple question like, "do you feel like hurting yourself now?" And it was probably 24 or more hours before I saw her. During this time she had actually gotten worse. They didn't call it seclusion. It was just lock her down because they didn't know what she was going to do and let the psychiatrist see her.

But she shared that with me. I listened. And one of the things that we really acknowledged was that putting her in any kind of seclusion should be the very last thing we do because that's probably going to make her worse. But it's just those little things and becoming sensitive to how we as clinicians have been taught to react and then basically ask questions later instead of getting the histories up front. What are your triggers? As many of the advocates have taught me — coming up with a plan before the crisis.

Dehumanizing Living Conditions and Processing By the Criminal Justice System

Mary Ann found the way body searches were conducted foreshadowed the institutional culture.

When you come in — kind of the rituals of body search and all it can be — it's how the person who is doing this, or persons, handle it, they become very important because it can be an intensely humiliating experience depending on who's doing it and how they do it. And whether they explain it to you or not.

Joy was transferred from a federal prison in California to another federal prison in West Virginia. She described the airlift and how dehumanizing it felt.

It was a disciplinary transfer. I was transferred out of the institution in four days. I went to San Diego to hold over and about three weeks later was on a plane to Alderson, West Virginia on the airlift. Now that is a

degrading, humiliating experience. I know that the criminal justice system was such a part of me that you become immune to its degradations and the shame that you go through — but the airlift even penetrated that emotional immune system.

Transporting women on the airlift is probably one of the most degrading experiences and I think it's degrading for everyone. I think it's particularly degrading for women since the focus here is on us — women.

The airlift — first of all at any one time the federal system probably has about 1,500 people in transit. In other words, they're transporting them either to another prison or to court or they just got sentenced. I mean the federal prison system is across the continent and so they have a lot of flexibility there.

And they have this very integral, complex — I'm not sure but I think they have at least three planes that transport and buses and other small planes. When you get transported on the airlift you don't take anything with you. You are either in a jumpsuit or khakis. You don't even have a change of underwear with you. You don't have your basic hygiene stuff. And the jail you spend the night at may or may not have any of that. And so, I traveled across country.

... You have your waist chains tied and you have feet shackles and you're even shackled on the airplane with your feet shackles. And you get on this plane and because there are so few women prisoners in relationship to men, that even if there's 10 or 20 traveling at one time, you only take up a very small part of a plane. So you have to walk down the aisle to go to the bathroom or to get to your seat. You have to walk through this plane of men who — God knows when the last time they saw a woman. You feel like they are visually undressing you. They all stink because they haven't been able to bathe. Just like you haven't been able to bathe. It's such a degrading experience. And if your waist chains got through your belt loops because you were in such a hurry when the marshals put these chains

on you, you can't even get your pants all the way down. That happened to me the first time. I couldn't even pull my pants down. The female Marshall had to help me pull my pants down to go to the bathroom. It's the most degrading experience I've ever had. And I've been strip searched and had pelvics. I mean I've gone through the gamut of personal body searches and urines and all of that. Nothing is to the experience of being transported by the U.S. Marshals on the airlift.

It took four days to get to Georgia. And then we waited in Georgia for not quite a week and then drove in a van from Georgia to North Carolina up to Alderson.

Sexual Harassment and Abuse

Marta talked about her difficulty dealing with male correctional officers.

You didn't get away with nothing. And they were mostly male. They weren't mostly female there. The males there were really kind of harsh and they were doing an article on Framingham, on the women there because the men used to take advantage of the women there. I don't know if the article came out but I really didn't like the surroundings. I'd rather have females than males. I wasn't comfortable with them because if you were changing or something, they would flick on the light and you're changing and you're nude. They'll stand there and look at you.

After Pat's arrest, she was sent to a state mental hospital for an evaluation where she was sexually abused by staff.

I was psychotic and was there for evaluation. I was sexually abused by staff while I was there. I reported it. And it was seen as a ploy — because I was a criminal case — to stay longer. The person was never removed from the unit. And it was seen as — because I was there under court evaluation for a criminal charge — it couldn't possibly be anything but.

Sharon described an episode with her parole officer.

I got out of prison. I did three years of a six-year, three-month sentence. I was in the Florida system. I stayed in the community one month and I struck out again. Went back to prison. Had a parole officer show up at my house with a six case of beer and we started committing crimes and I ended up with just one good month on the streets.

... To go to bed with me. What was he doing? He was probably doing what he did with most women on his caseload if he was interested. A friend of mine had met me at prison and went to the parole office with me and all he would say through the whole thing was — how come she doesn't have a bra on?

Lack of Knowledge About Trauma, Mental Illness, Substance Abuse and Gender

Linda talked about the general lack of knowledge about mental illness in the legal system.

Nobody wanted to listen to the fact that I was ill — not my attorney, not the Commonwealth attorney, not anybody else.

Well, you know, when I tried to tell my attorney — because my doctor was saying he needs to know these things — and he would say, "yes, but do you mean to tell me that your doctor's willing to say that you're not guilty by reason of insanity." I said no, but he wants you to understand that this is mental illness. This is not an aberration of the personality as far as someone just being mean. And he said, "It doesn't matter in Virginia. You're either not guilty by reason of insanity or you stand trial like everybody else." Virginia does not have a guilty but mentally ill plea, which usually involves either outpatient commitment or inpatient commitment, that other states have of course, so that wouldn't come into it. I mean this was in May. My court date wasn't until the 28th of October. So, the whole summer I dealt with this — nobody wanting to listen to the fact that I was ill and having my former boss talk about betrayal and this and that and the other.

We didn't even want to go to trial. We wanted a plea agreement from day one, to where that would include treatment as part of the plea agreement. She wouldn't listen. She wanted no part of it. She just refused to accept that that's what it was. Even though my doctor wrote a letter outlining everything, outlining what he had planned for me, and sent it to her. She ignored that. To her it was all an excuse. It was not an illness.

The judge didn't understand. I've talked with the judge since and now he has said to me, we're somewhat inadequate when it comes to dealing with issues like this because we're taught to deal in right and wrong, we're not taught to deal in ill and well.

Dr. Newkirk provided an example of the harm that can be done by staff who are insensitive to gender issues, trauma, and violence.

I had an older doctor who was extremely good-hearted. He would do just about anything in the world we asked him to do. But he was insensitive to women's issues. For example, one of the counselors came in with one of the inmates. He was going to see an inmate because she was having problems and he'd been seeing her for a long time. And the counselor said so and so is in crisis because she had just gotten word from home that her children were probably being abused by her father. The counselor shared with the psychiatrist that they had already contacted the Department of Family and Children's Services in the inmate's hometown. They were going to investigate. The psychiatrist's response was — "why would you want to do that to him?" It was automatic. You may get this man in trouble. He ignored the woman's issues.

Dr. Veysey offered her observations about how women in the criminal justice system are treated and the lack of attention to their issues, especially violence.

I guess from my own experience I've been invisible. I think for a woman that's probably the norm. We're taught to recede. We're taught that we're not important or not as important. I think women have to do pretty dramatic

things to be seen. And I think that's true whether you're talking about substance abuse, mental illness, or violence. I think if we don't bring ourselves forward clearly that no one will respond.

Given the numbers of women in correctional settings, it's not in an administrators' best self interest to give attention to women. They represent such a small proportion of jails and prisons —10 percent of jails, 6 percent of prison populations. Most criminal justice administrators would just as well not deal with women at all. And, certainly not have to deal with the huge number of issues that women bring with them.

I think invisibility is a tremendous, tremendous problem. At most facilities that I go into, there is nothing for women. There's one classification for women — female. They don't distinguish women based on specific needs. Whether a woman has a mental health issue that will make serving time difficult for her, the staff, or for other inmates. Whatever it is, there's one classification. That to me is invisibility. That women aren't distinguished in any way other than the fact that they're female.

We don't want to see violence or the implication violence has on our sisters, our daughters, our mothers, on our children. It strikes me as appalling, amazing that the numbers, the prevalence of rape, of incest, of physical abuse makes violence normative in our society for women.

Language Barriers

Marta described what happened to women who could not speak English.

They just cut off from everybody. They have a difficult time relating to c.o.'s (correctional officers). Where if you said something nice to them they think they be saying something bad to you and then they'll lock you up because they don't understand what you're saying. The Spanish people don't know how to speak English so it's kind of difficult.

Stigma

Niyyah quoted a friend's description of how mentally ill women are perceived in prison by both corrections staff and inmates.

"In prison it was real clear that the mentally ill were at the bottom of the ladder. They don't bother you and you don't bother them. You don't try to get any power. You don't try to get around people. You stay by yourself and you stay quiet. And that was comfortable because it was no gains. I knew I didn't count. I knew that if there was anybody going to be sacrificed it was going to be me. And I just understood where I was. And when they offered me an opportunity while I was in prison to go to the mental hospital, I turned it down. Because at least it was clear where I was in prison."

Linda talked about the stigma associated with mental illness and offered her insights into why stigma persists.

I think part of it is fear. And especially when they saw me. I mean I moved in their circles. I attended their charity functions. I attended their social events. "My God, if she could be mentally ill, I could be mentally ill." I think it is fear.

Laura Prescott talked at length about the stigma and the loss of credibility that women with mental illness often experience.

Stigma is associated with credibility. Stigma is a term largely used by the mental health system. Few people outside the system understand the term stigma as it is applied to describe the complex phenomena of discrimination experienced by those who have been labeled. Therefore, I like to think about using the term discrimination as it applies more broadly in a civil context and is therefore, a more accurate description of the experiences people have.

The effect of grouping individuals based on social assumptions has large economic, political, and social ramifications. Trying to combat those

assumptions while living with a condition that already makes life more difficult, can be devastating. The isolation and subsequent pressure to "keep it together" so that others don't pathologize your reactions is exhausting and "crazy-making" in and of itself. Once labeled, people are no longer free to have the same reactions as everyone else without being questionable. Actions, reactions, feelings, thoughts which were once considered what we call "normal," "credible," "believable," "trustworthy," are now grounds for intrusion, question, and sometimes even involuntary commitment. I believe that the effects of this constant undermining has led some to suicide.

Sharon talked about the harmful effects of labeling women.

I think we do this whole uncomfortable piece for me of separating women from their worlds. One becomes a drug addict or a prostitute or a criminal or a street woman. We make them less than a woman as a result of it. I mean it's kind of a variation of the red badge of courage in some ways. It's how we pariah women. They're not women, they're non-women in this world. So that our perceptions of them as human beings become altered by that label.

Dr. Brenda Lyles talked about how labeling women strips them of their humanity.

I think that somehow we've managed to look at each individual as a separate entity. I'm who I am. You are who you are. And that person is somebody else. No one's fate and success is dependent or impacted by the manner in which we relate to anyone else. I don't think that such a separation exists because I believe that there's a tremendous amount of interdependence among people. I really think that because society in general has clearly designated people with addictions and people with serious mental illness as nonentities and people who can be ignored, neglected, and dehumanized, women who are labeled with a disorder lose their capacity to be identified as important and essential contributors to the clinical and rehabilitative solutions needed to address their problems.

And I think that locked away in the minds of those people may be the cure for cancer, may be the cure for AIDS, may be a lot of the things that would make life a lot better for each of us. But instead, what we've done is chosen to put those people away because they're different from us. And I don't believe they are. I think there's a tremendous amount of interdependence among people. I think that because we have chosen to say that certain elements are not a part of us and we haven't started to look at people as people — and there's really no difference because we are all human — we don't really work on trying to get the best out of each person.

...women who are labeled with a disorder lose their capacity to be identified as important and essential contributors to the clinical and rehabilitative solutions needed to address their problems.

– Dr. Brenda Lyles

Dr. Veysey discussed the harm of paternalistic attitudes toward women.

In may ways it's dangerous to express what's happening to you in your own perceptions because it's pathologized. Everything, everything you say, everything you do is recast with whatever the diagnosis is so it's consistent with clinical impression instead of consistent with the individual's reality and experience. And clearly when that attitude goes into a treatment relationship, it becomes problematic unless there really is a human relationship between the two individuals. And again it goes back to degrees of listening. If you, as a therapist, don't have the time or can't listen to what I'm saying, or don't want to listen to what I'm saying, or if what I'm saying doesn't make any sense to you because you're unwilling to try to make it make sense, then you can't help me. You're limited by the tools at your hands without my involvement. And I think that's a huge problem, particularly in the mental health field where there is so much emphasis placed on medications and you need to know how I react to these medications. And you need me to give you good information because it is in both of our best interests.

Because of the unique social stereotypes around mental illness and what that means, it really complicates treatment because the voice is considered irrational. The person is considered irrational and can't possibly contribute to treatment.

Dr. Veysey talked again about stigma when discussing how consumers were treated when they were invited to participate in program planning and policy development.

There was a feeling that consumers were tolerated. Consumers were sought for their voice but not really as technical participants. There was clearly a distinction between the legitimacy of their voice and the legitimacy of experts' voices with consumers always losing out. Consumers not quite as expert in many ways — sometimes these folks can have the professional credentials — because they had a mental illness. Any time they acted in any way outside the norm or even barely within the norm, their voice was then discredited.

Little Support for Moving Back Into the Community

Mary Ann talked about how difficult it is to come out of prison.

And there were times when we were dependent on welfare, which is another system that's difficult to negotiate. I mean, and that's one of the things that's hard on the outside with psychiatric disabilities, is that your network of support in the community is so complex. You're dependent on so many different agencies. You have to — your housing is separate from your food stamps is separate from your probation officer and whoever else you're reporting to. And I've got to say this, in decentralized areas, like suburban counties here, it's just a nightmare to go to all the places. There's no single place where you can go and do an application for all these things.

And when you're still behind bars, there's not much kind of work release — the in and out thing for women is not as it is for men. So there isn't bridging time. At least in my experience. And I think for women that's extremely important. Less important for me because I have a man.

Tanya talked about her struggle to get housing when she was released.

> And I'm struggling, trying to do the right thing. And they're closing the doors at every turn.
>
> **– Tanya**

The Department of Human Services would not give me a welfare check because I was in a halfway house being taken care of by the Department of Corrections. And I couldn't figure out why don't they get it. I can't stay in the halfway house the rest of my life. I can't get out unless they give me a check to get a place to live.

So it turned out, my counselor told me this. She said, "we're just going to have to beat the system." And I figured that was my first experience — that the system that's designed to help people doesn't. It breaks down. It does not help people when they need it most.

And that can be very frustrating to a person like me. A person who already had this really messed up thinking and already would check out by using drugs when she got uptight when things didn't go right. And I'm struggling, trying to do the right thing. And they're closing the doors at every turn.

Dr. Sushma Taylor talked about how unprepared women are to deal with the world when they are released from prison.

By the time they are released they are disconnected from everybody. They are disconnected from family if they've been moved from one prison to the other. Poor families have probably not been able to visit them because they don't have the wherewithal to visit 200, 300, 500, or 1,000 miles away. So family is disconnected.

A lot of people say get on with your life. Particularly if they have long stretches of time they're doing. And there is a lot of disconnect. There's nobody waiting for them. They don't know how to work anymore. They don't even know what bus line to take. So simple, common decisions are difficult.

> But we are now expecting that they will go out there, find themselves a job, find themselves a place to live, and be able to be OK and function. That's a very large expectation.
>
> **– Dr. Sushma Taylor**

... And then the noise and the traffic of the daily life is so overwhelming. It would be like coming from a very small town and learning how to drive in a tiny, little, small town that had a population of about 40,000 people and then being dropped in New York City and saying — OK — drive. You would freak out. That's what happens to people in prison. Their life is on hold. So that when they come out they have even less. But we are now expecting that they will go out there, find themselves a job, find themselves a place to live, and be able to be OK and function. That's a very large expectation.

Ms. Michelle Petrino talked about the lack of resources and support for women when they leave Bedford Hills Correctional Facility and try to live in the community.

... Going back on the street to what? Welfare, drugs, a shelter? If you're lucky. And that's the piece that I think we really have to look at working on. Aftercare services for the incarcerated woman when she is leaving here. Whether it be somebody with mental illness and drug addiction or just mental illness. There's no place for them to go to live.

Funding. You do the social security application but you don't know if you're approved. So you go for your Medicaid card and your welfare and they give you $10. Where's $10 going to go today — when you may be a smoker and it's $2 for a pack of cigarettes?

It sets them up for failure is the way I look at it. I've been working on it at the Office of Mental Health where we are trying to provide increased services in the community. They need their medication. They go out with

a two-week supply and then what do you do after two weeks? If your Medicaid doesn't kick in you're going to be without your medicine. So we've even set up a system in New York City now with discharge planning — FAYS Drugs — where they will provide the meds if they have an intensive case manager to take them to get their medications, they'll get reimbursed later, or they'll get reimbursed from parole.

But something has got to be done regarding the housing issue. There's not enough housing out there for these women. Women come in from the City. They're here for 10, 12 years. They don't want to go back to the City because they know the drugs are right there. They might start using them again. It only sends them right back here. They have no family. So you find a really nice place in Westchester County and now Westchester County doesn't want them because they're not Westchester County residents. Well, they've been incarcerated in Westchester County for 15 years. Why aren't they a Westchester County resident? And we fight with that all the time.

Emphasis on Punishment Without Rehabilitation or Treatment

Niyyah was repeatedly jailed for behavior that related to her mental illness.

The experience in jail for me was one based upon the people just putting me there because there's no place to put me. I was never in jail and sentenced like my daughter for a major crime or anything like that. It was only — we don't have anyplace to put this crazy person who was on the street, doing the wrong thing, annoying somebody, being hysterical or something, and should quiet down. And sometimes I was not even charged with anything. They used to do a thing where they just held you until you calmed down.

So they would throw you in these drunk tanks I call them. Whether you were drunk or not — with drunks and prostitutes, with people that had all kinds of illnesses. You were the flotsam and the jetsam of society.

So I definitely didn't get any help. The help I got was that they let me out. As soon as somebody would come in and do whatever they do, they'd say — Oh, get her out of here. She's quiet. Or — Get her out of here, she smells.

Pat was in a forensic unit that was grossly understaffed.

What wasn't helpful is that there's not a lot there. You would think being a forensic unit for women — and at that time, I think it was the only forensic unit. Other than seeing Dr. E. — you know maybe I would see him during the week, maybe not. God bless the student intern, a psychology student that I saw twice (in 18 months) for hypnosis and counseling. And she was very helpful. And it was unfortunate that they couldn't get a replacement for her.

Linda talked about the futility of punishment without treatment.

This is an illness. Yes, it did result in behavior that broke the laws of the land but it was generated by an illness. Be it substance abuse or mental illness, it is still an illness. And, it's an illness that can in most cases be successfully treated.

Dr. Allen Ault talked about the futility of incarceration without research on what works or any focus on rehabilitation and treatment.

Too often politicians are using this as an excuse of a get-tough theory. It's an excuse to cut funds without any attention to what it does to future victimization. The word "recidivism " is such an impersonal word. I would rather refer to it as future victimization because that's what we are really talking about.

If we do not use the most effective programs to reduce re-offending in prisoners, then what we turn out is pretty scary. I remember when I was first a warden, I used to worry a lot about who we were turning out. What they would do to people. And I still worry about that.

We're now spending $27.4 billion a year in this country on corrections and less than one-half of 1 percent on research. I don't even know if that figure is that high. It's just such a small amount. And for that we're getting an average stay of 27 months in a prison system. There's been so little longitudinal research to say this works or this doesn't work.

The word "recidivism" is such an impersonal word. I would rather refer to it as future victimization because that's what we are really talking about.

– Dr. Allen Ault

Dr. Ault referred to major research that has been done in corrections.

That same research indicated that sanctions without treatment actually increases recidivism by 7 percent. But, I don't know that anybody is listening to that.

Dr. Sushma Taylor talked about the disincentives in the system and how they stand in the way of women asking for help.

One of the things I've often said is that in America we have the wrong system of medicine. In China you pay the doctor as long as you are well. The minute you are sick you stop paying him. So it's up to the physician to make you well as soon as possible so they can be back on the payroll. Here we pay when we're well and then we pay some more when we're sick under the HMO plan.

Similarly in the criminal justice system. Let's look at what we've done. We have taken law enforcement — we're no longer calling them peace officers — they're calling themselves police officers. In the penal code it says peace officer. Probation officers are individuals nobody wants to see when somebody has relapsed, when somebody doesn't have a job, when they've just had an altercation with their spouse, when they're in crisis, that is when they don't want to see their probation officer.

The only time you want to see your probation/parole officer is when you've got a job, you're clean, and you're doing well. Now think about what a disincentive it is that somebody who is supposed to be a resource is just a hammer. In the old days probation officers were social workers. Now they've become an extension of law enforcement. That has been a shift in our criminal justice policies, which of course has been really problematic for the parolees.

> You can't treat people like an animal and think that they're going to come out in two years or 10 years and know how to relate to other ordinary people in a nonviolent, nonaggressive fashion.
>
> **– Judge Gladys Kessler**

Judge Gladys Kessler reflected on her more than 20 years on the bench and expressed her concerns about any progress in treating women in the criminal justice system.

I don't think we've accomplished a whole lot for women in the system, and more and more women are coming into the system as we know it because they're used more and more in drug distribution. I think it has been that way for 20 years. I think that we've talked a lot, we've been to a lot of conferences. There's a recognition that more and more women are in the system, but I don't really see the system doing more for women now than it did many years ago. I really don't. It's a very pessimistic conclusion to reach, but as I look back on those 20 years, I don't see vastly improved facilities for women.

I don't think there are easy fixes. Maybe other people have them. You can't treat people like an animal and think that they're going to come out in two years or 10 years and know how to relate to other ordinary people in a nonviolent, nonaggressive fashion. I don't know how people can *not* see that. I don't understand.

Tanya spent years in various correctional facilities. She doesn't recall anyone ever talking with her about her drug addiction and repeated incarcerations.

Never, not even the first time I was arrested. And as I said earlier, I had no juvenile record. They sent me to Morgantown and I had some kind of initial conversation with a psychologist. That was it. And from that point on, they always sent me to jail. You know, nobody ever noticed that here's a person who was never in trouble as an adolescent. Here's a person who has above average intelligence who does well in school, who has the initiative to take all of these classes. There's hope for this person. Let's get her some help.

Tanya summarized her years of incarceration.

And they always talk about rehabilitation. That's the word they use to keep you locked up. Oh well, you're not rehabilitated yet. You can't come out. I'm not rehabilitated. I wasn't rehabilitated when I came here obviously and if you've put me here and done nothing to help me be rehabilitated then what do you expect me to be when it's time to go. I'm the same person you brought in here because you left me like that.

. . . You just perpetuate the problem when you gloss over the surface. And then when we come back busting the door down to a prison, the first thing the officer says is, "What are you doing back?"

Well, first of all, you let me out at 12:01 midnight. I was in Southeast D.C. at the jail. The one relative I have lives in Maryland. I didn't have a quarter to call them. It was snowing outside. When I came in it was a 100 degrees. I didn't have a coat. The jail coat that you let me use the whole time I was here, you took from me at the door because the population is so high I can't have a coat to take home. So I'm out in the street in the middle of December at 12:01 midnight and it's snowing. I don't even have a coat on. And you're asking me what I'm doing back here!

I had to do something. And even it I didn't have to do it, my low self-esteem, my hopelessness and just my sick thinking told me that I had to do something simply because I was so damned pissed off that you treated me like you did.

Chapter V

What Helped

All of the women described experiences or relationships with individuals that helped them begin to change and recover. For many of the women a loving and knowledgeable person — often an inmate or female staff — was critical. For others proper medication made an enormous difference. Some women described getting older and not wanting to spend their whole lives incarcerated. The women talked openly about the ways they were handled in correctional and treatment settings and some simple things that made a difference. The viewpoints offered by experts supported many of the stories told by the women.

Relationships with People Who Cared, Listened, and Could Be Trusted

Barbara was sexually abused over many years while she was in foster care. She stopped speaking as a result of all the trauma. After her foster father died, Barbara was placed in a group home for teenage girls. She described her relationship with the house mother.

Themes

- Relationships with people who cared, listened, and could be trusted
- Relationships with other women who were supportive and role models
- Proper assessment/ classification
- Well-trained staff – especially female staff
- Proper medication
- Programs – not just incarceration, but job training, education, substance abuse and mental health treatment, and parenting
- Inmate-centered programs
- Efforts to reduce trauma and revictimization/ alternatives to seclusion and restraint
- Financial resources
- Safe environments

There was one woman — the housemother at the place — she had a gut feeling about why I didn't talk. And to this day I'll always be appreciative of her. She brought my voice back by talking to me and saying things like, "I know you didn't deserve what happened. You're not the fault. It's not your fault." Things like that over and over. It took this woman months to get anything out of me. But she worked with me the entire time the house was empty. The private house for 10 was empty for about three or four months. I was dumped there ahead of time and, Mrs. R. was her name, she stuck with it even though no voice came back. She continued faithfully every day to say — "Let's play ping pong. Let's do something. You know you've got to come out of that." And I can't even describe the state I was in. And she brought me back out of it. She brought me back out of it.

Pat had a public defender and a psychiatrist in a maximum security federal prison who advocated for her and helped her to learn more about her family history of mental illness.

Through the public defender in Baltimore and the support of the forensic psychiatrist at the Lexington facility, they were able to work to have the case transferred so they could minimize the trauma of transporting me and being strip searched when I was already paranoid and fearful and anxious. And so they minimized some of the trauma by helping get the case moved. I stayed on the forensic unit for almost a year. And it was there that for the first time I was really on any kind of medications, found out about the history about my family, had any type of counseling.

Pat found her relationships with the female guards extremely helpful.

In terms of treatment in the forensic unit in Lexington, what was helpful was that I started to talk about my experience. Surprisingly the guards on the forensic unit were very well-trained. Not all of them, but the few that I maintained contact with were very supportive. And even though I didn't have a psychology counselor, at least it was somebody to talk with.

And the ones that were helpful were the women. The men were more into the correctional mentality where there's no such thing as mental illness. Even though they were working on a forensic unit. It's — you're a convict and all convicts are manipulative. I don't know if that's gender bias or perhaps because of their other correctional experiences. They may have been put in more difficult situations with the general population.

With the women there was a different level of conversation. I spent some time in restraints while I was at Lexington for trying to kill myself while I was in the forensic unit. There was just a different level of communication in terms of being able to go to them and say, "You know, I'm feeling like I'm going to hurt myself. I know there are 50 ways right here in this unit that I could do that." And for them to listen to that and not do the response, "We need to lock you down, we need to put you in restraints" — which was typically what would happen if you went to a male guard. And again, I don't know if that's gender bias or it just happened to be the people.

Pat talked more about how helpful the guards were in listening to her and letting her talk through her feelings.

What it helped me develop were some impulse control skills that locking me down didn't do. For example, if there was a shift where there wasn't someone that I could talk with and I was having those feelings, two things were going to happen and likely did. One, I'd have to find someone else to talk with. And if other inmates were not available to do that, then usually I ended up in restraints because I attempted to hurt myself.

So talking about it allowed me to say — I don't have control over these feelings, I know I'm going to act on them and I need some help intervening. And to be able to just sit down and just say — this is how I'm feeling. And usually if I could talk through it and I could just sit with someone and have a safety net, even if that meant that they were doing other things and I walked around while they did rounds or something — that made a difference.

> And so from what she had seen, she had at least taken me under her wing. I think I would have spent a lot more time in restraints or locked down if it hadn't been for her.
>
> **– Pat**

Pat found it was critical to just have someone be with her.

Because I would have acted on my feelings. And that was one of the things that several of the — actually, the one guard — and I don't know what her position was, like a discharge outreach worker, she wasn't a clinical person but was a correctional person. She was convinced that I would end up killing myself one day. And so from what she had seen, she had at least taken me under her wing. I think I would have spent a lot more time in restraints or locked down if it hadn't been for her.

Because there wasn't any in between — it was if you have those feelings and can't control them, then let's strip search you, put you in a cell, and lock it. Or, let's strip search you, put you in restraints, and nobody will come talk to you because we don't want to reward those behaviors. I'm not sure people don't understand that isn't just attention-getting behavior.

Mary Ann identified what makes good staff from a client or inmate's perspective.

I think as integral as it sounds, the most important thing is honesty with the people you're interacting with and a willingness to listen to you also. To hear and be heard. I think also staff who are experienced in dealing with people who are frightened, or who are psychiatrically ill, and are not frightened by the symptomatology.

At Alderson, I think the staff was genuine. I found people genuinely more helpful. They were an all-women staff. They seemed more professional.

Sister Elaine Roulet works closely with correctional officers. She described this important collaboration.

Well, in the beginning I thought security was here to watch the prisoners and security was here to make sure no one escaped. And programs were to keep people usefully occupied. And then I remember thinking they were like oil and water. They had two distinct jobs to do.

> This is my passion, my community. The last thing you could ever call it is work.
>
> **– Sister Elaine Roulet**

Then after awhile I began to see that they needed each other. You know an officer calls saying there's a woman on my unit crying and crying, something about her kids. He would refer her to me. Or I would call up and say, I just gave bad news, just keep an eye on her tonight. It wasn't a serious night watch but just a humane officer keeping an eye on her. This morning before you came an officer called me and said, "there's a woman who just came to my unit. She's crying. And I don't know what she is crying about, she won't tell me." And he sent her down here. She was seen obviously by somebody. I didn't see her. But some of my best referrals come from security.

Sister Elaine talked about her commitment to working with women.

This is my passion, my community. The last thing you could ever call it is work. And when I hear myself say — I have to go to work today, I realize I'm lying. I have to go where I belong. I have to go where the water gives me life. And there's a prison expression — I have a lot of juice. And it means I can ...

There's a Turkish poet who was in prison for 30 years. He wrote a long poem and at the end it says, "I could do 40, I could do 50 years, as long as the jewel on the left side of my chest doesn't lose its luster." And I think that's right. Here I'm able to keep my heart shiny bright by using it.

Dr. Bonita Veysey thinks it is critical for women to be in an environment where they can talk about their past traumatic experiences.

We need to allow women to be the owners of their lives; that it's OK to open up this can of worms. You need to help women learn the skills to process the violence, to understand it, but that they'll be OK. We will be OK. We can do this. We can look at terrible things in the past. God knows, we survived them. And the paternalistic implications of saying that, we as professionals, can't and won't deal with that. So. I can. I need to deal with this.

I think the most important thing is that we treat these women as people. That we build relationships, that we listen. And it's always a problem because you don't want to get too involved, but at the same time we can listen. Listening doesn't cost anything.

– Dr. Bonita Veysey

The women that we're seeing — women with mental health issues and women who have substance abuse issues and criminal justice involvement — until we deal with these root issues they're going to continue to cycle back through and through and through. Not to mention until we start dealing with them and say, "these terrible things happened to you, this is not what a parent is." What are we going to do with the next generation?

I think any time that you can connect, whether it's treatment staff, whether it's c.o.'s (correctional officers), on a human basis is helpful. That's often helped if you have a direct supervision facility, where staff are on the pod all the time with the women.

I think the most important thing is that we treat these women as people. That we build relationships, that we listen. And it's always a problem because you don't want to get too involved, but at the same time we can listen. Listening doesn't cost anything.

Dr. Cassandra Newkirk also found that women needed an opportunity to talk about their lives and experiences.

It was very hard to limit their conversations. It was draining because they were so needy. And what they needed was someone to listen to them. Even if they were in groups, seeing a psychologist, seeing somebody else, or they'd see me and they needed to talk.

We know that women talk to deal with their problems. They deal with their issues by talking about it — a lot of times not necessarily to get an answer but that's just the way we deal with our problems.

Dr. Newkirk changed her professional practice as she learned from women about what they found helpful.

First of all , I had to learn to listen. As a physician I was taught that in the clinical areas I had the answers. And usually where you were to go to get those answers was from a recognized text reference or someone who had been practicing longer than you had. Working with people who have received services in the environments we've been talking about, correctional systems and in mental health systems, has been an eye opener because a lot of allegations of abuse that my professional colleagues tend to say don't happen or happen only rarely, I would say probably happen much more than I would have liked to have thought.

And so I listened to their stories. I thought about situations I had found myself in and when I say I had to learn to listen, I also had to learn to listen for things that happened to me or had happened in my work environment that other people had done, and even that I may have done.

Ms. Michelle Petrino talked about "genuine concern" and what it means for women.

Genuine concern means to me that I listen. I have empathy. I will advocate for them to the utmost. I'm truthful and they're truthful with me. There's a definite trusting relationship there but there's still the boundary of therapist/inmate. I feel I do everything I can for that person. That there's a good bond there. I feel that they're going to get well, that I'm not doing it for

any gain for myself but only for caring for that person, making sure that the person is treated like a human being and that she gets the care she needs without being harassed or treated unfairly.

> I feel that they're going to get well, that I'm not doing it for any gain for myself but only for caring for that person, making sure that the person is treated like a human being and she gets the care she needs without being harassed or treated unfairly.
>
> **– *Michelle Petrino, R.N.***

Dr. Brenda Lyles pointed out how women are often discounted and need an opportunity to tell their stories and be believed.

Because they're mentally ill and they're addicts people ask what can these women know and what can they bring to the table? They bring so much to the table. They are the people who know a lot about how to work with people debilitated by these disorders and what's happening to them in treatment. I think that we've got to get behind them and surround them and be able to listen to them. It keeps us honest. I think it's critical that they're a part of everything that's done in terms of planning, implementation, and addressing the efficacy of treatment services. We must have entree to the women in treatment because they see clearly what interventions cause consumers to feel negated. It doesn't matter who the woman is, what social level she comes from, what her diagnosis is, her ideas and concerns are important.

Dr. Sushma Taylor talked about trust as central to relationships with women.

I had a lot of clients who were very good teachers, who were very eager to train me. I think beyond that it's just a case of liking them. I just genuinely like people. I like them and they sense it. They have a sixth sense. And they also know if you're trustworthy and if you will live up to your word. That probably is the single biggest factor in all of the 25 years that I've been working with people, particularly addicts. The one thing that

they want to know is that we are not going to let them down. We may not do everything that they ask us to do but we don't manipulate them. Or give up on them. We don't want to lie to them.

That's basically what they want. Particularly those who come from the criminal justice system. These are not people who bond particularly closely to others. They want to but they haven't been able to. They would like to trust but unfortunately they haven't met too many trustworthy people. Their own culture is full of untrustworthy people. Then they get caught up with the criminal justice system and the only thing trustworthy about the criminal justice system is that punishment will be there for them. That's about it.

Tanya talked about the women who helped her put her life back together.

There was nothing else for me to do. I ended up in that Women's Empowerment Series and I do believe if I had encountered it many years ago I would have a lot more years of recovery. What I found were two women who were attorneys who were very down to earth. They did not come in there with this attitude of I'm this professional and I've got all of this theoretical knowledge and I'm going to tell you what you need to do because I've read it in a book. That does not impress me because I have enough sense to know that what you read in a book does not apply to Jane, Susie, and Mary. You cannot help people like that. You do it on an individual basis. That's what I found in the program.

Those two women came and they brought the information, which was helpful. It was very practical. It was things for women who have never worked, places you can go that will hire ex-offenders. For women with children, places you can get low-cost therapy for you and your children if you're trying to reunite with them. Housing — low-cost housing, free transitional housing. Things that women in my situation really need to know about. They told us about that. After the sessions were over, they sat down and talked individually with us if we had issues. And they followed through. You never had to chase them down. They did what you needed them to do.

Relationships with Other Women

Pat found the relationships she developed with other inmates provided critical support.

You begin to develop some support systems with other inmates who are on the forensic unit to keep from being put in those kind of positions (restraints, lock down). You know, to this day I remember this song that this woman from Georgia, a young black woman who had robbed a bank and was very psychotic, and would repeatedly get put in restraints. And one day we were in restraints in the rooms next to each other. And to this day — I remember the song we sang.

And it was not a song that existed. It was one that she made up that was nonsensical. But that's something I had to hold onto because it's a kind of support that you wouldn't think about that there are ways of looking at one another, knowing that you are in pain together, and just being supportive in that way.

Sharon described the healing relationships she developed with women when she was incarcerated.

And I must tell you it was in prison that I learned to love women. It's hard to talk about but I think that we're disconnected in so many ways from each other and so many of the messages that go around are not to be connected. I've never seen anywhere — the generosity of heart.

The room I lived in was a big dormitory and all the beds were out — it almost looked like a big gymnasium. And there was a young girl there who had been in a fight in a bar and ended up in prison and who cried all the time in the night. I don't know how young, but I would say 17 or 18 years old. Her family was very poor. They had nothing. Most of the kids had no shoes. I mean, poverty that people from the cities don't understand. She never got letters. They couldn't afford stamps. Half of the family couldn't write.

And she would cry all the time. One Christmas I watched the women conspire to put together — you know they could only get four boxes a year and they had to be a certain size. You could get very little. And the women took from the boxes and made a box for her. And they conspired with one of the matrons to get the box to her and sent in from her family. So it was that kind of generosity.

Marta talked about being HIV positive and the love and support she received from other women in the treatment program where she was paroled to from prison.

You know they eat behind me, they drink behind me, and it doesn't bother them because they know you can't get it like that. And we're well educated. But they love me for who I am, not what I am. And that's what I love about that.

> But they love me for who I am, not what I am. And that's what I love about that.
>
> **– *Marta***

That we can talk and relate different issues that we have because we have one that's an alcoholic. We have one that does heroin. One who smokes. A couple of us who smoke crack. And then there's one that does all of it. So we've all got different experiences. So we can actually sit back and talk about what we've done with our lives. How we affected our children. Because our children are the ones that suffered more than we did.

Joy found treatment in a therapeutic community when she was released from prison. It was there that she learned to trust other women.

When I first came to Center Point I had no real conception of what support and sharing meant. I thought of support as a financial term. Sharing meant sharing material things and secrets with friends or those who I thought were friends.

Since coming to the program and seeing the work done here, both with others and myself, I see that the concepts support and sharing builds a safe, positive shelter for myself and peers to transform ourselves. Support allows me to feel pain, show my emotions, and not feel like I will be thought a sissy or weak. This support comes from seeing others sharing their deepest, most intimate feelings. By seeing my peers experience pain and growth, it gave me the encouragement and trust I needed to share my issues.

How many role models do you have? Somebody who has actually come through to the other side and can give you hope. Not just a list of social agencies you're supposed to go out and connect with. But I really mean hope. Because I think that's incredibly important.

– *Mary Ann*

Role Models

Mary Ann described how role models have been important in her recovery.

The support of other people has worked for me. And if you get scared, call me. I'll come over. And it's not just people who are talking the talk. It's people who are walking the walk and who have walked to the other side. And I think that's tremendously helpful.

We don't have role models. We don't know how to do this with grace and style. I mean, you're in prison. You have a mental illness. You have an addiction problem. How many role models do you have? Somebody who has actually come through to the other side and can give you hope. Not just a list of social agencies you're supposed to go out and connect with. But I really mean hope. Because I think that's incredibly important.

Laura Prescott talked about the importance of role models.

I would like to see more role models in the mental health system in general. It's important for both providers and people receiving services to see change, growth, and strength which can be acknowledged through the presence of

those who have "been there." A critical presence of those to whom the labels are applied in visible, responsible, decision-making positions is needed in order to combat preconceived notions of "competence," "ability," and "dangerousness" based on stereotyping and categorization. The acute absence of people in these positions in the mental health system supports discrimination against those they are attempting to serve. The implied message is one of exclusion.

Without role models, people who are experiencing difficulties in their lives can feel isolated and are robbed of the opportunity to find hope and meaning in those experiences. I think substance abuse programs have done a tremendous job in this particular area. Because the notion of recovery is predicated on a model of peer support rather than professionalism, there isn't always a lot of separation between those receiving services and those providing them. For this reason, individuals have an opportunity to share their experience, strength, and hope with each other and not fear being pathologized. It's a very powerful and life-affirming model.

Dr. Sushma Taylor talked about the treatment staff as role models.

Our staff are active role models. For clients there are behavioral consequences. We take away privileges when we must. We also give privileges. We bring in outside speakers. We take clients out into the world. We teach them civic responsibility. Clients have to give four hours of volunteer work to one of our programs or within the same program — I tell them this is for all the amends that you owe to the community and to society.

They observe my concept of community. Community values are part of Center Point's corporate culture in that everybody in this corporation advances the value system — whether it is a bookkeeper who has nothing to do with counseling, secretary, or the maintenance worker. The whole culture is one of actualization, self-help, responsibility — responsibility to parents, responsibility to children, responsibility to community.

Dr. Allen Ault emphasized the importance of good role models.

I think part of the cognitive programs is the modeling. It is a very important part of that. I think too often they have had nobody to model after and are not currently experiencing somebody that they respect. So, I think it's a very important part of the program.

Proper Assessment/Classification

Dr. Cassandra Newkirk talked about the importance of minimum standards for assessment.

I think minimum standards should involve adequate and appropriate assessments and that would include substance abuse issues and mental health as well as the medical history. Medical histories tend to be pretty well taken. A lot of systems don't ask about the abuse history — in the context of medical — but more are doing that. So I think adequate and appropriate histories for all women in all systems.

Dr. Newkirk described what is needed for a proper mental health assessment.

People who have been trained to get the histories. And I say trained because I think that there needs to be a lot of retraining in a lot of staff. Mental health as well as medical — to really do thorough histories. And all of this is ironic. What we're trained to do is very in-depth histories and physicals on all aspects of people's lives. But usually what happens when you get out in the real world, out of the academic setting, is that you really aren't given the time. So a lot of things are cut down. I think a lot of us just get out of the habit of doing it. I think you need to go back to what you were taught.

I think the minimum standard is the assessment. If you do appropriate assessments then you can figure out what you can and can't do in that setting. In a jail setting you can usually farm out a lot of your services a lot easier because it's the county. And it's actually better to do that because

the majority of people are going to get out. If you can contract out with those agencies to do it for you in the jail when they're already hooked up — the systems that do it that way find that it works a whole lot better.

Dr. Newkirk talked further about her own education in assessment.

I remember one case in particular. My medications weren't working. The woman wasn't getting better. I remember asking my psychologist colleague who was very well versed in trauma — I wanted a second opinion from him.

> I did a lot of talking and that's how I learned a lot about what I didn't know. I learned to listen to the women differently.
>
> **– Dr. Cassandra Newkirk**

He saw this lady for me. He said I was assuming she was psychotic and I was giving her anti-psychotic medication and she wasn't getting better. He said I don't know what people look like when they're psychotic and when they need medication. But, I know when people are dissociating and I think she is dissociating.

And my comeback to him was I pretty much knew when people were psychotic but I wasn't quite tuned in to when they were dissociating. I hadn't seen that much. So when we put our two heads together — my medicine wasn't working because I wasn't giving her the right thing. She was actually dissociating in front of my eyes and reliving her trauma. So when she told me she was hearing voices, but in the context of reliving her past trauma — I didn't recognize it.

So my whole thinking about the thing changed. I came to talk more to my colleagues. The department (of corrections) hired quite a few people who worked with abused women. So they brought in a lot of experts. They also had to do training for all of the staff. I did a lot of talking and that's how I learned a lot about what I didn't know. I learned to listen to the women differently.

Well Trained Staff — Especially Female Staff

Ms. Kate DeCou described her staff and the importance of training.

We carefully select people who are motivated to work with women and who have unique skills in some areas of women's lives for the permanent positions on the unit. On our staff, we have a parenting specialist who runs our parenting programs. We have a counselor whose unique background is substance abuse. Another counselor has been on the board of directors of a domestic violence shelter in the community and has worked in that field for many years.

With the officers it's different. We do not choose the officers who are on the unit. They are male and come to the unit through rotation. What we have found is that the officers become confident and positive in working with the women if they receive a detailed orientation. We try to reach out early to offer tips and clues about who the women are, why women are so interactive, and what issues they should know about. For example, if a woman is crying intensely or having nightmares, we try to help officers distinguish the proper level of involvement and what information to pass on quickly to counselors for the most effective intervention. The officers become allies on the women's team instead of buying into the problem-woman stereotype.

We find the officers are eager to know why the women are so different. And the females do act differently from the males. We have 150 women on the floor. Our pods are much noisier than the men's because the women are so much more vocally interactive. The officers who come to our unit who have also worked in the men's areas comment on this. While we track noise levels, we also acknowledge that too much silence would stifle the women's personalities and we work for a medium ground. So we believe that staff training is important to build a supportive team of people who are not afraid to show both firmness and compassion. Those who are motivated to work with women are important to cultivate.

Proper Medication

When Pat was incarcerated at Lexington she was treated with Haldol which helped to greatly reduce her symptoms.

Well, I was much calmer, much more clear in my thinking, and much more tolerant of being around people, which I had not been up until that point. And what I complained of as headaches at that time — since my car accident when I was a freshman in college and that was kind of a trigger of hospitalizations — I now understand what these headaches were. But that kind of ... the symptoms went away.

The headaches are the voices, the cloud of things that make your head hurt. And I would describe them as headaches. And the Haldol helped them to go away. And at that point in Lexington, I was really dealing just basically with major depression in terms of not being able to fit all the pieces together. Being sure that if they said I did it, I must have done it. And not being able to help my attorney put things together in any meaningful way, but not wanting to dispute it either because I just wanted to deal with whatever the consequences of my behavior were. Whether it was jail time or whatever.

After receiving numerous diagnoses and medications, Pat finally found an effective medication regimen that included treatment with the drug Resperidol.

Resperidol is one of the newer, atypical antipsychotics. It's in the Haldol family. It basically will reduce the paranoia of the voices for me and makes things a lot clearer. And where before, because of my illness and the paranoia, I was much more withdrawn, it also affects those symptoms so that I'm much more able to maintain relationships or seek them out and not be so passive.

Mary Ann was helped by proper medication. She described what it felt like to finally find a medication that worked.

But I did agree to see him (the psychiatrist) four times and what kept me going back was that I woke up one morning and all of the noise in my head was gone. It felt like I was born again. I don't know how to say this, I felt like my whole life — I had never seen the world in sunlight. I saw the dust dancing in the sunlight. And I saw the grain of wood in the floor and there was nothing inside my head. Nothing. It took away the static. The kind of static which is nonsense in rhymes and images that had always been in my head, even when I slept.

Programs — Not Just Incarceration, But Job Training, Substance Abuse Treatment, Mental Health Services, and Parenting

> One of the things was — and I think it's true for all women, I think it's true for poor people — that I had no sense of options. I lived in a very black and white world.
>
> **– Sharon**

Sharon talked about the benefits of getting help with her education and how that improved her options for taking care of herself.

When I was in prison in Florida I had one good experience there and as a result of that some subsequent good experiences. The University of Florida in Gainesville is very close to the prison and the Psychology Department did an internship program one year and assigned to me some guy who came in.

He had me pulled out and I got into the University of Florida and they did a whole bunch of tests on me to find out what my directions were. One of the things was — and I think it's true for all women, I think it's true for poor people — that I had no sense of options. I lived in a very black and white world.

Sharon described what she believes makes a good addictions treatment program.

The majority of people mature out of drug addiction. The programs that are effective help that person mature out sooner. Help that person to get a handle on what's going on with themselves. People are given some encouragement around making some choices in their lives and begin to feel better about themselves in being able to do that.

Ms. DeCou described the programs at the Hampden County Jail.

> They look at their experiences of abuse throughout their life from many angles and begin to realize they have choices.
>
> **– Ms. Kate DeCou**

We have groups up here. For example, we do have an incest survivors group, which is designed as a treatment program for women who want to really begin to work in a treatment way on their early childhood hurts. We only permit people to enter that group who appear strong enough to handle it without acting out on the pods. There are a surprisingly large number who fit that description, in fact, we have waiting lists. We have been impressed that even women who enter the facility with severe behavioral symptoms can perform well in these groups and even ask for them once their behavior is stabilized. The more women begin working on their issues in jail, the clearer they become about what kind of services will support them in the community. Many inmates have never received counseling except for crisis intervention or 12-Step programs.

We also have domestic violence groups. Some of the women also do serious work on these issues. They look at their experiences of abuse throughout their life from many angles and begin to realize they have choices. Another healing experience explores the responsibilities and hurts of motherhood. People begin speaking about themselves as mothers and this turns to their own experiences as a child and ways they have been parented. We encourage women to do journal work in English and Spanish. We buy journals for most groups. Besides writing, we also teach them to use breathing techniques to deal with stress, especially at night. These are just some of many group experiences offered in our setting.

Marta found help in the addictions treatment program she attended in prison.

The program wasn't just based on substance abuse, it was on behavior, because the behavior comes with the addiction. Where if you're an addict, you're going to have behavior problems when you're trying to be clean. The attitude comes out. You get physically violent because you don't have the drug to turn to. Also, being incarcerated — Framingham helped me because I got clean and sober. Not that I wanted to but it was against my will. I had to do it.

Judge Kessler emphasized the importance of long-term treatment for drug addiction.

If it's not a treatment program that is at a very minimum three months, it's a joke. And, I think most people feel it should be six months or a year. Well a year is certainly what we have to do if it's going to be successful.

Joy talked about the importance of a therapeutic community — a safe, drug-free, and supportive environment.

And so I was referred to Center Point from the U.S. Probation Aftercare Service. And I got in. I really didn't have a clue what that was all about. I knew that I needed some help but by the time I got there I had six months clean — because I had to do parole, I had to do two paroles in the halfway house and Center Point. But really there were some issues that had to be dealt with, as much as I wanted to deny it.

Center Point's treatment believes that addiction is like a bio-psycho-social-spiritual disease. And I certainly needed all of those addressed. I mean I knew how to program, I knew how to follow the rules — but I was never initiating any emotional reflections. In fact, if anything, my control of my emotions and my lack of spontaneity was more an issue.

Center Point was Joy's bridge back to the community.

The prison culture and the whole lifestyle is a very key component of working with addicts, particularly those who have been through the criminal justice system, because you take on an identity and that becomes you. You use it to describe yourself as you're a convict. And as I was saying earlier, you leave it and you are totally alienated, totally empty. And so you go back to what is familiar.

And I think that's why the TC (therapeutic community) in a free-world community has the opportunity to almost detox somebody from prison. It still provides a structure because people that have lengthy incarcerations rely on it. It's the only way they know how to do life. They can really do quite well in prison. It's when they're out and left responsible to create their own life and structure that they don't have a clue. And so the TC, because it's so structured, gives them really a way to kind of transfer those survivor skills. What survivor skills did you use to survive in your previous life — whether on the streets, in prison, ripping and running — that you can use these skills to turn around and have a positive influence on your life.

Joy recounted a specific example of how Center Point helped her to reintegrate back into the community.

My problem was not abiding by rules, my problem was fitting into society. I had a perfect driving record. I hadn't been driving for eight years so they made me the house driver to get me used to going into the community and just being in the free world.

Driving a vehicle and picking up donations and taking clients places — and you know, little duties. It was like no, her thing is not to be isolated away from her using environment. Her goal is to get back into the community with very safe steps. Because I wasn't at the phase where I could leave unsupported. So I always had to have someone with me. So my treatment was to get used to being in the community, not removing me to get away from environmental factors. Mine was to learn to be with the environment.

Brenda was incarcerated twice for crimes related to her addiction. After her second incarceration she went to N Street Village where she began her recovery process.

Well when I got out of prison that time I ended up where I began the recovery process. I ended up in N Street Village, which is a continuum of care that has space for the mentally ill, space for substance abusers, homelessness, and it's an all female block.

> I wasn't trying to tell these people for the first time in my life what I already knew. I was just willing to do it someone else's way.
>
> **– Brenda**

I get to N Street Village and I really start off in a nice shelter. I can leave in the morning and come back at night. I can come in at four for food and shelter and clothing. And so I use a couple of times after I get out. I'm at the shelter. I really don't want to use anymore. And I recognize that I need some help with it.

So N Street Village is this whole continuum of care. It has all of these different places for women, including a day center. So I go to Harriet Tubman House, which is a pre-treatment house, and that's across from the night shelter. And that's where I found out — I actually stayed in Tubman House almost three months before I went to treatment because treatment is hard to get into. There's a whole process involved in that. I wasn't trying to tell these people for the first time in my life what I already knew. I was just willing to do it someone else's way.

Dr. Newkirk talked about how women with substance abuse and mental health problems need access to appropriate services.

Access does not mean provided on-site. Access means that the facility or the system can be sure that it is provided. In a jail setting — it costs too much to do it there — that's a lot of services to be provided on-site but, instead to have access to emergency crisis teams that come in, contracts

with local hospitals to do medical and mental health care and counselors who have special training.

In prison systems, and I'll take state systems for right now, access is very important. Access at the state prison tends to have a lot of people on-site to do it. But, depending on where the prison is located, you may contract out for local services. What we found, especially in specialized services, is that it's easier to contract out with individuals or groups than to hire them as employees of the prison system because usually you can't pay their fees to hire them as full-time employees. And the other thing that happens in a lot of places, they get burned out because a lot of people in private practice do many different things. That's what keeps them from getting burned out. But a system has to weigh that, since we're talking about women, how many female offenders they have to serve and where.

One of the biggest problems in the state prison systems is that the prisons tend to be built in rural areas to boost the local economy. And a lot of these rural areas are away from your metropolitan areas where you have specialists. That gets to be a very big problem.

Dr. Allen Ault talked about the importance of structured programs where both staff and inmates are held accountable.

Well, I think the only thing we have that's really worked is very structured programs, very structured behavioral programs. There hasn't been good research with just female inmates. In the meta-analysis (recent research on interventions with prison inmates) the majority of those studies are with male inmates. But what's in these would indicate that behavioral programs would also be beneficial. It has to be well-planned, planned for each individual, and a very structured and very cognitive approach.

I think too often when there's no structure it's just more like anarchy than good treatment. And I don't think the staff, nor the patients or the inmates, know what's expected of them. They're not held accountable. I think this is very important that everybody be held accountable.

> Many of these women also have children and one thing that they themselves say is so hard is finding a way of dealing with their children. They've never been parented themselves.
>
> **– Dr. Bonita Veysey**

Dr. Veysey talked about the importance of behaviorally oriented treatment plans as tools to help people change.

I think there's attitudinal change and I think there are practical changes. The attitudinal changes are obviously the hardest things to do and those are, for example, when you fill out a treatment plan, that you really involve the voice of the person you're treating.

I think in terms of mental health — both mental health and substance abuse — it's important to have behaviorally directed plans. Things that create safety. If you do A, B will happen. If you do C, we will do D for you. Cause and effect. Very spelled out.

Many of these women also have children and one thing that they themselves say is so hard is finding a way of dealing with their children. They've never been parented themselves. How can they learn to parent? They need to have A, B this is what you do. These are the consequences for what you do. These are the benefits of what you do. Whatever it is.

I think there are opportunities to hold women to behavioral contracts. Put punishment in that isn't horrendous. That isn't horrific. So, typically if you get a ticket, if you get written up for a disciplinary incident, you may spend two weeks in administrative segregation. That means you're alone. You're only out of that cell for a brief period of time each day. Some women find that impossible to do. Now you can hold women to that two-week period, but say every third day to release her to a community event so that she can do her punishment in a humane way. I think that's easily done.

Inmate-Centered Programs

Over the past 28 years, Sister Elaine Roulet has built a multi-faceted, inmate-run program that helps women to keep connections with their children.

> See what most prisons do when you come through the gate — you leave your talent at the gate. And they lose what's special. You all wear green. You all have a number. You're all alike. And that's not true. We're not all alike.
>
> **– Sister Elaine Roulet**

So my journey from the very beginning — I believed in inmate-centered programs. I coined those words in my vocabulary two days after I got here. It's an inmate-centered program and it means that anything that can possibly be done by the inmates is done by the inmates.

See what most prisons do when you come through the gate — you leave your talent at the gate. And they lose what's special. You all wear green. You all have a number. You're all alike. And that's not true. We're not all alike.

I think what happens here is you have the incredible experience of watching women who have been empowered doing incredible things. This woman on my right is doing the Summer Program, the whole thing. The woman on the other corner is the Children's Advocate. She has volunteers. There are many components to the Children's Center — the parenting programs, the advocacy, the infant center, the nursery, the prenatal classes — all run by inmates, all taught by inmates.

And if you have talent — we watched Angela grow from a 17- year-old to a capable woman. To have people talents — Antonia, you see her in the Laundromat— she's a born counselor, she's a woman of color and she's earthy. She's got 25 years and her daughter's in — she's got 15. Tony's an earth mother. I watch her talk to the women.

Ms. Michelle Petrino described the development of an inmate-centered program to deal with problems arising from the growing population of adolescents at Bedford Hills.

You have to be creative. You have to be flexible. You have to look and talk with the women. See what they need. This became apparent to me only recently in the last year when the superintendent asked me to join a group to see what we could do because we had so many adolescents acting out here.

The inmates said we have so many adolescents acting out here. We've got to do something with these young adolescents. They're just acting out too much. And it came when the Division for Youth started sending their adolescents when they became 18 into the maximum security facilities. We got 50 at that point that were under the age of 18.

So we started meeting with the women up on the hill. There were several of us — Family Violence was involved, a couple of correctional officers, myself, the superintendent. We all met with some of the women that were interested in developing something for these kids so they wouldn't fight and act out and get in trouble.

When we really looked at it we only had 42 inmates here who were under the age of 21. So we said, OK, let's look at it differently. Let's approach it differently. Who is functionally adolescent? Because if you look at victimization history, they get fixed at a certain level when abuse and trauma happened to them. So that you're dealing with a woman who's 30 but functioning at 15. So when we're looking at adults who were now functioning as adolescents our numbers just blossomed.

So then we started looking — we have this group that acts out, that act like adolescents. Then how do we develop a program to reduce violence. So we split it up into different sections. One group was to look at what kinds of activities we could have these people doing on weekends. So they developed a teen center. They developed a special crafts building. Groups on the weekends and evenings occupy their time. They had special gym

programs that they could participate in, just for them. Then we looked at the family violence piece and dealing with the anger management piece and dealing with impulse control. They develop special groups that would do that. Then I was charged with developing — it's almost like an extension — an expansion of the therapy aid program.

... At Riker's Island they call them suicide prevention aids. They have inmates watch the inmates that are suicidal. But, we didn't want to specify that. We wanted to have some of the women trained in mental health that live out on the floor so that they could see somebody who is just starting to not shower, somebody who is not eating, to identify signs of depression or identify signs of psychotic process starting. And then they make a referral to mental health so that we could do more preventive stuff than waiting for something to happen and you have to react. So we did just that. We just completed the program, the training piece. Now we have to develop the program description.

Efforts to Reduce Trauma and Revictimization/Alternatives to Seclusion and Restraint

Mary Ann described a body search that was conducted in a humane and professional manner.

First of all, it was two women guards and it was just handled straightforwardly. We have to do this. This is why. This is what will happen. This is why it will happen and it can be uncomfortable. We don't want to make it that way. We're not trying to hurt you but these are the rules and we have to do them. We know as women that this is humiliating or can be. And it was just handled in a matter of fact way. You know I'm going to do this. I have done that. Now I'm going to do this. I'm going to ask you to lean over in this way. And the other guard would have to watch. I mean, if you get a running commentary that keeps you in touch. Because if you're an abuse survivor some of these experiences can really trigger old stuff. It really can. And I suppose for these people who are doing it — there's a question too because sometimes people do get out of control and fight.

And yet I understand that within the kinds of institutions that have to practice this that it's a necessity. But I think if it's presented as a necessity — as everybody goes through it — it's a lot better than it can be. I think the matter of factness of it and the use of language is important. If demeaning language is used in that kind of circumstance, it could cue you into this.

Mary Ann referenced the Recommendations of the Massachusetts Committee on Seclusion and Restraint[4] as a critical tool for dealing with women who are psychotic.

They'll take you out. I mean, you'll be knocked to the floor and put in isolation. I've seen situations where women are chiefly psychotic and whether it's drugs or a combination of drugs and psychosis, the guards need tools in knowing how to deal with and assess the situation. I really think that's a problem. And I think there's a lot of assumptions that the person who is psychotic doesn't know what's going on and it really doesn't matter how you treat them. And I think that's a real problem because although you may not have a complete memory, if you are treated in ways that are demeaning, the emotional content comes through.

One of the tools that's given me a lot of hope has been the use of the screening tool from Massachusetts. I think that to assume when somebody is symptomatic — either to blame it always on drugs — I think one of the major things is education.

Dr. Veysey offered some guidance on conducting medical examinations and strip searches.

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[4] The final report of the Massachusetts **Task Force on the Restraint and Seclusion of Persons who have been Physically and Sexually Abused** was issued on Jan. 25, 1996. This report provides innovative and model guidelines for alternatives to restraint and seclusion. It can be obtained through the Department of Mental Health in the State of Massachusetts.

If there is a medical examination within the first 24 to 48 hours that includes a pelvic exam, you can explain that to them. Tell them who is the staff that's going to be there. Informing women is the first thing.

If you can have female staff who conduct strip searches or at least are present in the room during pelvic exams. I think that's important — to have female officers on staff.

Ms. Laura Prescott talked about the use of seclusion and restraint for women who are in crisis and outlined some alternative strategies for intervention.

Unfortunately, it's in times of crisis when women become most vulnerable to revictimization in all systems of care. In order to prevent this, women receiving services in mental health, correctional, and substance abuse systems need to have a role in planning what will help them ahead of time. If treatment providers explained their emergency protocols to women when they enter the system and asked specific questions about what helps and what doesn't, everybody concerned would be subject to far less difficulty in the long run. This is a proactive position and it requires engaging with the women directly to develop treatment plans before a crisis instead of assuming that the current protocols are effective and adequate.

Prior planning with the woman, developing alternatives for the expression of rage, loss, grief and pain, and training teams to react differently to women in crisis can lead to less intrusion and restimulation of trauma and response. Training and sensitizing staff to approach intervention, starting with talking, not wearing badges, starting with a one to one interaction instead of being slammed to the ground by four or five men. If even some of this could be accomplished, people working in these systems would find women de-escalated much faster because they are active participants in their own lives. Women can actually heal from their experiences because they are getting some of what they need, usually a connection at a time when they feel most vulnerable and in danger of losing control.

> Restraint, seclusion, and intrusion are reactions that are very costly to both staff and women involved, both are hurt in the process.
>
> – ***Ms. Laura Prescott***

Prior planning, availability of alternatives for expression, active participation by the women involved in developing that plan, awareness of crisis protocols, and adequate oversight regarding the implementation of the protocols, all make everyone safer, including the staff. Restraint, seclusion, and intrusion are reactions that are very costly to both staff and women involved, both are hurt in the process. The cost can be seen in the long-term negative outcomes — for staff in terms of injury and future complications with crisis interactions and for women in terms of suffering from the effects of retraumatization, lower self-esteem, heightened sense of shame, feelings of humiliation and rage. It looks effective in the immediate crisis because it stops whatever is going on. But I would argue that these institutional practices exacerbate the underlying issues. Therefore, the next time those same women have a crisis, staff are facing the compounded effect of victimization.

Ms. DeCou described innovative ways they have responded to women who require some behavioral intervention.

For our mental health inmates, we very extensively use this type of behavioral management thing that leaves a lot of carrots for them instead of being punished by going to the hole — segregation. We've worked out a wonderful team with our department of mental health forensic unit for those inmates who have severe mental health problems, maybe severe borderlines who tend to self-mutilate or hit the wall or make suicide attempts. As tension builds and as we see symptoms rising, our plan involves things like — if you hit the wall this week you're punishment will be the segregation area for three hours at a time. If you do it again, we'll increase it to six hours. So we are very unusual — this is not typical of a corrections style of operating.

They don't like it. For those people who have severe mental illnesses, the concept of being alone and isolated usually maximizes or worsens their symptoms. They hate it. They hear noises. They get more stressed by the extreme isolation. So three hours over there is enough to get their attention a lot of times. And on top of that, we find that the attention that they get goes a long way. A lot of them really love and respond to the perception that staff care that much about them to work with them on these issues.

Financial Resources

Linda had the money to pay for a good lawyer and a good psychiatrist.

I feel like I was given an opportunity to move on with my life. Had I been poor and not had the money to pay for a good attorney, not been able to get good care, I probably wouldn't have ended up that way. I probably would have been down in Goochland somewhere at the women's prison or I would have spent a month or six weeks or however long at the detention center and never gotten help.

Safe Environments

Sharon described the environment she created for women in the Family Violence Program at Bedford Hills Correctional Facility.

What I do is not complicated and I know I help people mature out of addiction earlier. I create safe places, people control their spaces. I create safe places where it's OK to be honest, where people don't judge each other, where people can explore and ask questions and not feel stupid. I create safe environments where women can just be, they can talk. If they want to listen, they can listen. If they want to bullshit, they can bullshit. And it's OK.

Someone might say that doesn't sound too good. But they're going to be cared for in that environment. I've been calling them vision circles because it creates a vision of potential for people. That we can support

each other and not even like each other maybe. But we can create environments as women where we can stop and think about what has happened in our lives and think about what feels OK. What doesn't feel OK? And whether we should hold on to what doesn't feel OK our whole lives so we have to play these things over and over again.

And we talk about things. Those things we don't resolve, we replicate. And we look at what replication means in our lives — the same guys, the same kind of environments, and the same kinds of — every time I have this problem I look for the same solution over and over again knowing darn well that solution doesn't work. Well why? And we explore that. There's nobody with an answer. There's no expert. It's about human conditions and it may be different for me about how and what works.

I just create an environment where barriers don't come up. The women have been abused at so many different levels of the system, abused in the families, so the trust issues are already undermined very early on. They come and they tell us. Women talk, they tell.

> When you've been abused your whole life you don't know how to play. That's part of the work. To lighten life up. Not to make everything so heavy and complicated.
>
> **– Sharon**

There are so many ways to do this. I've brought people in to do improv theater with the women and we created a psychodrama piece. It's a piece of a whole complex because that is what the women wanted to do, was to find a very poignant way of talking about the sounds and words and actions they experience in the abuse in their lives. It was a heavy piece when we finished it.

I used to bring them jelly beans and we'd have jelly bean fights. I'd bring them games and we'd play games with each other. When you've been abused your whole life you don't know how to play. That's part of the work. To lighten life up. Not to make everything so heavy and complicated.

Joy found safety in a therapeutic community.

> It was years and years of unfinished business and baggage that I finally was able to let go of. And only in a safe environment could I do that.
>
> **– Joy**

And it was safe for me, very, very safe. When I eventually went through the therapeutic process of talking about my sexual abuse in a quiet, heavy psychodrama, and not everybody has that opportunity. It was years and years of unfinished business and baggage that I finally was able to let go of. And only in a safe environment could I do that. I mean, I always felt safe, always, always felt safe.

What made it safe was that there was structure. I mean that to me was safety because that was kind of what I could relate to.

Dr. Newkirk talked about the value of giving women a quiet space where they can just be alone.

So it's learning what is helpful and what's not helpful because some women will tell you they need to be given medication and put in a quiet room. But what we don't understand is a lot of times we don't need to lock the door. They need to go in a room, they need to have the door closed, but it doesn't have to be locked.

And we learned that in the prison system too. They have quiet rooms. And if you think about a prison that has 800 women and they're going through some changes, where do you go to find some peace and quiet? And one of the things we had to do was develop a quiet room. We developed a room that had a half glass picture window. So they could close the door and shut out the world but security felt comfortable because they could really see what the person was doing. But if I wanted to go in there and talk, security couldn't hear. And the person could go in there and be quiet.

They could turn their back on the outside world but they could still be observed. Security is a big issue. So those are some of the simple things that you can begin to do.

Dr. Veysey described what is it to create a safe environment for women.

We have to create safe places. And make corrections safe. We have to be respectful of women's areas, women's bodies, women's spaces — both emotional and physical.

I think women have been told all of their lives that they do not have control, that they're out of control, that they can't be the owners of their lives. I think that treatment has a duty to help women gain a sense that — I can make decisions for myself, I can make a life better for myself, I don't have to be a victim, I don't have to go back into this relationship, I don't have to use drugs, I don't have to whatever...

> We have to create safe places. And make corrections safe. We have to be respectful of women's areas, women's bodies, women's spaces — both emotional and physical.
>
> ***– Dr. Bonita Veysey***

I think we have a real responsibility for giving women hope and options. We need to be willing to allow women to make mistakes without blaming them, without punishing them.

Chapter VI

Taking Responsibility/Getting Better

Many women described a point in their lives when they realized things were not going to change unless they took responsibility for themselves and their actions. In many cases, women were helped by professionals and other women to get to that point. Some of the women described what this experience was like. Some of the experts talked about how they have helped women to move to this point.

> **Themes**
>
> - Reaching "bottom"
> - Wanting to and doing things differently
> - Accepting the past
> - Taking responsibility

Reaching "Bottom"

Joy described being at her lowest point and beginning to feel like she wanted to change.

I was still at that all time low, I just never showed it. See, that all time low would only come in the deep dark of the night. That all time low would only come when I would think about 20 years in prison, when I would think about possibly never having children, when I would think about all the other things. But on the exterior, I was very detached from my life. I continued to use drugs as much as I possibly could and had a lot of disciplinary problems. Got caught with drugs, got in fights with cops, got in fights with other inmates, got caught coming out of the men's unit, got transferred to Alderson, West Virginia, on a disciplinary, and I think that's probably when I started to get a clue. I was 30 years old.

On my 30th birthday I was still at Pleasanton [California]. I'd even gotten some drugs that day. I sat all through the four o'clock count crying. It's like, I'm 30 years old, and I'm going to die in a penitentiary. I'm 30 years old and I have like 20 years. I'm going to die in here. And up until then

it didn't really matter that I was there. Soon after that I was transferred to Alderson (a maximum security federal prison in West Virginia), and getting transferred to Alderson was a real wake-up call.

> I had finally reached a point in my life – and it took me long enough to get to that point -- where I was not quite as self-centered as I had been.
>
> **– Tanya**

Tanya described "reaching bottom" on her last return to prison.

I knew something was different, because it did not seem like old home to me. I was crying all the time. I wasn't excited to see the people who were always there when I got there. It was rough. By this time my son was in high school. My sister wasn't sending the money like she used to. My dad had since passed away, so I didn't have him. My grandmother was 70-some years old. She couldn't help me. It was very difficult for me. I was barely able to buy cigarettes.

And not only was she not sending money, I started to notice a change in myself. That I was not asking her to send me money. I had finally reached a point in my life — and it took me long enough to get to that point — where I was not quite as self-centered as I had been. I always thought that she was supposed to take care of me when I was in jail without giving any consideration to the fact that she was already taking care of my child for me, and had been taking care of him for his whole life.

And I wasn't asking her. So it was difficult for me. It was not an easy period of incarceration as it had always been before. Before I had all the comforts of home. Whatever a woman could have in prison, I always had it. It wasn't like that the last time. Not only that, I started to feel a lot of emotional discomfort. I was very sad a lot. I cried a lot.

I really started agonizing over my relationship or lack of relationship with my son. I started to think about things that I just never gave consideration

to before, and I started seeing — literally, I'd see women die. Almost drop dead in jail. One woman used to do my hair. She was doing my hair like that Saturday. That next day she got very sick. She had AIDS. They sent her up to D.C. jail to the infirmary supposedly to get some good care, and she died two days later up there in a pool of blood. And she banged on the door. She was hemorrhaging. They wouldn't go in the room, because there was so much blood, and they knew that she had AIDS.

> Finally, I guess I realized that I'm not really exempt. That the very same things that are happening to other people will eventually happen to me if I don't change my way of life.
>
> **– Tanya**

And this woman died. It was like a wake-up call for me. Finally, I guess I realized that I'm not really exempt. That the very same things that are happening to other people will eventually happen to me if I don't change my way of life. And I started going to NA [Narcotics Anonymous] meetings right in Lorton. The blessing was I really believed in it. I really believed that God puts the people in my life that I need in my life right at the time I need them.

Dr. Taylor talked about how women feel when they come to Center Point and how she and her staff assist women in taking responsibility for themselves and re-integrating into the community.

They're pretty tired by the time they come to us. People don't exactly go into the drug culture because they want to. They don't wake up one day and say, you know, I've decided I'm going to be an addict. Or, I've decided I'm going to be a criminal. That is not a decision that they make outwardly. Sometimes it's a passive decision. Sometimes it's an impetuous decision. Sometimes it's going along with the crowd. But they're stuck with it.

Wanting To and Doing Things Differently

Tanya described how she began to change.

So I met people. I think I made a conscious decision to just do things differently. It finally dawned on me, I probably had one of my good ideas that was really a good idea, and what dawned on me was that the stuff you have done for the last 25 years keeps getting you all screwed up. It's not that big of a deal. You just need to do something different. If you've been accustomed to doing "A," then this time you need to try "B." "A" will still be there if you don't like "B," but you need to try something different, and that's what I did.

Tanya talked about the importance of hope.

I think the message that I can give to people is that it doesn't matter where a person has been at, we should never give up on each other. There's always hope, and I'm just not paying lip service to this. I do a lot of things. I do volunteer work with other women in recovery and transitional homes. I give my money and my time. I just give of myself. I'm there for newcomers. So, I guess, the other thing I'd like to say is I really, really try to give it back because I firmly believe that I didn't do this myself. I did not have the capacity to turn my life around by myself. I know I didn't because like I said earlier, I'm not a dumb person. If I had the ability to do it, I would have done it a long time ago. I wouldn't have waited 25 years.

Sharon described her determination never to get locked up again.

When I went back in I really did some hard looking because I knew that when I left the first time, it wasn't just to get out, I didn't give them lip service. I never wanted to come back. It was a horrendous experience. It was a horrendous system... and having watched somebody die in front of me from lack of medical attention, having almost died giving birth myself for lack of medical care in prison — because I had a baby the first year I was in.

I never wanted to go back. And I wasn't out a month when I was back. I decided when I went back in, what a mess I was coming in. I was worse when I came back. I was less equipped to deal with problems. And, I was pretty determined not to let that happen again.

> I needed to fight for me, which I had never done in my life – for somebody else, but not for myself. And I got out.
>
> ***– Sharon***

I fought to get out to a college program in Gainesville. It was agonizing but it was good for me. It made me fight, and I needed to fight. I needed to fight for me, which I had never done in my life — for somebody else, but not for myself. And, I got out.

Accepting the Past

Brenda talked about the severe abuse she experienced as a child and how she had to learn to move beyond those experiences.

I looked to the time that I was with my grandmother, which was pretty severe physical abuse, but I had a clean home, went to school every day, to learn some — for instance, like being on time. Being clean. All of these kind of things that I didn't stand a chance of learning if I had stayed with my mother with 10 other children in a house that was eventually condemned.

You know, so there were all of these pieces kind of coming together, and, actually, the difference in recovery — the difference that allowed me to recover — the difference that allowed me to acknowledge that all of these things were true, but so what. That didn't mean that I had to continue to destroy myself.

I had really finally found out that — beyond when I was actually physically being abused, when I was actually sexually being abused — when that had stopped being reality, then I continued. I continued to put myself in situations where it happened again and again and again in a number of different forms.

Ms. Petrino talked about the enormous guilt women feel and how she works with them to come to terms with their guilt and frustration.

> Sometimes a lot of blame was placed elsewhere and they have to look, finally look in the mirror.
>
> – ***Michelle Petrino, R.N.***

Guilt. Frustration. Guilt related a lot of times to family and not being the mother that they were supposed to be and now being separated. You see a lot of reality setting in once they're free of drugs and alcohol. You see a lot of people finally recognize that they have [an] illness, once they get on the right medication as opposed to using illicit drugs to treat their own mental illness, to start dealing with issues. Sometimes a lot of blame was placed elsewhere and they have to look, finally look in the mirror.

One exercise I do is I have them walk over to the mirror, and I say, "Who do you see? What do you see? Do you like what you see?" And that might even be a homework exercise. We do journal writing, have the women keep journals, when they're having thoughts or feelings, write it down, and then talk about it in the next session. So you'll hear a lot of different things. Some of the stories are really horrible, when you think about what their lives have been, and what their kids' lives are and have been and once you think you've heard the worst of the stories somebody else comes in with a worse story.

Taking Responsibility

Pat talked about the importance of taking responsibility for her behavior.

Everybody was trying to explain the way the behavior had happened, this criminal behavior, because I couldn't possibly be a criminal, it had to be my illness. But how could the criminal justice system do this?

And at that point, I was not interested in explaining the ways of behavior. I wanted to accept the behavior in terms of yes, I'm responsible, even

though I can't put all the pieces together. And I wanted to make it part of my past. The mental health professionals were trying to figure out why this wasn't a mental health issue and why it was a criminal issue.

And, so I think people need to understand that even if you have a mental illness or a substance abuse problem, you need to be responsible for the behaviors that are associated with it.

> And, so I think people need to understand that even if you have a mental illness or a substance abuse problem, you need to be responsible for the behaviors that are associated with it.
>
> – ***Pat***

Sharon talked about power, responsibility and choices.

I want to talk about programs and power ... use the language. I mean women used to think I was crazy when I first started talking about language. Empowerment is around groups, not individuals. I have difficulty ... but for lack of anything else, I'll use it.

I said you have to have power. Feel it. Get comfortable with it, use it. What happens if somebody walks up to you, says something to you that you don't want to do. You have choices. I'm not going to do it. Smack them in the mouth if you don't like what they said. I mean, there are a range of choices and options that you have in dealing with that interaction, as long as you are clear about the consequences of each choice.

After many years of trying to get help, Mary Ann finally found somebody who made a difference. She talked about the nature of her relationship with that psychiatrist and the process of mutual respect.

And see, what I learned when I finally got to somebody who really treated my illness was that it's a process of mutual respect. I had to respect the psychiatrist to give information about things, but he also had to trust me to tell him what was going on, even when it was very shameful and frightening,

because he could only treat the symptoms that he knew existed. And there are barriers of shame in talking about that, and I know that's more common for people with OCD (Obsessive Compulsive Disorder), that secretive, shameful quality.

According to Dr. Taylor, the job of the treatment community is to help women to become unstuck.

So I tell my staff that the clients are pretty well lost. So what you have to do is break it down into very small incremental steps and you've got to take them through these steps. Things that staff take for granted — clients don't know how. Men in my program don't know how to tie a necktie. I teach them to do that. Women don't know how to dress. So I teach them. They don't know how to hold the right knife and fork. We teach them that. We don't want clients to feel inadequate or out of place in any setting. And so it's our job to make them feel comfortable, and this is skill mastery — social skills, life skills, and psychological skills. I guess that's probably what makes this program different.

We take people into our family/community. We believe in them, we don't give up on them, and we go the extra nine yards on their behalf.

Chapter VII

Conclusion – Where Do We Go From Here?

When I set out to work on this project I wanted to hear from women who had been through the criminal justice system about what helped and hurt their recovery from mental illness and/or substance abuse problems and return to life in the free world. Curiously, these perspectives were nowhere to be found in the literature. I thought it would be extremely useful to hear their thoughts. Maybe that would lead to positive and beneficial interventions. I also wanted to hear the opinions of experts — leaders and innovators — about what they thought helped and hurt. I expected some differences between the perspectives, but surprisingly, there was little. All the people I interviewed urged more humane and economically sound responses to the "crime" problem and solutions that focused on rehabilitation, economic self-sufficiency, and safety.

It is so tempting now to conclude this work with a comprehensive list of recommendations for where we should go from here. I could list recommendations for improving programs and treatment in criminal justice settings, some for enhancing services for women as they return to their communities, and still others for making better public policies to address crime in our society.[5] I'm going to resist the temptation. Frankly, I don't believe most of these women belong in prison. But this debate is futile as long as we are unwilling to make our criminal justice system more effective in deterring crime or in preventing people who commit crimes from returning to prison. There is not the political or moral will at this time. So instead, I will conclude by talking about first steps — simple, manageable steps we can take to avoid hurting women when they are in the custody of the criminal justice system. Steps that are humane, safe, and cost little to implement. I believe we can achieve these goals and that they will make a difference.

[5] I did ask each of the 20 individuals I interviewed for their recommendations on how to improve conditions for women with mental illness and substance abuse problems in the criminal justice system. Their recommendations are in Appendix II.

> There is no reason why institutions have to brutalize women as they process them. We can take simple steps to end the brutality.

Most importantly, we can "handle" women differently. There is no reason why institutions have to brutalize women as they process them. We can take simple steps to end the brutality. One, we can tell women what is happening to them as it is happening. Many women are very frightened when they enter the criminal justice system. They have lost complete control of their lives and don't know what is going to happen to them next. Some are taken off medication that helps them to control their symptoms. Others are withdrawing from narcotics, alcohol, and other drugs and have no buffer between them and the reality of their lives. Simple information about what is happening to them could make such a difference in relieving some of their fear.

Secondly, we can assess women and identify their problems. We have the resources and knowledge to assess women for trauma, mental illness, and substance abuse problems. It is possible to implement plans that will help women to live with their incarceration rather than exacerbate their symptoms. For example, if a woman is an incest survivor — and many women in jails and prisons are — restraint by male guards that re-enact an early rape experience by pinning her down and putting her in four point restraints should be eliminated. There are many different ways to intervene with women who are for whatever reason, acting up or acting out. These alternatives are probably safer for everyone. Let's use them.

Thirdly, we can use female guards for strip searches and have women staff present for gynecological exams. Women are intensely vulnerable in these situations and it is unnecessary to make it so dehumanizing and hurtful.

Fourthly, we can train correctional officers so they are better equipped to work with women. As many of the women pointed out, correctional officers who understood them were often instrumental in their recovery. They

treated women humanely, helped them to live with and work through their feelings rather than act on them, and genuinely made their lives better. This could be such an important investment in making institutions safer.

Finally, we can implement clear policies that prevent sexual harassment of female inmates by correctional staff. It has become clear through class action suits by female inmates across the country that sexual harassment is happening in far too many institutions. These practices must be stopped by implementing sanctions against those responsible for preying on female inmates.

The women I interviewed did not ask to be let off the hook. They accepted responsibility for their crimes. They were willing to pay restitution. They just wanted some help — to deal with their past trauma, to get clean and sober, to become stabilized on medication, to get a job, to find decent housing, to be reunited with their children. Some got this help from compassionate people they met while incarcerated. Some got it from the other inmates. Many came out of prison more impaired than when they entered, but with a commitment to do everything they could not to return. They were fortunate to find help in treatment programs, experienced professionals, self-help groups, and their families. It would take so little for us to do so much more — just some compassion, understanding, and support.

Sister Elaine Roulet recounted a call she received from Desmond Tutu, the Nobel Peace Prize winner and South African Archbishop. He said, "Today's my 25th anniversary and I want to celebrate mass where there's the most pain and I can't think of any place that has more pain than a women's prison." A women's prison has more pain than anywhere else because the women there have experienced trauma beyond our comprehension. If we listen to their stories and respond with kindness and compassion we can make a difference. That is where we can go from here.

Appendix I

Helpful Resources for Planning and Implementing Services for Women

This is a list of some basic resources that will be helpful to individuals who want to learn more about working with women who have histories of trauma, mental illness, and substance abuse problems. It is by no means an exhaustive list. It is only intended to get the reader started.

BOOKS

A Vision Beyond Survival: A Resource Guide for Incarcerated Women, edited by B.V. Smith and C. Dailard. Washington, D.C.: the Law Center, 1995. [For ordering and cost information contact the National Women's Law Center, 11 Dupont Circle, N.W., Suite 800, Washington, D.C. 20036, (202-588-5180.]

This resource guide was developed for incarcerated women. It is organized in five sections: (1) negotiating the prison system; (2) community transitions; (3) maintaining family ties; (4) staying healthy; and (5) community resources.

A Woman's Way Through the Twelve Steps, Stephanie S. Covington. 1994. [Available from Hazelden Educational Materials, Center City, MN 55012-0176].

This book provides a new interpretation of the Twelve Steps of Alcoholics Anonymous that is designed to be more accessible to women. It is based on interviews with women and their own interpretations of the Twelve Steps.

Dare to Vision: Shaping the National Agenda for Women, Abuse and Mental Health Services.

Proceedings of a conference held July 14-16, 1994 in Arlington, Virginia. Co-sponsored by the Center for Mental Health Services and Human Resource Association of the Northeast. [The report can be obtained through Human Resources Association of the Northeast, 187 High Street, Holyoke, Massachusetts 01040, (413) 536-2405].

Dare to Vision is the written record of a national meeting that was held in 1994 on trauma, violence and mental illness among women. The meeting brought together trauma survivors and professionals and developed a national agenda for improving services and policies on these issues.

Final Report of the Task Force on the Restraint and Seclusion of Persons Who Have Been Physically or Sexually Abused. Massachusetts Department of Mental Health, Task Force on the Restraint and Seclusion of Persons who have been Physically and Sexually Abused, Jan. 25, 1996.

This report provides important guidelines for assessing and treating women with mental illnesses who have a history of physical and sexual abuse. It provides recommendations on appropriate interventions and alternatives to the use of restraint and seclusion procedures which have been found to be harmful interventions with this group of women.

Getting Sober, Getting Well: A Treatment Guide for Caregivers Who Work With Women. The Women's Alcoholism Program of CASPAR (1990). [For ordering and cost information write the Women's Alcoholism Program of CASPAR, 6 Camelia Avenue, Cambridge, Massachusetts 02139].

Getting Sober, Getting Well is a comprehensive treatment guide for people who work with women who have alcoholism, drug addiction, and trauma histories. It is based on the experience of the Women's Alcoholism Program of CASPAR.

In Their Own Words. Maine Trauma Advisory Groups Report. June 1997. [For ordering information write the Department of Mental Health, Mental Retardation and Substance Abuse Services, Trauma Services Office, #40 State House Station, Augusta, Maine 04333, (207) 287-4250]

In Their Own Words is a book based on the words of survivors of abuse and the professionals they trusted to talk with about their experiences with trauma. It explores both what helped and hurt them in dealing with their trauma and recovery and provides recommendations for improving treatment.

The Kinship Care Source Book: A Complete Resource Guide for District of Columbia Caregivers Raising Children of Family and Friends. Edited by Mary K. Bissell. The D.C. Kinship Care Coalition, Inc.

"The fundamental goal of The Kinship Care Source Book is to empower kinship care families by providing a user-friendly manual with relevant information that can be generally applied to the many individual kinship care arrangements in the District of Columbia." The Source Book provides answers to the most commonly asked questions regarding legal options, permanency planning, public benefits, housing, medical services, child care, education, incarcerated parents and support groups. It includes a resource guide on where to go for help and advocacy information on improving local policies to support kinship care families.

Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs (1994) Center for Substance Abuse Treatment/ U.S. Department of Health and Human Services.

This is a comprehensive guide designed to address issues and offer strategies for the effective care of women with substance abuse problems. The manual also addresses issues relevant to many women who are in treatment, including violence, sexual abuse, and co-occurring mental health problems.

For sale by the U.S. Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington, D.C. 20402-9328.

Program Compendium for Women with Co-Occurring Disorders in the Criminal Justice System. The GAINS Center (1997).

The **Program Compendium** provides a description of programs that serve women with co-occurring disorders in the criminal justice system. It is organized by state and includes a program description, contact person, telephone number, and address.

Available from the National GAINS Center, 262 Delaware Avenue, Delmar, New York, 12054, 1-800-311-GAIN.

Trauma Recovery Skills: Development and Enhancement, Maxine Harris and Jerri Anglin, Community Connections (1996). [Obtain by contacting Maxine Harris or Jerri Anglin, Community Connections, Washington, D.C. (202)546-1512].

Trauma Recovery Skills: Development and Enhancement is a comprehensive skills training guide for working with women who have histories of trauma, mental illness, and substance abuse problems.

FILMS

We Are Not Who You Think We Are. A VIDEO ACTION FUND production in collaboration with the Family Violence Program at Bedford Hills Correctional Facility. [Available from VIDEO ACTION FUND, 3034 Q Street, Washington, D.C. 20007, (202) 338-1094].

We Are Not Who You Think We Are is a film made by women incarcerated at Bedford Hills Correctional Facility in Bedford, New York. It is a dramatic account of their life stories.

Voices from the Inside. A documentary by Karina Epperlein. [Available from New Day Film Library, 22D Hollywood Avenue, Hohokus, New Jersey 07423, (201)652-6590].

Voices from the Inside follows a theater artist into a federal women's prison where she encourages a racially mixed circle of women to find their own voice through poetry and creative expression. It includes scenes with their children on the outside. The women tell their stories and share their experiences of prison life.

Appendix II

Recommendations

A. Programs in the criminal justice system

1. Realistic programs that are designed to help women with their basic needs.
2. Good assessments that include a history of physical and sexual abuse.
3. Individualized care.
4. Appropriately trained staff.
5. Gender-specific services.
6. Drug and alcohol treatment. Mental health treatment.
7. Treatment on demand.
8. Appropriate and adequate health care services.
9. Nurseries in prisons.
10. Family-based care.
11. A federal program to provide new-age medications to women who are incarcerated.
12. More HIV/AIDS education programs.
13. Education programs for women who don't speak English.
14. Do no harm.

B. Programs to prepare for release

1. Meaningful and realistic discharge planning.
2. Transition programs including programs that will accept women coming out of prison who have psychiatric problems.
3. Resources on the outside — including housing and jobs.
4. Alternatives in health care and mental health and substance abuse treatment.

C. Public Policy

1. Don't get tough on crime by cutting back on critical services for people who are incarcerated.
2. Reduced sentences.
3. Maintain separate correctional facilities for women and men.
4. End violence against women in correctional facilities.
5. Establish a task force that focuses on the multiple issues facing women who are in corrections.
6. Develop a specialized women's division with corrections at all levels.
7. Emphasize treatment over punishment.
8. Develop a protocol for the use of seclusion and restraint for women with a history of mental illness and trauma.
9. Reduce stigma by encouraging individuals to publicly acknowledge their own experiences with mental illness and addiction.
10. Provide the public with more education about women who are in the criminal justice system.
11. Put a moratorium on prison construction.
12. Provide direction to states on how to spend their federal Medicaid dollars.

D. Prevention

1. Start younger.

E. Research

1. Conduct research on what works in preventing crime.
2. Conduct research on what helps women with histories of trauma, mental illness, and substance abuse problems who are in the criminal justice system.

Appendix III

Survey I – Interviews With Women

1. Demographic Data

Name: Race/Ethnicity:
Age:
Address:
Telephone Number:
Number and Ages of Children (and any information about children women share):

2. Treatment Experience While Incarcerated

Please describe the treatment you received while incarcerated — health care, mental health services, substance abuse services.

What was helpful?
What was not helpful?

3. What Made A Difference?

a. What made a difference in helping you to begin the recovery process (begin the process of change)? Please describe this process.
b. Were there certain people who helped you to stop using (please describe these individuals and what it was about their approach or interaction with you that made a difference)?
c. Were there certain people who made a difference in helping you to gain a proper diagnosis and course of treatment (please describe these individuals and what it was about their approach or interaction with you that made a difference)?
d. Were there certain events that happened in your life that helped in your periods of recovery/stabilization? What were they? Please describe for each period if more than one.
e. Did having concrete information about your illness play any role in your own acceptance of your mental illness/addiction?
f. What role did having proper medication play in your recovery/stabilization?
g. How do you define recovery?

4. What didn't help (what obstacles did you encounter)?

   a. Can you identify specific things that happened to you while you were in the criminal justice system that made it hard for you to begin recovery/stabilization?
   b. Did anything happen to you that made you feel like you were reliving a bad experience you had before? What happened?
   c. Were you ever put in isolation or restraints? If so, please describe those experiences.
   d. What was your lowest point? Why?

5. Do you have children?

   a. If yes, what happened to your children while you were incarcerated?
   b. Did you see them while you were incarcerated?
   c. Were you reunited with them after your incarceration?
   d. What would have helped you to maintain contact with your children during your incarceration?
   e. What do you think would have helped your children while they were separated from you?

6. In your experience, what are successful approaches to helping women who have both mental illness and substance abuse problems?

7. Please describe what it is like to have your history of incarceration, mental illness and substance abuse problems and how you have come to terms with the stigma associated with your history.

8. If the President asked for your advice about ways to improve treatment for women in the criminal justice system with the dual problems of mental illness and addiction, what recommendations would you make?

9. What training do you think would help individuals who work with women in the criminal justice system who have mental illness and substance abuse problems to do a better job?

10. How do you think formerly incarcerated women can assist/inspire/mentor women who are in the criminal justice system or just coming back to the community? Can you give some examples of where you see your vision in action today?

11. Mental Health and Substance Abuse History

Please describe your mental illness and substance abuse history including diagnosis, medications, and treatments. Please describe your family history of mental illness and addictions.

12. Criminal Justice History and Experience

Please describe your arrest and incarceration history and experiences.

Survey II – Interviews With Experts

1. Demographic Data

Name: Race/Ethnicity:
Organization:
Address:
Telephone Number:

2. Experience and Setting

Please describe your work and educational background including your current job and responsibilities.

3. What Makes A Difference?

   a. What do you think makes a difference in helping women to begin the recovery process (begin the process of change)?
   b. When you think of the people who can make a difference in the lives of women with mental illness and substance abuse problems who are in the criminal justice system, who are these individuals and what makes them effective?
   c. What steps can be taken to help women get proper assessments and interventions (including medications)? Is this happening in the institution you are affiliated with? If yes, please describe. If no, why not and what are the obstacles that are standing in the way?
   d. What factors do you think are important in helping women to stabilize?
   e. How do you define recovery?

4. What doesn't help (what obstacles stand in the way of women recovering and staying out of the criminal justice system)?

5. In your experience, what are successful approaches to helping women who have both mental illness and substance abuse problems who are in the criminal justice system?

6. Why do you think so many women with mental illness and substance abuse problems are ending up in the criminal justice system? What steps can we take to help them to stay out?

7. Please describe how you think stigma affects women with mental illness and substance abuse problems who are in the criminal justice system and your ideas about how we can reduce the stigma associated with these illnesses.

8. If the President asked your advice about ways to improve treatment for women in the criminal justice system with the dual problems of mental illness and addiction, what recommendations would you make?

9. What training do you think would help individuals who work with women in the criminal justice system who have mental illness and substance abuse problems to do a better job?

10. How do you think formerly incarcerated women can assist/inspire/mentor women who are in the criminal justice system or just coming back to the community? Can you give some examples of where you see this vision in action today?

About the GAINS Center

The National GAINS Center for People with Co-Occurring Disorders in the Justice System was established in 1995. The Center gathers information about mental health and substance abuse services provided in the justice system, tailors materials to the specific needs of localities, and provides technical assistance to help them plan, implement and operate appropriate, cost-effective programs.

The National GAINS Center is a partnership of the Substance Abuse and Mental Health Services Administration (SAMHSA) — the Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS) — and the National Institute of Corrections, the Office of Justice Programs, and the Office of Juvenile Justice and Delinquency Prevention.

The GAINS Center is operated by Policy Research, Inc. in collaboration with the Louis de la Parte Florida Mental Health Institute. For more information, contact:

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