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Doing quality time : development of a feminist treatment program for women prisoners and their children

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DOING QUALITY TIME

DEVELOPMENT
OF A
FEMINIST TREATMENT PROGRAM
FOR
WOMEN PRISONERS AND THEIR CHILDREN

A Thesis

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The Faculty of the

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by

Ann Rebecca Pierce Harrison

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ABSTRACT

DOING QUALITY TIME

by Ann Rebecca Pierce Harrison

This master's thesis focuses on the lives of women prisoners, and how one model community-based treatment program for incarcerated women and their children grew into a space for healing and growth, guided by feminist principles. The literature review documents the increasing population of women incarcerated in California's prisons; explores connections between antecedent social problems affecting women in conflict with the law, and the social consequences of corrections policies for incarcerated mothers, their children, families, and communities; establishes that women have needs and behaviors during incarceration that are different from those of men; and concludes that women in prison are not getting their basic needs met, and continue to be marginalized and underserved in comparison to male prisoners because corrections systems are paramilitary institutions built for and controlled by men.

The body of the study consists of three chapters which detail the history of California's Community Prisoner Mother Program, the history of the prisoner advocacy agency, Friends Outside in Monterey County, and the collaborative effort I led to develop the Friends Outside Community Prisoner Mother Program into a feminist treatment program. The final chapter discusses the competitive contract renewal process which resulted in an expanded contract with the California Department of Corrections and recognition as a statewide model. This chapter also explores my conclusions regarding policy and program strengths and weaknesses, and offers recommendations for work with women prisoners and their children.

Dedicated to my mother, Nancy Cox Crockett, who died at 40. Thank you for your strength and joy in life, your feminism, your fight for my education, and your belief in me, heart and soul. And to my children, Amber and Justin, you have taught me much and been my gift. I love you. And to the circle of recovering women who love and support me and help me find my womanspirit. Thank you. And to the hundreds of imprisoned women who have shared their stories and lives with me. You are my teachers, my sisters on the journey, my hope. I am humbled by your courage.

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INTRODUCTION

Since 1980 the number of women imprisoned in California state prisons has increased by 826% (California Department of Corrections 1998). The majority of these women prisoners are incarcerated for nonviolent drug offenses and drug-related property offenses. This explosion in the number of incarcerated women is being fueled by the current "war on drugs," which has generated stricter sentencing laws that require mandatory prison sentences for nonviolent offenses in cases which formerly would not have resulted in prison terms. California is currently engaged in the most extensive prison construction program in the United States, in part to accommodate this remarkable influx of women into state prisons (California Department of Corrections 1998).

The implications of this situation are far-reaching, particularly because the majority of incarcerated women were the primary caretakers of their dependent children before their imprisonment. Research discussed in Chapter I indicates that the effects of the forced separation of children from imprisoned mothers perpetuates generational cycles of substance abuse and incarceration. Researchers who focus on women prisoners agree that the real solution to this situation is to provide chemical dependency treatment programs and services to women whose nonviolent offenses are primarily motivated by drug addiction and substance abuse. Unfortunately, addiction treatment resources currently available are insufficient to meet the needs of the general population of chemically dependent women, much less women prisoners.

My study describes the lives of women prisoners and focuses on how the Friends Outside Community Prisoner Mother Program (CPMP), a community-based treatment program for incarcerated women and their children, came to be a space for healing and growth, based on feminist principles. The study examines the profile of women in

California prisons, questions the efficacy of incarcerating women whose conflict with the law derives from oppression, victimization and addiction, and explores the limitations of treatment options currently available to meet the needs of the prisoners, their families, and their communities.

The major focus of the study is the three-year process of program development I undertook as the program manager of the Friends Outside CPMP. When I became manager of the program, I was a graduate student in women's studies and had begun to conduct research on women and addiction in general. I initially approached my new job intending to apply my education as a feminist social scientist to my work in the program, but did not plan to incorporate this job into my research. I soon realized that I had landed in a situation rich with possibilities for feminist research.

Soon after beginning my work at the CPMP, I realized that women prisoners are among the most disempowered, marginalized groups of women in the society. Their histories reflect exponentially the intersections of gender, race, and class oppression in addition to the further disenfranchisement of prisoner status. Women prisoners have often internalized the hatred projected onto them by society as feelings of shame. They are seen and see themselves as failures in all of the socially acceptable roles for women. And once incarcerated, once a part of the "inmate" population, they are further marginalized because they are women, receiving far fewer "services" than male prisoners.

The focus of women's studies theorists and practitioners is the transformative nature of the feminist perspective applied to long-standing social realities resulting from white male supremacist oppression of disempowered groups, especially groups of women. As my passion for and understanding of the issues of women prisoners grew, I began to realize that researching and reporting the work in which I was engaged with the women

prisoners and the program development,would be a valuable contribution to women's studies literature generally, and specifically to the study of women prisoners.

Methods and Organization of the Study

My thesis presents a case study of the emergence of a treatment program for women prisoners and their children rooted in feminist social science. The Friends Outside Community Prisoner Mother Program holds a contract with the California Department of Corrections to provide residential treatment services to women prisoners and their children in a community-based setting. As the program manager of the CPMP, I guided the development, over a period of three years, of a comprehensive addiction and trauma recovery treatment model which then received an expanded contract and recognition as a statewide model program.

The process of conducting research as a participant observer is a distinguishing characteristic of much feminist research. My initial research focus on women and addiction and later on women, addiction, and imprisonment stems in large part from my own personal experience of addiction, which included a limited degree of conflict with the law and my recovery from addiction. My dual role as program manager of the research site and social science researcher offers an interesting opportunity to provide the field of women's studies with an insider's view of a population of women rarely addressed. Prisons are closed systems and few researchers are afforded the opportunity to conduct long-term study of prisoners. While my perspective involves a distinct subjectivity, the value of insight informed by years of experience with women prisoners far outweighs a claim of dispassionate neutrality. However, my training as a social scientist informs my work with the analytic perspective of a committed researcher.

My position as program manager of the CPMP provided me with important sources of data, enabled me to develop trust with prisoners and staff, and allowed me to test the program design in the treatment milieu. In addition to my direct observation of the program and its participants, I had access to the case files of participants, as well as numerous opportunities for informal interviewing of Friends Outside staff and CDC staff who have years of experience with correctional settings and women prisoners. I was able to develop, implement, and test programming strategies in a process of refining the program design.

All of these methodologies provided rich sources of information which informed my research. However, the participants' case files proved to be disappointingly inadequate. While the case files do suggest a CPMP participant profile similar to that presented in the literature on women prisoners, I was not able to tabulate consistent or complete data on the CPMP participants for this study. There is documentation of all women who entered the program; however, when I attempted to gather specific data on each woman, I found that many files are missing or incomplete. Friends Outside did implement a rudimentary data collection process in 1995, but some of the information has been lost. As with many community-based programs managed by nonprofit agencies, data collection and analysis is seriously lacking. Programs operating with limited funding and attempting to provide quality programming typically allocate energy and resources to needs such as staff training, purchase of curricula and materials, and other service provision enrichment efforts. The problems with the participant files illustrates the need for management information systems to be established and implemented by CDC, and I make this recommendation in the final chapter.

I have arranged the thesis in chronological order because I aim to describe the process as a living, evolving experience. I intend for the reader to gain insight into the

situation of the women prisoners and the process of program development in a manner that reflects the unfolding process that I myself experienced. Chapter I presents a review of relevant literature. I document the exploding population of women unnecessarily incarcerated in California's prisons and explore connections between antecedent social problems affecting women in conflict with the law and the pathological social consequences of corrections policies for incarcerated mothers and their children, families, and communities. The literature review establishes that women have needs and behaviors during incarceration that are very different from those of men, and I conclude that women in prison are not getting their basic needs met and that they continue to be marginalized and underserved in comparison to male prisoners because corrections systems are paramilitary institutions built for and controlled by men. Chapter II describes the history of California's Community Prisoner Mother Program (CPMP), the history of the prisoner advocacy agency, Friends Outside in Monterey County, and the first two years of operations in the Friends Outside Community Prisoner Mother Program. Chapter III describes my first year as manager of the Friends Outside CPMP, during which I assessed the program's needs and attempted to begin the process of development to create a quality treatment program. Chapter IV details the collaborative effort I led to develop the Friends Outside CPMP into a feminist treatment program. Finally, Chapter V describes the process of competing for the CPMP contract renewal, which resulted in an expanded contract with the California Department of Corrections and recognition as a statewide model. The final chapter also explores my conclusions regarding policy and program strengths and weaknesses and offers recommendations based on my research and years of experience working with women prisoners and their children.

Publication of my work in developing a successful feminist treatment model for the Friends Outside CPMP is consistent with the goals of women's studies in that it provides

education and increases awareness regarding the provision of pioneering feminist treatment options to this most marginalized and forgotten population of women. The success of a treatment modality based on a gender-specific and culturally sensitive approach to addressing the problems of addiction, crime, and incarceration, about which many Americans are concerned, illustrates the effectiveness and credibility of feminist social science.

CHAPTER I

REVIEW OF THE LITERATURE

Although there are committed, talented researchers, clinicians, and advocates working through several agencies, institutes, and universities to study, understand, and educate others concerned with the truth about the lives of women prisoners, they are few in number. While my review of the literature is not exhaustive, it does reveal remarkably consistent data, findings, and recommendations regarding this population of women.

The literature convincingly argues that the needs of corrections systems, society, and the majority of women prisoners, would best be addressed by developing and implementing sentencing policies intended to decarcerate nonviolent, chemically dependent women in conflict with the law. The literature also suggests that the best method of dealing with decarceration would be to expand community-based treatment programs that provide alternative sentencing sites in which to offer residential, comprehensive services and programming that meets the needs of the women, their families, and society.

With a 1997-98 budget of $3.7 billion, the California Department of Corrections (CDC) currently employs the largest staff of any California state agency (43,991) and operates 33 state prisons, 38 minimum security firefighter camps, and 52 community corrections programs to incarcerate 155,276 prisoners (California Department of Corrections 1998). Since the early 1980's CDC has been engaged in the largest prison construction program in the United States, adding a projected 51,268 institutional beds at a total cost of $5.27 billion (California Department of Corrections 1998). Many have come to refer to the Department of Corrections as the "prison industrial complex," which is replacing the defense industry as one of California's major economic forces.

Within this massive agency there are a total of six community-based alternative sentencing treatment sites offering Community Prisoner Mother Programs which have the capacity to effectively serve the needs of women prisoners, their families, and communities. Despite the preponderance of research which documents the serious need for this type of alternative sentencing option, only 94 of the 10,869 women in California's prisons in California have access to these programs (California Department of Corrections 1998).

Do legislators and politicians truly understand the consequences of engaging in simplistic "tough on crime," "war on drugs" rhetoric designed to win elections? Are the needs of women prisoners, their children, and their communities seriously considered by a government agency which is growing at an alarming rate, employs 43,991 staff, and continues to build more prisons which will require untold numbers of more employees to operate them? The research reviewed here implicitly explores these questions and essentially illustrates the fact the criminal justice system in the United States, and the California Department of Corrections (CDC) in particular, are clearly not dealing with the issues concerning women prisoners effectively. In fact, there appears to be significant conflict of interest between CDC's expansionist agenda and the findings and recommendations of expert researchers in criminology, sociology, chemical dependency, and women's studies. Additionally, it appears that in many ways, though the numbers of women prisoners have grown exponentially just in the past twenty years, critically needed understanding of issues related to women prisoners has not.

History of Women's Imprisonment

According to Nicole Hahn Rafter, author of *Partial Justice: Women, Prisons and Social Control* , the history of women's imprisonment can be divided into three distinct

periods. During the first, from approximately 1790–1870, prisons for both women and men were simply custodial, with no thought to rehabilitate prisoners. Because the numbers of women in the prisons was so small, they were at first housed with the men. Over time separate quarters were created for the women, where they had limited access to any services provided to the men (Rafter 1997).

During the second period, from about 1870–1970, the reformatory approach began when women from the middle class became involved in trying to help women prisoners. This was generally the time during which middle class women were moving into public life by doing social work with other women and children as in the settlement house movement. Women's reformatories were established around the country to help minor women criminals who were perceived as more deviant, more difficult to reform, than men. Women were treated as childlike and in need of much help in reforming. In order for them to be helped, women were incarcerated in state prisons for minor "crimes" such as alcoholism or promiscuity, for which men were never sent to state prison. Women were actually imprisoned for being a "bad mother," having out-of-wedlock babies, or flirting and could be held for up to five years for these "crimes." The women's reformatories were run by women and offered a variety of gender-role-based programs designed to provide domestic housekeeping training to the primarily white, working class inmates. Women prisoners were actually paroled out to middle class families as servants and could be returned to prison if they did not behave to the employer's satisfaction (Rafter 1997).

Women convicted of serious felonies such as assault, murder, and arson had continued to be kept in the men's custodial prisons throughout this period. In the 1930s, with an increasing number of men being sent to prison, and with states no longer able to afford to incarcerate women for petty crimes, convictions of women for minor crimes

decreased and only women convicted of serious felonies were then sent to the reformatories (Rafter 1997).

The third period in the history of women's imprisonment in the United States began during the late 1960s, when the country's attitude towards prisoners became increasingly more punitive. Conventional wisdom declared that rehabilitation efforts with criminals had failed, the push for mandatory minimum sentences rather than indeterminate sentencing gathered support, and serious discussions about abolishing parole began. More recently, although activist efforts have pressured some women's institutions to continue their attempt to provide quality programs, the explosion in the numbers of women prisoners entering the system is making even these small programs difficult to maintain. As politicians have become increasingly more skilled at manipulating voters' fear of crime, the "get tough on crime" approach to dealing with criminals has resulted in a nationwide campaign of prison construction to accommodate the return to a punitive, custodial approach to managing women and men prisoners (Rafter 1997).

Prior to the 1980's very little attention was focused on the seemingly invisible population of women prisoners. In one significant early work, the pioneering book *Women In Prison: Inside the Concrete Womb*, first published in 1973, Kathryn Watterson interviewed hundreds of women prisoners and dozens of women guards and prison administrators around the United States. Through the personal stories of women prisoners, Watterson focused national attention on a population of women most of the public had never considered. *Women In Prison* explored the intersecting social issues impacting the lives of women prisoners: poverty, racism, unequal access to education and employment, family violence against girls and women. In essence, *Women In Prison* was the first look at the oppression of women through the lens of the lives of women prisoners.

Writing in the forward to the 1996 edition of *Women In Prison*, Watterson expresses her disappointment at the fact that little about prisons has changed in the twenty three years since she wrote the book:

> I thought the facts would become self-evident. But it's clear that the public still doesn't understand how prisons work . . . that the vast majority of men and women in prison are locked up for years for petty property crimes, drug addiction, vagrancy . . . that prisons warehouse and destroy the lives of our most poverty-stricken Americans—people who would never spend a day in jail if they had economic resources.
>
> I also thought that politicians would realize that to stop crime, we had to pursue workable alternatives to prison such as intensive probation . . . drug education and treatment, schools, job training, parenting programs, literacy programs, and counseling—programs that cost a fraction as much per person per year as prison and that are many times more effective.
>
> I thought we might get smart. But I was wrong. . . . In fact, not only are things the same, but they are worse (Watterson 1996, xiii–xiv).

Watterson's work first identified many areas of needed research concerning women prisoners which have been focused on more recently during the 1980s and 1990s. In California and elsewhere, a number of activists, scholars, advocacy organizations, university institutes, and governmental agencies have been attempting to generate reasoned, effective responses to the problems and needs of women prisoners as this seemingly invisible population of women has been growing exponentially almost unnoticed by most of the public. A number of books, articles, reports of demonstration projects, statistical analyses of corrections data, commissioned studies, and survey research projects have created a profile of women prisoners, identified their unique problems and needs, evaluated the availability and quality of existing programs and services, and generated findings and recommendations for improving the situation.

The recent increase in the number of women in conflict with the law is creating an alarming crisis which appears to be spinning out of control. Between 1980 and 1994 the population of women incarcerated in United States state and federal prisons increased by

386% compared to a 214% increase for males. At the end of 1994 one out of every 130 women in the total population was in prison, in jail or on probation or parole (Acoca and Austin 1996). In California in 1980, there were 1,316 women in prison; in 1995 there were more that 8,000 (Owen and Bloom 1995). As of January 1998, 10,869 women were incarcerated in the four women's prisons and one coed prison operated by the California Department of Corrections (California Department of Corrections 1998). The California system incarcerates women at a rate of approximately 50 per 100,000, has the largest population of women prisoners in the United States, and has the largest women's prison in the world (Bloom, Chesney-Lind, and Owen 1994).

Causes of the Increase in Incarcerated Women

Between 1980 and 1998 the number of women imprisoned in California increased by 826 percent (California Department of Corrections 1998). All four of California's women's prisons are currently operating above their design capacity. California Institution for Women (CIW) in Corona opened in 1952, Northern California Women's Facility (NCWF) in Stockton opened in 1987, Central California Women's Facility (CCWF) in Chowchilla opened in 1990, Valley State Prison for Women (VSPW) in Chowchilla opened in 1996, and the one coed prison, California Rehabilitation Center (CRC) in Norco opened in 1962, are between 65 to 93 percent over capacity (Bloom, Chesney-Lind, and Owen 1994).

The vast majority of women in California prisons have been convicted of nonviolent crimes with over two-thirds serving sentences for drug-related and economically motivated property crimes such as shoplifting, petty theft, and burglary. In fact, between 1982 and 1992 the number of women imprisoned for violent crimes dropped by 16.7 %, while the number of women imprisoned for drug offenses increased

by 28%. Men commit almost twice the number of violent crimes as women and women are significantly more likely to be incarcerated for drug crimes than men (37.8% vs. 23.8%). By all measures the increase in the number of women in California prisons appears to be the result of mandatory minimum sentencing laws, especially for drug crimes, enacted as part of a politically motivated, "tough on crime" strategy supposedly designed to protect society from major drug criminals assumed to be dangerous male predators. (Bloom, Chesney-Lind, and Owen 1994).

Profile of Women Prisoners

A 1994 study comparing data on California women prisoners with national data indicates a consistent profile for women prisoners across the United States (Owen and Bloom 1995). This profile, not surprisingly, suggests that California women prisoners come from our most vulnerable groups of women. Over half the women in the state's prisons are African American (46%) and Latina (14%), with over one third Anglo/European American (36%) and 4% listed as "Other." Most of the women are between the ages of 25 and 34 (Owen and Bloom 1995).

The vast majority of women prisoners are or have been drug/alcohol addicted. Drugs of choice are generally identified as the "harder" drugs such as crack, heroin, and methamphetamines. Most women report long histories (often with first use prior to age 18) of poly-drug use including alcohol (85%), marijuana (77%), and prescription drugs (40%) (Owen and Bloom 1995).

The majority of the women come from economically disadvantaged families and communities. The families of origin have generally been unstable, chaotic, often drug addicted and violent. Growing up, many of the women experienced periodic abandonment by one or both parents, with most being raised in single parent situations by

the mother or grandmother. It is not unusual for the women to have been introduced at an early age to drug use by their parents or other family members. Sixty three percent have family members who have been incarcerated. Almost all (80%) of these women are struggling with serious issues related to trauma and abuse which began during childhood, such as incest, molestation, and other forms of physical and/or sexual violence, and which often carried over into their adult lives (Owen and Bloom 1995).

Almost half of women prisoners have a history of involvement in the juvenile justice system from an early age. This involvement includes running away (54%), often from abuse, juvenile arrests (45%), probation (31%), with time spent in foster homes (14%), juvenile hall (32%), and California Youth Authority (10%) (Owen and Bloom 1995).

Not surprisingly, the majority of women in California prisons did not complete high school. Few have marketable job skills due to their limited education and drug abuse history, with about half never having been employed at all. Of the women who had worked, most had held low-wage, low-skilled jobs. Many of the women have relied on welfare, drug dealing, prostitution and other illegal activities for income. The most common reason cited for employment problems or not working was substance abuse problems (Owen and Bloom 1995).

Almost half of women prisoners in California have never been married (42.9%), but 80% report having dependent children—two, on the average. Researchers agree that the arrest and incarceration of a parent is extremely traumatic for families, especially for children (Bloom and Steinhart 1993). When a father is incarcerated, the family experiences trauma but is likely to remain intact, because the mother usually holds the family together and provides ongoing parenting, including making sure the children maintain contact with their father through prison visits. Conversely, when a mother is

incarcerated the father rarely stays with the children or facilitates continuing contact between the children and their mother while the mother remains in prison (Barry 1995).

Many incarcerated women are separated from their children by hundreds of miles and experience great difficulty maintaining telephone and visiting contact with them. Over half of the dependent children of imprisoned women never visit their mother while she is incarcerated. Many children are cared for by grandmothers and other relatives who are economically disadvantaged and cannot afford to travel long distances to insure mother-child visits. In cases where children are in the foster care system, visiting becomes even more difficult, often making it impossible for the mother to meet court-ordered family reunification requirements, sometimes resulting in termination of her parental rights (Bloom and Steinhart 1993).

Need, Availability, Quality of Programs and Services for Women Prisoners

The prison system operated by the California Department of Corrections (CDC) was designed to serve the needs of the predominantly male population of prisoners. With the growing influx of women prisoners presenting it with multidimensional issues such as inadequate health care, homelessness, chemical dependency, parenting issues, educational and vocational training needs, and mental health needs, the system is failing to adequately provide necessary services. Even with all the evidence pointing to the connection between substance abuse and incarceration, only three percent of prisoners have access to treatment, including weekly Alcoholics Anonymous or Narcotics Anonymous meetings (Covington 1998).

Several studies published between 1992 and 1996 have utilized feminist perspectives on women's development and oppression in analyzing of the needs of women prisoners and in making policy and programmatic recommendations to meet those

needs. The results of reports from a variety of sources are remarkably consistent. In 1992 the U.S. Department of Justice, National Institute of Corrections funded a report conducted by the National Council on Crime and Delinquency (NCCD) which surveyed community programs for women offenders across the United States. *Female Offenders in the Community: An Analysis of Innovative Strategies and Programs* (Austin, Bloom, and Donahue 1992) identifies issues and needs of women in conflict with the law and barriers to meeting those needs, and describes progressive programmatic responses, including treatment philosophy, program design, organizational management, and service delivery methods.

Barriers to provision of appropriate services identified within the criminal justice system by the NCCD report include the following:

- Tension between a criminal justice system that fosters dependence and a female population which needs to become more independent;
- Gender, race, and cultural biases in the criminal justice system that have a negative impact on women of color;
- Potential value conflict between the needs of the criminal justice system and the needs of the offender, i.e., treatment vs. sanctions;
- Imposition of male paradigms on women that fail to address their unique needs, i.e., parenting and independent living skills;
- Models of probation and parole that set women up to fail in the community by their lack of attention to basic survival issues , i.e., homelessness, child care needs (Austin, Bloom, and Donahue, 1992, 6).

In its assessment of community-based programs nationwide, which includes the Community Prisoner Mother Program (CPMP) in California, this NCCD report states that the most promising programs provide a combination of supervision and services that address the unique needs of women by providing structure and safety while fostering self-sufficiency through an emphasis on accountability. The report identifies programs that utilize the empowerment model of treatment by focusing on skill building and

competencies development as being more effective than those utilizing the deficit model which attempts to "cure" women of emotional disorders.

> Effective therapeutic approaches are multidimensional and deal specifically with women's issues, including alcoholism/addiction, parenting, relationships, gender bias, domestic violence, and sexual abuse. . . . Conditions that appear to positively influence the outcome of correctional interventions for women . . . included: a continuum of care design including clearly stated program expectations, rules and potential sanctions (structure); consistent supervision (accountability); ethnically diverse staff, including a balance of professionals and recovering ex-offenders (role modeling); coordination of community resources (case management); and ongoing practical and emotional support (aftercare) (Austin, Bloom, and Donahue 1992, 21–22).

The NCCD report makes policy recommendations which include increased development and utilization of "gender-specific" community based programs by the criminal justice system, and development of corrections policies that focus on the needs of the children of women in conflict with the law and emphasize family preservation (Austin, Bloom, and Donahue 1992).

Why Punish The Children? A Reappraisal of the Children of Incarcerated Mothers in America, a book published in 1993 by the National Council on Crime and Delinquency, clearly outlines issues of poverty, racism, and oppression of women in terms of the impact of a mother's incarceration on her children. Among a number of policy recommendations, the book focuses on the need to develop and utilize sentencing reforms for mothers in conflict with the law which would avoid unnecessary incarceration and provide community-based sentencing alternatives for mothers and their children, "such as Community Prisoner Mother Program in California" (Bloom and Steinhart 1993, 63).

The California State Senate Concurrent Resolution (SRC) 33 Report on Female Inmates and Parolees is the work of a commission appointed in 1991 by the California State Legislature to review and make recommendations concerning women prisoners and

parolees. The SRC 33 Commission included members of the judiciary, correctional and academic communities as well as service providers to women prisoners and parolees. "In approving SCR 33, the State Legislature indicated . . . that the population of women in California's prisons has a disproportionately high number of minority and low-income women . . . and . . . a large proportion . . . are single mothers, drug users, and . . . are in prison for less severe . . . less violent crimes than men." (Senate Concurrent Resolution 33 Report 1994, I)

The commission analyzed a variety of issues such as education, employment, substance abuse, parental status, sentencing and alternative treatment programs. They surveyed services and programs available to women prisoners and parolees, and presented their findings and recommendations in a Final Report published in 1994. The SRC 33 Report identifies three core concepts which inform its entire contents:

> Female inmates differ significantly from males . . . in terms of their needs while incarcerated and upon their release to the community on parole. . . . These differences should be recognized . . . and . . . policy makers should pursue the opportunities these differences offer to coordinate efforts for improved treatment, public safety, programming, and reintegration into the community and success on parole;
>
> Female inmates and parolees generally have a lower rate of commitment to prison for violent offenses and exhibit significantly less violent behavior in prison than males. These characteristics offer . . . opportunities to develop, for very specific targeted female populations, demonstration programs, punishment options, intermediate sanctions, and other means of holding inmates accountable for their actions without decreasing public safety; and,
>
> Upon release to parole, over 95 percent of all female inmates are sent back to the communities from which they were sentenced. The successful reintegration of these women into their communities is, to a large degree, dependent on those communities sharing responsibility with the CDC and its Parole & Community Services Division for the supervision, care, and treatment of these women (Senate Concurrent Resolution 33 Report 1994, S-1) .

The SRC 33 Report presents a discussion of the concept of "equal protection under the law" as applied to women in prison, stating that "women must be given access to

vocational or educational programs which are on parity with . . . programs available to men . . . even though those programs differ somewhat in subject matter and focus as long as the overall package . . . is comparable . . . and . . . there are legitimate, nondiscriminatory, fact-based reasons for any differences." The report goes on to advocate for creation of management, treatment, and programming options which meet the unique and specific needs of women within the context of equal protection, stating that the "acknowledged difference in the profile of the majority of women in prison shows the compelling, legitimate, nondiscriminatory, fact-based need for programs which reflect the unique and specialized needs of female inmates." (Senate Concurrent Resolution 33 Report 1994, IV).

The SRC 33 Report reflects the women prisoner sociodemographic profiles and issues detailed in the previous research referenced above. Additionally the SRC 33 Report links drug addiction and family histories of addiction, abuse and criminal behavior, with women prisoners' tendency to manifest low self-esteem and dependent behavior. SRC 33 also finds that women prisoners respond differently to imprisonment than men, struggling with significantly more emotional problems related to being separated from children. While incarcerated, women demonstrate less violence and more motivation than men, enabling them to participate in and successfully complete more programs than male inmates. Unlike male parolees, women rarely have a partner or spouse to return to upon their release, and women almost always plan to reunite with their children after prison (Senate Concurrent Resolution 33 Report 1994).

The SRC 33 Final Report organizes its recommendations into major categories which essentially repeat those of previous studies. These include increased focus on family needs and coordination of services, increased substance abuse/addiction treatment programming, policy changes regarding sentencing and development of alternative

sentencing options, management guidelines, staff training, and increased utilization of the Community Prisoner Mother Programs (Senate Concurrent Resolution 33 Report 1994).

Profiling The Needs Of California's Female Prisoners: A Needs Assessment, a study funded by the National Institute of Corrections, U.S. Department of Justice, and published in 1995, reports findings of a three-phase research project which gathered data on women prisoners in the four institutions then extant in California and compared it to national data, establishing a consistent profile of women prisoners. This study surveyed existing programs within the four institutions and in the community, developed a program needs assessment, and made recommendations. The document reports findings consistent with previously conducted and reported research.

> Both our data and the research literature on women and imprisonment stress the prominent role played by substance abuse, physical and sexual abuse, and poverty and underemployment in the lives of female offenders. . . . Our survey data also support the contention that a significant portion of female prisoners are not dangerous, are not career criminals, and thus do not represent a serious threat to the community, indicating the utility for community-based sanctions and community involvement in correctional programming (Owen and Bloom 1995, 18).

The report concludes that the California prisoner profile and program survey indicate five major areas of unmet needs system-wide: need for increased community interventions at all levels to include alternative sentencing options; need for educational and vocational training to develop economic self-sufficiency; need for increased substance abuse treatment for the overwhelming majority of women prisoners incarcerated for drug related crimes; need for an increased programming focus on family and personal issues including the issues related to family violence and sexual trauma in the lives of women prisoners; and a need for monitoring and expansion of existing programs both in the institutions and the community (Owen and Bloom 1995).

Since the early 1980s, researchers at the Stone Center for Developmental Services and Studies at Wellesley College in Massachusetts have been searching for innovative therapeutic models and theories of women's development that reflect women's lives honestly and clearly. Clinicians and scholars at the Stone Center have been challenging traditional models of "human" development informed by male culture which define maturity and health in terms of separation and individuation, and which consistently define women as lacking and deficient. Feminist theorists and practitioners working at the Stone Center with the guidance of Jean Baker Miller, author of the pioneering book *Toward a New Psychology of Women*, are in the process of analyzing and redefining psychological theory. Their relational theories of women's development grounded in the feminist frameworks of connection and diversity have been gaining influence and recognition (Jordan et al. 1991).

In 1993 the Massachusetts Committee on Criminal Justice funded the Women In Prison Project of the Stone Center

> to initiate the development of an integrated relational and diversity approach to the care and treatment of women in prison and after release. The project consisted of four phases: three conferences to introduce the work of the Stone Center to the Department of Correction administration and staff and to post-release service providers; a series of focus groups and interviews with women in prison to assess their developmental histories, their relational profiles and their perceptions of their present and future needs; interviews with staff to develop a training framework based on relational and diversity theory; and, piloting and evaluating the training framework in a series of educational process groups with Department of Correction staff and incarcerated women (Coll and Duff 1995, 1).

In a final report titled *Reframing The Needs Of Women In Prison: A Relational and Diversity Perspective*, researchers identified profiles and needs of women prisoners consistent with those of the other studies reported here. Identified needs included increased access to educational and vocational training, substance abuse programs, and

trauma recovery treatment, and need for services focusing on family maintenance and reunification with dependent children upon release from prison (Coll and Duff 1995).

The innovative aspects of this Stone Center project stem from its grounding in feminist relational and diversity theory. Relational diversity theory of women's development emphasizes women's need for mutuality and growth-enhancing connections in healthy relationships and the harmful consequences of disconnection, violation and abuse in relationships, as defined by different cultural and class perspectives. Relational diversity theory of development embraces women's strengths and diversities. Connections are seen as the foundation for emotional growth and healing, and as support for evolving definitions of self, autonomy, and cooperation. Establishing and building relationships is fundamental to women's sense of worth, pleasure and achievement (Miller 1991).

The multidimensional integrated model of treatment suggested by the Women In Prison Project Report provides for mental health services informed by a relational perspective, embraces diversity and respects the cultural contexts of relationships, incorporates research on psychological gender differences, provides process groups which enable the creation of mutually empowering relationships, and recognizes women prisoners' perceptions of themselves (Coll and Duff 1995).

In 1996 The National Council on Crime and Delinquency published another report focusing on women prisoners. *The Crisis: Women in Prison, The Women Offender Sentencing Study And Alternative Sentencing Recommendations Project* surveys, analyzes, and compares data on women incarcerated in Connecticut, Florida, and California prisons. This study defined four specific goals: to participate in the definition of the ongoing crisis concerning the apparently uncontrollable growth in the women prisoner population by analysis of national data; to develop a more detailed profile of

women prisoners through individual interviews with 151 randomly selected women in state prisons in Connecticut, Florida, and California; to advocate for regional expansion and utilization of community-based programs as sentencing alternatives; and to present policy recommendations based on information generated by the study (Acoca and Austin 1996).

The study's broad analysis of national data comparing women and men prisoners revealed findings similar to previously referenced research. The majority of women were found to be serving time in prison for more non-violent drug and property crimes than the men, presented little threat to their communities, and would most likely not have been sentenced to prison before the "drug war" laws were passed during the 1980s. Women prisoners experienced more serious drug problems and required more intensive levels of interventions and treatment than men. The women prisoners were more often primary caretakers to their dependent children prior to their imprisonment, and the separation had caused significant trauma and disorganization in the children's lives, placing them at high risk. Women prisoners were found to have more physical and mental health problems which require more medical assistance, are unique and specific to women, and require multifaceted treatment not generally necessary for male prisoners (Acoca and Austin 1996).

In designing the questionnaire for use during the interviews with 151 women prisoners the researchers focused on "eliciting information about areas of the women's lives that had not routinely been explored in other studies. Paramount among these were . . . immigration status . . . indications of learning and perceptual disorders . . . her perception of the crime and arrest that had resulted in her current imprisonment." (Acoca and Austin 1996, 41). The questionnaire's design was intended to invite the women being interviewed to tell their stories including detailed accounts of their own childhood,

the births and lives of each of their children, and perceptions of older children's involvement with drugs and the juvenile justice system.

> A majority of the women interviewed were women of color from low-income backgrounds. Few were married at the time of their arrest and most were mothers–single caretakers of young children. A majority were young, with a median age of 34. Approximately one in ten were non-legal immigrants.
>
> Among the most common characteristics of women in prison were histories of profound physical and sexual abuse, entrenched histories of drug and alcohol dependence, and family histories of arrest and incarceration, particularly among siblings.
>
> Close to half of the women were in prison for the first time and a majority were here for nonviolent drug and property offenses.
>
> The women reported that some of their children had already experienced a range of serious stressors. More than one-third had been separated from their mothers before they were three years old. Some children were having difficulty in school or had already entered the juvenile justice system. Due to the geographical isolation of the women's prisons and other factors, few children were able to visit their mother regularly, if at all (Acoca and Austin 1996, 42–43).

This study presents policy recommendations suggesting that violence against women and children be viewed as a "major and pervasive public health threat and a primary precursor to involvement in the criminal justice system" (Acoca and Austin 1996, 6). Additional recommendations emphasize the need for early identification, intervention and treatment for at-risk girls and young women, including substance abuse and trauma recovery treatment, pregnancy prevention, and alternatives to juvenile incarceration for girls in conflict with the law. Other strong policy recommendations address the need to re-evaluate mandatory minimum and determinant sentencing laws for non-violent crimes, and to re-evaluate drug policies and shift funding away from law enforcement and corrections toward substance abuse treatment and alternative sentencing options that provide community-based treatment for women in conflict with the law and their children (Acoca and Austin 1996).

Social Justice for Women (SJW) is a non-profit agency in Boston, Massachusetts which has been providing substance abuse treatment and other services to women in

conflict with the law since 1986. SJW defines its philosophy as a belief in women's ability to change negative lifestyles. "The agency's framework is feminist, relational, holistic and empowerment based . . . SJW specializes in designing and implementing alternatives to incarceration. The agency has particular expertise in providing alternative services and sites for women who are pregnant . . . with children . . . at risk for HIV infection, and women with AIDS who are involved with the criminal justice system" (Buccio-Notaro, Molla, and Stevenson 1996, 1).

In a 1996 report for the American Society of Criminology titled *Social Justice For Women Creates Alternative Sentencing Services and Alternative Sites For Women Involved In The Criminal Justice System*, clinicians and staff present data and analyses of the agency's four programs which support alternative sentencing options for women. The SJW report clearly defines alternative sentences as "court imposed sanctions that seek to attain the traditional criminal justice goals of rehabilitation, deterrence, incapacitation, and retribution. Alternative sentences decrease the number of individuals sent to prison, thus decreasing prison overcrowding, while preserving restitution" (Buccio-Notaro, Molla, and Stevenson 1996, 1).

Building on profiles and needs assessments of women prisoners consistent with those detailed in the above referenced studies, the SJW study presents an excellent case for alternative sentencing grounded in a feminist, relational perspective on the needs of women prisoners, their children and society.

> [T]he criminal justice system has never been geared to address women's unique needs. Penal institutions have been designed and created by men and until very recently primarily focused on male programming. Also, historically, women have been only a small portion of the prison population. As a result, women are rarely viewed as a special population and alternatives to incarceration or prison based services have never been geared specifically for them. There are some underlying causes for this lack of attention to women including: 1) women's status in the criminal justice system mirrors their status in the larger society; 2) men have traditionally directed and planned the criminal justice system and they were

> unaware of the special needs of women; 3) political atmosphere has not been conducive to what is perceived as special treatment for offenders; and 4) the low numbers of women in the system precludes giving them any serious attention (Buccio-Notaro, Molla, and Stevenson 1996, 3).

The SJW report asserts that alternative sentences for women "make economic sense for society . . . may be the best solution for the first time offender . . . offer judges a range of . . . options . . . [because] . . . women are less of a threat to society than men . . . [and] . . . the 'trauma of incarceration' brutalizes women to the degree that further impairs their ability to become productive members of society." (Buccio-Notaro, Molla, and Stevenson 1996, 6-8) The report goes on to question whether the criminal justice system is the appropriate social response to addiction.

Woman-Specific Substance Abuse Treatment Models

Prior to the current wave of the women's liberation movement, women who were alcohol or drug addicted were most often perceived as deviant, "fallen women," whose broken character must have invited this basically masculine problem upon themselves. Alcoholism and drug addiction in women was generally ignored, overlooked, underreported, undiagnosed and untreated. In the 1970's advocacy by feminists helped generate interest in and funding for research and development of prevention and treatment strategies for women needing help with addiction. Feminists working to develop and implement models of treatment informed by an awareness of women's needs have long known that women addicts are marginalized, ignored and underserved. A twenty-year-long struggle to influence policymakers, administrators, and practitioners to study, analyze, and implement women-sensitive treatment models at all levels continues today.

A number of clinicians and researchers working in the field of women and addiction have recently begun to respond to the crisis being generated by the incarceration of women for addiction-related, nonviolent crimes such as Driving Under the Influence (DUI), possession and/or sales of drugs, and economically motivated property crimes related to drug addiction. Recognizing that women prisoners are so marginalized as to be almost invisible, some feminist practitioners and theorists are beginning to focus on needs particular to this population of women as it becomes increasingly obvious that the increase in women's addiction is closely linked with the alarming increase of women in prison.

Writing in the *Journal of Psychoactive Drugs* in 1987, Beth Glover Reed reviewed the previous ten years of research, demonstration projects and rhetoric "to examine the reasons why so little progress has been made in reaching out to and providing gender-sensitive treatment services for women experiencing problems with alcohol and other drugs." (Reed 1987, 151) Reed then goes on to define gender-sensitive treatment services "as those that (a) address women's treatment needs; (b) reduce barriers to recovery from drug dependence that are more likely to occur for women; (c) are delivered in a context that is compatible with women's styles and orientations and is safe from exploitation; and (d) take into account women's roles, socialization and relative status in the larger culture" (Reed 1987, 151). A list of core services for alcohol and drug dependent women is included in this article: 1) medical and health care services; 2) child-related services; 3) family services; 4) vocational training; 5) skill training for self-esteem and coping; 6) chemical dependency education 7) legal assistance; 8) sexuality and intimacy counseling (Reed 1987, 156).

Wellisch, Anglin and Pendergrast studied institutional and community-based drug treatment programs for women offenders and concluded that program staff should be

composed primarily of women who reflect the ethnic mix of the clients as much as possible and who can function as role models. They emphasize the need for vocational training to facilitate opportunities in higher paying fields of employment than the traditional women's jobs such as cosmetology. Additionally these researchers advocated for programs to assist women in maintaining or reconnecting relationships with their children and for adequate health care (Wellisch, Anglin and Pendergrast 1993).

Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs was published in 1994 by the Center for Substance Abuse Treatment, U.S. Department of Health and Human Services. This book offers valuable guidelines to service providers for effective woman-sensitive care of chemically dependent women. In addition to focusing on outreach, comprehensive service provision, and continuum of care after treatment, the book addresses the needs of diverse groups of women such as lesbians, women of color, women with disabilities, and women in conflict with the law (Center on Substance Abuse Treatment 1994).

The CSAT guide acknowledges that many criminal justice system staff have limited knowledge and/or training in the area of substance abuse problems in the women prisoners they are charged with managing. They are often unaware of the scope of issues involved in addiction for women in conflict with the law, such as a background of sexual and physical violence as related to prostitution or other criminalized behaviors. Criminal justice personnel often have no respect for substance abusing women prisoners, viewing them more negatively than the male inmates. This further stigmatizes incarcerated women, possibly creating barriers to treatment programming. "Women in the criminal justice system generally fear that disclosing their need for substance abuse treatment will result in additional sanctions" (Center on Substance Abuse Treatment 1994, 139).

Because women prisoners enter treatment burdened with multifaceted sets of problems they are afraid of the prospect of change, and do not have any confidence in their ability to create healthy lives for themselves and their children. To assist each woman to identify her strengths, increase self-esteem, and facilitate growth and healing, effective treatment services support women in effectively relating to themselves, their families, and communities. Truly comprehensive programs facilitate community linkages which provide networks to support women's emotional and physical health and their financial, legal, spiritual, and family needs during and after treatment. The CSAT comprehensive treatment model for women identifies the following list of clinical issues which should be addressed during treatment:

- The etiology of addiction, especially gender-specific issues related to addiction (including social, physiological, and psychological consequences of addiction and factors related to the onset of addiction)
- Low self-esteem
- Race, ethnicity, and cultural issues
- Gender discrimination and harassment
- Disability-related issues, where relevant
- Relationships with family and significant others
- Attachments to unhealthy interpersonal relationships
- Interpersonal violence, including incest, rape, battering, and other abuse
- Eating disorders
- Sexuality, including sexual functioning and sexual orientation
- Parenting
- Grief related to the loss of alcohol or other drugs, children, family members, or partners
- Work

- Appearance and overall health and hygiene
- Isolation related to a lack of support systems and other resources
- Life plan development
- Child care and custody (Center on Substance Abuse Treatment 1994, 178).

In 1996 the National Center on Addiction and Substance Abuse (CASA) at Columbia University published a report titled *Substance Abuse and the American Woman*. This major report analyzed statistical data documenting the increases in women's drug use, including alcohol and tobacco, across a variety of sociodemographic factors. Acknowledging that the "stigma surrounding female substance abuse, which for cultural and historical reasons is greater than that for men, has discouraged many women from seeking help," this report discusses the unique treatment needs of chemically dependent women (Center on Addiction and Substance Abuse 1996, 12).

Issues identified include the need for childcare, or a children's component in all treatment settings, health care, transportation, support for dealing with post traumatic stress issues and depression related to physical and sexual violence, and help with parenting, life skills, and eating disorders. This report also presents research which supports the need for women-only treatment programs staffed by women providers who can serve as role models. "The environment may be more nurturing and supportive . . . [and] women may feel more comfortable speaking about issues such as domestic violence, sexual abuse and incest, shame and self-esteem in groups without men. . . . In co-ed settings, women are less likely to attend group therapy than men, and when they do, they are less likely to talk." (Center on Addiction and Substance Abuse 1996, 115).

In "Elements of Effective Services for Women in Recovery: Implications for Clinicians and Program Supervisors," Laurie Drabble (1996) develops the following list of issues as key to effective programs: medical care/health care, emotional/physiological,

life skills, partner and parenting, and culturally specific/population specific services. This article emphasizes the importance of providing staff with "training for working with diverse populations of women, instituting measures to assure diverse staff composition and creating environments and linkages that support participant cultural identities" (Drabble 1996, 17). Drabble also discusses the importance of the concept of empowerment as fundamental to individual recovering women as well as to the philosophy and design of programs, stressing empowerment as critical in terms of feminist principles in the context of service delivery. "The commitment to the individual and collective empowerment of women [appear] to be a driving force behind [staffs'] dedication to their own work" (Drabble 1996, 17).

Stephanie Covington is a well known expert and advocate in the field of women and addiction who has published numerous books and articles on the subject. In 1987 Covington began focusing on the needs of women in prison, conducting research and developing treatment approaches for this population. Her most recent work develops a model of women's treatment and recovery based on theoretical frameworks of addiction, trauma, and psychological development designed for application with women in prisons and community settings.

> To develop an integrated model for the treatment of addiction, it is important first to develop a sound theoretical framework, asking ourselves to what theory of addiction we are ascribing. The next step is to utilize a theory of women's psychological development, which refers to how women learn, grow, and heal. Lastly, it is important to incorporate a theory of trauma since the majority of women who are chemically dependent, especially those in the criminal justice system, have experienced emotional, physical and sexual abuse in their childhood and/or adulthood. The definition of trauma needs to be expanded to include racial prejudice, witnessing violence, and the stigma, stress, and abusiveness of incarceration. (Covington 1998, 144)

The traditional medical model of addiction theory views addiction as a disease within the individual which affects her physical, emotional, mental, and spiritual well-

being. Covington's model expands on this by adding environmental and socio-political components, explaining that many women grow up in families and areas where drug dealing and addiction are normative (environmental), and that the over-prescribing of antidepressants, amphetamines, and psychoactive drugs by physicians and the seductive marketing of alcohol affect women adversely (socio-political). (Covington 1998)

The theoretical framework of women's development Covington utilizes in her treatment model is the Relational Model pioneered by feminists at the Stone Center. In providing treatment for chemically dependent women intended to encourage them to change, grow, and heal.

> [I]t is critical that we place them in programs . . . where relationship and mutuality are core elements . . . where women can experience healthy relationships with their counselors and each other . . . the criminal justice system is designed to discourage women from coming together, trusting, speaking about personal issues or forming bonds of relationship . . . many women are not safe in our criminal justice system where they are vulnerable to abuse and harassment from correctional staff." (Covington 1998, 145)

The last element in Covington's treatment model is the theory of trauma developed by Judith Herman (Herman 1992). Herman's theory of trauma recovery defines three stages of the healing process: safety, remembrance and mourning, and reconnection. Stage One (safety) addresses the women's issues of physical, emotional, mental, and relational safety. During Stage Two (remembrance and mourning) the survivor tells her story and grieves the loss of self and damage from the trauma. In Stage Three the she looks toward the future, creating a new self (Covington 1998).

Covington goes on to identify four issues women identify as key to their addiction and recovery, and which contribute to relapse. These are the self, relationships, sexuality, and spirituality. Covington emphasizes spirituality as being particularly confusing for women prisoners. "Spirituality is about transformation, connection, wholeness, meaning,

and depth. . . . The design of the criminal justice system is antithetical to spiritual values, and it is essential that any recovery program designed for women in this system find a way to help each women find her own definition of 'higher power'" (Covington 1998, 148).

Summary

The literature on women prisoners and the substance abuse treatment needs of women documents the skyrocketing numbers of women being incarcerated in federal and state prisons in the United States and the fact that their service needs are not being met, either within prison or in community-based settings. The profile of women in prison illustrated by the literature indicates that a disproportionate number are women of color, and that most are young, single mothers who are undereducated and underemployed, are primarily convicted of nonviolent drug and property crimes, and pose little threat to their communities. The histories of most women in prison include intergenerational physical and sexual abuse, substance abuse and criminal behavior as well as abuse and harassment in correctional settings. Correctional systems have been developed to meet the needs of male offenders and because of their unique needs, women prisoners have not been provided necessary services within institutions, or in the community upon parole.

The literature supports the validity and necessity of community-based, gender-specific programs for women prisoners which meet the needs of women and their children, the criminal justice system, and the society. The research demonstrates convincingly that while the criminal justice system has begun to offer some minimal programs and sentencing alternatives for women in conflict with the law, existing programs cannot begin to meet the needs of women prisoners and their children.

Several of the researchers referenced here cite California's Community Prisoner Mother Programs as an innovative, valuable model of alternative sentencing which

should be developed, expanded and replicated (Bloom and Steinhart 1993, Senate Concurrent Resolution 33 1994). Currently, the CPMP contracts awarded by California Department of Corrections (CDC) provide only 94 beds to the thousands of women prisoners throughout the state system who meet eligibility criteria for the program. Historically, the utilization and quality of service provision by the CPMPs has been limited and inconsistent. CDC has not funded enough CPMP sites statewide, and the sites in place have not developed their quality of services to meet the needs of the population.

My thesis describes the evolution and development of the Friends Outside in Monterey County CPMP, which I have managed since 1993. Between 1993 and 1996 I guided a collaborative effort to develop and implement a woman-specific model of treatment based on feminist principles which resulted in the program's being awarded an expanded contract and acknowledgment from CDC as the model CPMP in the state. It is my intention to help educate the general public, CDC, other service providers, and women studies scholars and activists concerning the need for increased funding, expansion, and replication of this kind of model program for women in conflict with the law.

CHAPTER II

BEGINNING

January 1979–June 1993

Historically, California law provided that incarcerated women could keep their newborn babies with them in a Prison Nursery Program. Penal Code 3401 allowed that women who delivered babies while in state custody could keep their infants with them until the age of two years and two months. No prison nursery was ever created, and when women sued to enforce this law, the courts ruled that the program was discretionary and did not require the California Department ofCorrections to implement the program. State legislators later rescinded Penal Code 3401 (Ellen Barry, telephone interview, January 1997).

History of California's Community Prisoner Mother Program

In 1979, legislation was passed mandating the creation of the Community Prisoner Mother Program (CPMP). California Penal Code 3210-3224 required that CDC enter into contracts with private and/or public agencies to establish community-based residential programs to provide an alternative to incarceration for eligible prisoner mothers and their preschool-aged children, to be administered by CDC's Parole and Community Services Division (P&CSD). The CPMP was supposed to teach and improve parenting skills, enable mother-child bonding and/or reunification, offer substance abuse treatment, and provide educational and vocational training to facilitate a positive, successful reentry into the community upon parole. Prisoner mother participants would remain under the jurisdiction of CDC and would be subject to CDC progressive discipline

procedures and be returned to prison custody, if necessary (California Penal Code 3410 *et. seq.* 1979).

The law lists specific criteria for eligibility and denial to participate in the programs and states that if "any woman received by or committed to the Department of Corrections has a child under six years of age or gives birth to a child while under the jurisdiction of the Department of Corrections, such a child and his or her mother shall, upon her request, be admitted to and retained in a community treatment program established by the Department of Corrections subject to the provisions of this chapter" (California Penal Code 3410 *et. seq.* 1979). Unfortunately, restrictive interpretations of prisoner's eligibility criteria by CDC staff and other barriers have historically resulted in underutilization of the CPMP (Senate Concurrent Resolution 33 Report 1994).

Six years after the law was passed the program still had not been effectively implemented. Only one CPMP contract had been awarded and fewer than 15 women and their children had access to the program. CDC had failed to develop procedures to notify women prisoners formally that the program was available, provide orientation or application processing for women who had learned, usually by chance, about the program, or establish a waiting list of eligible women. No CDC staff had been assigned or trained to interpret the eligibility criteria or provide any reliably consistent information to women prisoners interested in the program (Ellen Barry, telephone interview, January 1997).

In January 1985, Legal Services for Prisoners with Children filed a class action lawsuit, *Rios v. Rowland,* on behalf of women prisoners against CDC, demanding that the Department reform and expand the CPMP. In its December 1985 annual report to the legislature, CDC addresses progress made in securing community beds, reporting ongoing operation of 36 work furlough programs for men providing a total of 1,051 beds,

but making no reference to women's CPMP beds (California Department of Corrections 1985). CDC published a Request For Proposals early in 1986, which resulted in responses from seven qualified providers (California Department of Corrections 1986a). In its December 1986 annual report, CDC informed the legislature that two new CPMP contracts had been awarded, bringing the total number of beds to 65 (California Department of Corrections 1986b). The June 1987 quarterly report announced no actual further increase in CPMP beds, but projected an additional 28–38 beds to come on line by September 1987 (California Department of Corrections 1987).

The *Rios v. Rowland,* case was settled in 1990. During the five years that the case was in litigation, a total of six CPMP sites were established bringing the total number of beds to 84. CDC staff still had not been trained and their handling of the notification, orientation, application, appeal, and waiting list processes for the women wanting CPMP placement continued to be poorly managed and extremely confusing. The *Rios v. Rowland,* settlement attempted to remedy these and other problems by clarifying eligibility criteria, requiring standardization of all procedures, mandating improved medical care, and requiring the appointment of a statewide CPMP coordinator. The settlement additionally provided for plaintiffs' review of CDC compliance with all of its terms, inclusion of the settlement agreement in all orientation materials given to new and transferring women prisoners, and posting of the settlement agreement in all CDC institutions housing potential prisoner-mother applicants for the CPMPs (*Rios v. Rowland* 1990).

Unfortunately, though problems addressed in *Rios v. Rowland,* have been somewhat relieved, ongoing reports of continued difficulties raise questions about CDC's commitment to maximum utilization of existing CPMP beds and to further expansion of the program (suggested by researchers, service providers, and many legislators).

> Delays have occurred in the processing of CPMP applications for a variety of reasons. For example, it has been reported . . . that many otherwise eligible applicants have waited for many months to be placed in the program because of long delays in the provision of necessary dental and medical services in the institution. In addition, applicants have reported difficulty in obtaining information about the program from counselors, difficulty in obtaining applications, instances where applications have been lost . . . and instances where counselors have discouraged applicants from applying to the program . . . [and] pregnant applicants have been advised that they could not submit applications until they could produce a birth certificate, a situation which is contrary to statutory and administrative guidelines (Senate Concurrent Resolution 33 Report 1994, 28).

CDC has continued its expansion of the primarily male, work furlough community corrections beds, in an attempt to keep pace with the rising prison population. However, in response to an 826% increase in the population of women prisoners during the 18 years since the first CPMP went on line, the number of female CPMP beds has never been higher than 99, and has remained constant at 94 since Friends Outside in Monterey County obtained its CPMP contract in 1990 (California Department of Corrections 1998).

HIistory of Friends Outside in Monterey County

Friends Outside National Organization was founded in 1955 by a women named Rosemary Goodenough, who became aware of the trauma experienced by families of prisoners and decided to offer assistance to the wives and children of men who had been arrested in San Jose, California. Friends Outside in Monterey County (FOIMC) was established in 1969 when Goodenough organized a small group of volunteers in Salinas, California to provide childcare for families visiting men incarcerated at Soledad Prison thirty miles south of the town. Goodenough's efforts resulted in the formation of the Monterey County Chapter of Friends Outside, located in Salinas (Friends Outside in Monterey County 1995).

Friends Outside in Monterey County remained an all-volunteer organization until 1974 when the group began to obtain limited funding for its efforts to assist visiting families at the prison and provide services to parolees. In 1977, with a paid staff of six and numerous volunteers operating out of donated office space, FOIMC incorporated as a non-profit agency and received major funding through a contract which enabled the agency to establish the current site of the Family Visiting Program on the grounds at Soledad Prison. Services include help with transportation, childcare and meals during visits, crisis intervention, information and referrals, counseling, and general support for the (primarily) women and children who utilize the program (Friends Outside in Monterey County 1995).

Friends Outside's first residential program was a halfway house for parolees established in 1975. Originally located in the building currently housing the CPMP, the parolee halfway house changed its location in 1982, and expanded its programs and bed-capacity to 32, enabling FOIMC to obtain major contracts to provide services to state and federal male inmates prior to their parole. This program facilitates a smoother reentry into the community for participants by providing employment services, substance abuse counseling, domestic violence prevention training, and life-skills development. Participants are monitored closely by a full-time staff ensuring round the clock supervision and support. In 1990 this program was updated, was renamed the Community Corrections Reentry Center (CCRC), and expanded its programs and contracted bed capacity to 42 (Friends Outside in Monterey County 1995).

In 1975, as part of its services for parolees residing in the halfway house FOIMC began offering assistance in obtaining jobs. This assistance has grown into a full-service Employment Program funded primarily through the Job Training Partnership Act. The Employment Program staff provide comprehensive job search training for potential job

applicants, as well as financial support to obtain necessary clothing, work related tools, and transportation for work (Friends Outside in Monterey County 1995).

After moving the halfway house in 1982, Friends Outside established the Hospitality House Program in its former location to provide overnight housing for women and children visiting at Soledad Prison thirty miles south of Salinas. At the time motel accommodations were limited and too costly for most of the women who came to the area with their children to visit men incarcerated at the prison. Friends Outside in Monterey County had originally been started by Goodenough and the early volunteers in 1969 to assist these visitors (Friends Outside in Monterey County 1995).

Most of the Hospitality House clients arrived with little or no money, driving unreliable, unlicensed cars, with several children in tow. Many women, loyal to their imprisoned men, traveled long distances with no money or other resources, to bring children to visit their fathers. Women often risked having a car break down, or being caught with an illegal vehicle or no driver's license, to visit the men in prison. Many women had no idea where they would stay when they arrived in the area. Friends Outside's goal for the Hospitality House was to provide a safe homelike environment for the women and their children during these stressful times (J. Elizabeth Husby, personal communication, May 1996).

After three years as a business and administrative support staff person, J. Elizabeth Husby was promoted to the position of Executive Director of Friends Outside in 1980. Responding to the growth of the corrections industry in California, and the corresponding need for community-based alternatives to prison, Husby has guided the agency through its significant expansion and development of all of the current programs. Her vision is clearly reflected in the agency's mission statement: "The mission of Friends Outside is to assist at-risk youth, prisoners, and their families with the immediate and long-term effects

of oppression and incarceration, and to act as a bridge between those we serve, the community at large, and the criminal justice system" (Friends Outside in Monterey County 1995, 1).

Motivated by her belief in the potential for people to survive and heal from social injustice, Husby has built on Friends Outside's original commitment to the visitors at Soledad Prison by creating programs first for the mostly male parolees and inmates and their families, and later during the 1990s, for the exploding population of women prisoners and their children. "We are a crime deterrent agency, working to prevent family cycles of crime, family estrangement, and violence" (J. Elizabeth Husby, personal communication, May 1996).

Husby says that it was her experience working with the women at the Family Visitor Program and the Hospitality House that informed her understanding of the needs of women involved with the criminal justice system. "I began to see how limited the women had been in areas I take for granted in terms of life skills they didn't have, and I realized that they need so much." Feeling ambivalent and frustrated about the efficacy of the Hospitality House program, Husby began to think about other models of assisting women. In 1989, after closing the Hospitality House, she learned of California Department of Corrections (CDC) efforts to expand the Community Prisoner Mother Program (CPMP) and decided to obtain a contract (J. Elizabeth Husby, personal communication, May 1996).

Friends Outside Community Prisoner Mother Program—Helen McCaig House

Husby had not been aware of the *Rios v. Rowland* lawsuit filed in 1985 on behalf of women prisoners to force CDC into compliance with legislatively mandated provision of Community Prisoner Mother Programs. Reflecting on CDC's attempts to respond to the *Rios v. Rowland* suit, it is instructive to note that Friends Outside, a leading agency in the growing field of community correctional alternative programs, had not been approached by CDC in any way concerning the required CPMP expansion. Husby recalls that she learned about the CPMP during casual conversation with CDC regional parole staff (J. Elizabeth Husby, personal communication, May 1996).

Following up on the initial information and discussing the CPMP with colleagues and the agency's board of directors, Husby became committed to the program and began preparations to site a CPMP in the building which had formerly been the Hospitality House. After 12 years of experience contracting with CDC, Husby was accustomed to the difficulties of working with a huge bureaucracy responsible for incarcerating hundreds of thousands of people. "The regional parole coordinator at the time was very supportive of Friends Outside and believed in community-based programs for inmates. We didn't have to compete for the contract, and CDC was unusually helpful in getting us going," she says. CDC's Paroles and Community Services Division (P&CSD) Region II staff actually assisted Friends Outside with funding for renovation of the Victorian house where the CPMP would be located, supported the agency with the city of Salinas in getting the necessary permits and clearances, planned to provide intensive training for the new program's staff when hired, and made a commitment to Husby that women would be slowly assigned to the facility to allow the newly hired staff to bring the program on line in a methodical, controlled manner (J. Elizabeth Husby, personal communication, May 1996).

In June 1991, the Friends Outside Community Prisoner Mother Program began operations in a renovated, 2200 square foot, two-story Victorian home on a residential street in Salinas, California. Named the Helen McCaig House, in honor of a long-time local activist for women prisoners, the facility was intended to house ten mothers and ten children, and twenty-four-hour-a-day monitoring would be provided by two to four staff persons . A full-time program coordinator, a part-time case manager and part-time clerical support staffperson, and eight full-time staff monitors had been hired (J. Elizabeth Husby, personal communication, May 1996).

The first week of a planned two-week training facilitated by CDC staff had been completed when Husby was informed by the P&CSD Region II Coordinator that there were ten women prisoners and their children from a program in Southern California who had to be relocated. The options available for relocation were limited: Helen McCaig House or back to prison. Consistent with the mission of Friends Outside and her own values, Husby opened the doors of the Helen McCaig House a week earlier than planned, enabling ten women and their children to avoid further separation, and foreshadowing the program's ability to respond to a crisis with creative, solution-oriented, value-driven management decisions (J. Elizabeth Husby, personal communication, May 1996).

Husby remembers the first year as being understandably difficult. The program design was meant to facilitate mother-child bonding and/or reunification and to provide parenting skills development, substance abuse treatment, and educational and vocational training to facilitate a positive, successful reentry into the community upon parole. "The woman we hired as the first program coordinator had a background in education and was serious about serving the residents. She did a great job setting up the contacts with the adult school, the outpatient drug classes, and other resources, but working with women prisoners is different from other populations. There's no degree you can get in

community corrections management," Husby says. The first coordinator stayed with the program for about nine months (J. Elizabeth Husby, personal communication, May 1996).

Throughout the following year of operation, (fiscal year 1992–93) the Helen McCaig House CPMP continued to experience growing pains. The second program coordinator initially presented herself as having had experience in correctional settings and, thinking this might be a strong asset, Husby hired her. Although she stayed in the position for about ten months, Husby recalls being disappointed with her management abilities. "She did not have the maturity or experience to lead the staff or residents, wasn't committed to meeting the residents' needs, and shakily maintained what her predecessor had accomplished. She needed a lot of supervision, wasn't focused, and had no ideas for developing the program. Basically I think she was self-absorbed and saw the job only as a career step, and left after about one year" (J. Elizabeth Husby, personal communication, May 1996).

In addition to staffing issues and other problems to be expected with any newly established program, there were difficulties associated with the facility's site. Because of very limited space in the residential facility (Helen McCaig House), the program's administrative office was moved to another Friends Outside building several blocks away from the renovated Victorian house. This meant that the program coordinator, case manager, and clerical support staffperson had to travel, or transport residents and their children, back and forth to conduct business and/or service provision activities, making it extremely difficult to supervise residents or staff and maintain consistency within the program. Also due to limited space in the residential building, there was no classroom in which to conduct groups, training, or education sessions for the resident mothers and no separate childcare area (J. Elizabeth Husby, personal communication, May 1996).

Husby also recalls difficulties in working with the CDC regional parole staff responsible for contract oversight, who after an initial period of unusually positive assistance with program start-up, became unavailable at best. "After we got the program going, the regional parole coordinator who had been so helpful in getting us the contract was transferred. I was reminded that when it comes to CDC, your experience depends entirely upon the individual currently staffing the position you are required to deal with to complete a project. There are no consistent standards." CDC provided no program model with which to meet the programming goals. They were uneducated about substance abuse and resistant to the concept that substance abuse treatment was necessary for the residents' successful program outcomes, and allowed only for Alcoholics Anonymous or Narcotics Anonymous meetings to be provided (J. Elizabeth Husby, personal communication, May 1996).

Problems with the local parole agent assigned to work with the CPMP also created difficulties in managing the program. The contract between CDC and Friends Outside required that a local parole agent would be assigned to work as a collaborative team member with CPMP facility staff in monitoring the program residents. This local parole agent was called a Reentry Specialist (RES) and was expected to provide direct correctional supervision of the residents through enforcement of CDC rules, management of the progressive discipline process, and disposition of consequences for infractions, including possible return to custody if necessary (J. Elizabeth Husby, personal communication, May 1996).

Unclear direction from the regional parole administrators regarding the role and responsibilities of the RES created significant problems. CPMP staff reported confusion related to behavior from the RES which appeared to be attempts on her part to supervise the staff and give them orders. The worst problem that Husby recalls is the RES's

entrenchment in prison culture where parole agents routinely manipulate prisoners and parolees to develop them as informers or "snitches" who can gather potentially damaging information about other prisoners. Clearly, this type of relationship between the RES and individual residents was antithetical to program goals of building healthy living and relationship skills. Overall, Husby remembers the situation with the RES as being very confusing and disempowering for CPMP residents, staff and management, creating significant barriers to meaningful program development (J. Elizabeth Husby, personal communication, May 1996).

Finally, as has historically been typical with community correctional programs, funding and/or technical support for development and maintenance of management information systems has not been available to Friends Outside or other providers contracting with CDC until very recently (1997). Data I have gathered from existing files do allow for documentation of the actual annual number of program participants and some additional, incomplete sociodemographic data. During its first year in operation (fiscal year 1991-92), the Helen McCaig House CPMP served a total of 29 residents and 29 children. Of the 29 resident mothers, 10 were Anglo/European American, 5 were African American, 3 were Latina, there was 1 Native American, and the race/ethnicity of 10 of the residents is not available in the data. The 12-member staff originally hired to open the CPMP consisted entirely of Anglo/European American women. There was no childcare coordinator and case management was extremely minimal.

The second year in operation (fiscal year 1992-93), the Helen McCaig House CPMP served a total of 25 residents and 25 children. Of the 25 resident mothers, 12 were Anglo/European American, 7 were African American, 2 were Latina, and the race/ethnicity of 4 of the residents is not available in the data. The 12-member staff employed by the CPMP in May 1993 was consisted of 11 Anglo/European American

women and 1 Latina. There was no childcare coordinator and case management was extremely minimal.

After two years in operation, the Friends Outside CPMP continued to struggle with significant problems related to unclear contractual expectations and lack of support from CDC, difficulties with the RES, staff limitations, and lack of sufficient funding to develop the program adequately. Additionally, Husby had become increasingly convinced that the program had to address the women's need for help with substance abuse, or the other programming would be ineffective at best. In early 1993, when the second program coordinator resigned, Husby resolved to recruit a coordinator with expertise in substance abuse treatment for the job (J. Elizabeth Husby, personal communication, May 1996).

CHAPTER III

STRUGGLE

July 1993–June 1994

When J. Elizabeth Husby hired me to be the program manager for the Friends Outside Community Prisoner Mother Program (CPMP) in June, 1993, I was employed as an addictions counselor in a co-educational chemical dependency treatment hospital and conducting graduate research on women and addiction through the Women's Studies program at San Jose State University. I had eight years of experience in my own personal recovery and in working with recovering women and researching their needs within a feminist framework. I had never worked in any type of corrections setting, and had no experience with women prisoners as a specific population. I knew almost nothing about the CPMP, except that it was a residential program for ten prisoner mothers and their children.

During my first week at Friends Outside, Husby facilitated my initial orientation to the program, explaining that the CPMP had been managed unsatisfactorily over the previous two years since it had been established. She believed that my immediate predecessor's exclusively corrections approach had been limiting and that the program was significantly underdeveloped. Husby indicated that she recognized that the program needed to address the resident mothers' substance abuse issues, and that it was my expertise concerning women and addiction which had, in large part, motivated her to hire me. We agreed that creation of the quality program we both envisioned would require development of progressive, gender-specific, culturally sensitive treatment services to meet the special needs of a diverse group of women and address the damage done by

oppression in the family systems and institutions they've encountered throughout their lifetimes.

Throughout the eight years of my own personal recovery from addiction and work with other chemically dependent women, I had become increasingly frustrated by models of rehabilitative treatment based primarily on men's experience in Alcoholics Anonymous and research conducted on male populations (Wilsnack and Beckman 1984, Reed 1987, Kasl 1992, Roth 1991). Most programs, professionals, and training in addiction and recovery that I had experienced, rarely acknowledged that women's needs in treatment might differ from men's. During the late 1980s and early 1990s, as a feminist and a graduate student, I had been studying the limited available research on women and addiction. Through this study and my practical experience, I had been developing an understanding of woman-specific addiction, treatment, and recovery models and trying to incorporate a feminist perspective in my work with women. I suddenly found myself in charge of a women's program and in a position to implement the kind of feminist, woman-specific models of treatment I believed in.

My vision for the CPMP required that the program be grounded in a feminist understanding of women's oppression within patriarchal systems and women's need for empowerment to survive these systems. "That oppression is a function of patriarchy is what is relevant to our discussion of addiction, because oppression creates the emptiness and fear that lead toward addictive behavior. The desire to live gets turned into a struggle to survive the pain of our system. Instead of affirming life, we are taught to medicate ourselves in order to cope with it" (Kasl 1992, 55).

Poverty, racism, and violence have been clearly linked with women's addiction and imprisonment. Many researchers and clinicians believe that women use substances to cope with life stressors while men tend to use alcohol and other drugs for recreation.

Gender roles and socialization across the economic and cultural spectrum in United States society continue to place women's status below that of men, reinforcing women's educational, economic, political, and social disadvantages. Women also suffer more gender-related physical, sexual, and emotional violence and trauma in their families and society. These conditions cause women to struggle with low self-esteem, fear, shame, physical injury and pain, and emotional pain and depression, which can lead to alcohol and other drug addiction and/or conflict with the law (Reed 1987, Kasl 1992, Owen and Bloom 1995, Coll and Duff 1995, Covington 1997).

I have come to believe that for women to heal from addiction, imprisonment, and related trauma, they need to be empowered to deal effectively with complex physical, emotional, and socio-political issues in the context of oppression in their lives. The treatment model I aimed to develop would nurture respect and partnership between staff and residents working together to generate intervention strategies and programming elements to address complex treatment issues. The ultimate responsibility for the women's recovery would rest with them, within the resident community, through their interpersonal relationships and the daily struggle to support and hold each other accountable for the recovery process. The most important therapeutic component of the program would be in the women's connections with each other, and the positive support and role modeling from staff.

The remainder of this chapter describes the process of assessment, diagnosis, and attempts to begin program development during my first year at Friends Outside CPMP between July 1993 and June 1994. The narrative addresses the categories of program, staff, and resident community. Without management experience or familiarity with the correctional system, and with no training from Friends Outside, I began my work at the CPMP aiming first to learn and maintain the program's existing systems. I planned to

utilize this learning process to diagnose problems, conduct a needs assessment and create a program development strategy. I began my process of on-the-job training looking for a definitive guide to the program's service model. None existed.

The Program

The California Department of Corrections (CDC) nine-volume Departmental Operations Manual (DOM) contained no sections specifically detailing rules and regulations for the CPMP. In my search for the CPMP program model and guidelines, I found a variety of internal Friends Outside documents, log books and forms, a CDC packet titled "Statement of Work," and a set of CDC "Draft Regulations" dated 1991. From these minimal sources and conversations with Husby, other Friends Outside staff and CDC staff, I learned as much as I could about the CPMP model, rules and regulations which had not yet been finalized and published in the DOM.

The CPMP is designed to provide twenty-four-hour staff supervision in a safe, home-like environment for mothers and children. CPMPs are meant to offer parenting classes, vocational training, and substance abuse classes intended to facilitate improved parenting relationships and prisoner mothers' successful community re-entry upon parole. Program sites are operated by private service providers who contract with CDC to operate individual CPMPs in several locations around the state (California Department of Corrections 1992).

Individual program operations are overseen by CDC's four Parole and Community Services Division (P&CSD) regions. P&CSD regional headquarters manage the institutional waiting list of pregnant or parenting prisoner mothers who have been approved for placement in a CPMP. When beds become available in any of the seven programs, the regional parole staff arrange for a woman from the waiting list to be

transported from the institution where she is incarcerated to the CPMP to which she is assigned. A local parole agent is designated as a Re-entry Specialist (RES) and is responsible for working with the contracting agency's management and staff to monitor CPMP residents and administer CDC rules and regulations. The regional P&CSD staff are also responsible for auditing the individual programs and working with contractors to improve operations and deal with problems regarding audit issues (California Department of Corrections 1991).

Programming is to be structured in three phases. Phase I-Entry Phase consists of the resident mother's first 30 days in the program and allows time for her to reunite and bond with her child, become acquainted with staff and peers, adjust to the program, and accept and maintain basic responsibilities. Staff provide initial orientation to the program including explanations of CDC and Friends Outside rules, guidelines, and progressive discipline procedures. During Phase I residents are restricted to facility grounds and may not leave the program unless escorted by staff (California Department of Corrections 1992).

The length of Phase II-Program Phase depends on length of the resident's prison term, lasting until she reaches the final 120 days of her sentence. During this phase the resident works with the case manager to identify problem areas, seeks alternative solutions, and accepts "criticism as a means of increasing awareness and changing negative behaviors. Focus is on developing positive relationships with others and learning effective parenting skills" (California Department of Corrections 1992, 6).

During Phase II, residents are able to request daily "facility passes" to meet their programming plans in the community. To request such a pass a resident must fill out a pass request form which details her proposed itinerary, including addresses and phone numbers. If approved for a facility pass, a resident must be reachable by phone at all

times except when en route between locations. Facility passes are granted for classes, medical appointments, children's activities, and shopping for food and other necessities (California Department of Corrections 1991).

During Phase II residents are also eligible to earn 24-hour Temporary Community Leave (TCL) passes to stay overnight with approved pass sponsors. Approved pass sponsors are required to be a member of the resident's immediate family, and must undergo a CDC background check. Common-law husbands must be able to document a positive long-term relationship with the mother and/or her child to be eligible to be a pass sponsor. Lesbian partners are ineligible in all circumstances. Residents must turn in application forms which provide the family member's personal information in order to initiate the approval process (California Department of Corrections 1991).

Phase III-Pre-Release Phase consists of the resident's final 120 days in the program and emphasizes pre-release and parole planning. Eligible residents may be allowed to obtain jobs in the community if they are assessed to be ready for employment and if they are legal residents of the county in which the CPMP is located. Because there are so few CPMP sites, the majority of the residents are not local county residents while in the program, so most are ineligible to work prior to their parole. During Phase III residents continue to be eligible to take facility passes to meet programming needs and to earn 24-hour TCL passes to stay overnight with approved pass sponsors (California Department of Corrections 1991).

Throughout all phases of the program, residents are expected to participate within CDC and CPMP facility rules and guidelines. The daily schedule establishes wake-up and lights-out times, meal and chore times, routine on and off-site programming activities, and children's activities. The residents are expected to coordinate their use of the pay-phone, laundry facilities, and program van transportation through use of sign-up

schedule sheets. They have the opportunity to receive approved visits from approved family members on weekends (California Department of Corrections 1991).

Supervision of resident prisoner mothers is carried out through a variety of custody and security activities based on institutional models. Staff monitors are expected to follow a daily task assignment sheet which requires implementation and documentation of regularly scheduled "inmate counts," random room searches, random collection of urine samples from residents for drug screening, signing of residents in and out of the facility and monitoring of their approved movements in the community through phone contacts. Staff are also responsible for approving and tracking all residents' financial activity, approving, inventorying, and tracking all resident property located in the facility, and monitoring, logging, and tracking the use of all tools, knives, cleaning products and equipment. All of these custody and security activities are documented in each resident's house file which is maintained by staff. If residents fail to follow CDC or Friends Outside rules and/or guidelines, staff are responsible for documenting and maintaining progressive discipline procedures (California Department of Corrections 1991).

Progressive discipline procedures are intended to be identical to those in the prisons as defined and established by CDC, and adapted to the community program setting. CDC disciplinary actions are divided into two categories and must be documented by CPMP staff. Minor infractions such as violations of CPMP facility rules or guidelines are documented on a CDC "128 A" form. Major infractions are documented on CDC "115" forms and can be received for violations of CDC rules or any criminal behavior. These major infractions are classified as either administrative or serious (California Department of Corrections 1991).

Infractions that result in documented disciplinary actions have come to be referred to in the vernacular as 128s and 115s by residents, CPMP staff and CDC staff. The 128s

are written to document behaviors which, if repeated, could lead to a 115. The 128s are given to residents for infractions such as failure to complete chores, failure to follow the daily schedule and/or attend programming activities, or inappropriate communication which may be disruptive but is non-violent. Possible consequences for receiving a 128 are relatively minor such as increased counseling, loss of pass privileges, and/or additional reading or written assignments related to the infraction. CPMP facility management and staff are responsible for documentation and disposition of consequences for 128s. Repetition of this type of infraction can result in a 115 (California Department of Corrections 1991).

Major infractions which result in 115s carry heavier consequences ranging from being given hours of "extra duty" chores and assignments, to being returned to Phase I with house restriction and loss of pass eligibility, to the extreme consequence of being returned to prison, or being "rolled up," in the vernacular. Residents typically receive the less serious administrative 115s for deviating from their approved facility pass itinerary, for refusing to cease ongoing disruptive behavior and/or verbal abuse, or for a pattern of repeating minor 128 infractions. Consequences generally imposed are house restriction, loss of passes, and/or extra duty hours (California Department of Corrections 1991).

A serious 115 results from any non-violent criminal behavior such as shoplifting or other theft, receiving a positive urinalysis screen indicating drug use, possession or sales of drugs, and/or extended unauthorized absence from the facility (escape). Any violent behavior such as physical abuse of a child or assault on staff or other residents also results in a serious 115. These serious 115 infractions most often result in the resident's return to prison (California Department of Corrections 1991).

The RES assigned to the CPMP facility is responsible for administering 115 procedures once the facility staff investigates and documents the details of the situation

and the infraction. Because 115s can result in serious legal consequences, the RES must follow due process laws regarding timelines within which the resident must be served with the 115 (similar to a criminal warrant) and be given a hearing (similar to a court hearing) in which to admit or refute the charges. Regional CDC staff, not the RES, must conduct the hearing, and the resident has the right to call witnesses in support of her claims (California Department of Corrections 1991).

During those early months at Friends Outside, as I familiarized myself with the basic three-phase model of the CPMP, I quickly realized that the program was severely underfunded and underdeveloped. Treatment was impossible under the circumstances. Case management is the dynamic process that guides staff and residents through a quality, comprehensive, individualized treatment experience. Through assessment, treatment planning, implementation and review, regular counseling sessions, and discharge planning, case manager and resident work together exploring and defining needs, goals, and progress during treatment. The CPMP had staffed a part-time case manager position since opening in 1991, but she had not been effective. The few case files I found in her office were disorganized and incomplete. There were no assessment, treatment plan, case note, or discharge plan forms. The files contained no assessments, written treatment plans, or consistent case notes of any kind. Essentially, case management did not exist in the program.

The only regular weekly programming elements conducted on-site were a parenting class provided by a teacher from the Salinas Adult School, and one house meeting with staff and residents. One resident was attending weekly Narcotics Anonymous meetings on a regular basis. The California penal code and the CDC documents I had studied stated that the program should provide comprehensive services, but the reality was that

the program was not providing much more than basic housing of the mothers and their children.

While the seemingly unending custody and security procedures appeared at first to provide some structure for the program, this impression was incorrect. Often, the custody and security activities were not conducted consistently. In fact, the situation was generally chaotic and confused. All of the dozens of blank forms used by the residents were kept behind the staff's front desk, or as it was called, the "control desk." Residents were required to ask staff for each and every blank form as they needed it. The daily schedule listed four regular count times, times for completion and approval of chores, and wake-up and lights out times, but often the schedule was not followed by residents or staff, who constantly blamed each other for the problem of the moment.

Generally, most activities occurred in a random, haphazard manner. There were no scheduled times for access to medications, or deadlines for turning in necessary paperwork such as pass requests or savings withdrawals. There were no regularly scheduled grocery shopping trips, no phone, laundry, or TV schedule. If residents wanted to go grocery shopping, they approached the staff desk and demanded to be taken shopping, and/or use the phone, watch TV, do laundry, or go on a facility pass. The residents expected to be driven by staff in the facility van whenever they needed to travel to programming activities beyond walking distance. All of the children went to different doctors and clinics, making it difficult for staff to support the mothers in following through on the children's health care needs. Staff and residents' behavior often appeared to indicate feelings of helplessness and frustration. Disciplinary procedures were repeatedly misused by staff, applied inconsistently and unfairly in attempts to assert control over the residents. I began to sense the depth of confusion which infused the milieu.

In every instance, the CDC system and staff emphasize the importance of custody and security. In CDC culture, control of inmates is the priority; treatment and rehabilitation services, if addressed at all, are marginalized. Human dignity and respect are lost in this system, overwhelmed by fear, anger, and dependency. I began to understand that the appearance of control, maintained through custody and security activities, often disguises the dysfunctional, chaotic undercurrent of daily life in correctional settings. A community-based CPMP is obviously different from a maximum security prison, but the influence of the CDC system was clear. The replication of this system within the CPMP was oppressive and is common to systems that abuse women. Gradually I learned that the overriding barrier to the goal of developing a feminist, empowerment model of treatment, would be "prison culture," where dehumanization, dependency, dominance and submission are the norm.

Throughout my early assessment process, I had been somewhat shocked by the dysfunctional and disorganized condition of the CPMP, where most of my initial attempts at positive changes had been resisted and sabotaged by staff and/or residents. Beginning to understand prison culture, I saw that the program needed to develop a reasonable degree of structure and clearly articulated expectations, within which staff and residents could relate to each other. I believed that consistent, appropriate management of custody and security activities, especially progressive discipline, would minimize the power-over, control dynamic between staff and residents. I hoped that by nurturing accountability between residents and staff, the program could replace oppressive attempts at control with an empowering sense of collaborative treatment. Development of therapeutic groups and other services would have to remain secondary while I attempted to replace chaos and abuse with a sense of respect, support, stability, and accountability, in the milieu.

The process of infusing a sense of empowerment into the milieu was exceedingly slow. The oppressive systems were deeply entrenched in the program and very resistant to change. Aiming to nurture accountability and empowerment, we started with small, simple, but significant details. Unlimited access to all blank forms was facilitated by relocating them to wall-mounted files in common areas. A local phone line was installed for residents' programming needs, to minimize the need for staff to dial out each call on the desk phone. All residents and children were assigned to one centralized medical clinic. Residents in Phase II who were eligible to leave the facility unescorted by staff, were required to learn and utilize the public transit system buses for transportation on all facility passes except after dark or in inclement weather. A detailed weekly schedule was developed by staff with input from residents. Wake-up, lights-out, paperwork submission deadlines, counts, mealtimes, medication availability, chore times, TV hours, laundry and phone access, house meetings, shopping trips and other staff-transported activities were all defined and clearly listed on the weekly schedule.

In the fall of that year (1993), I rewrote the residents' orientation packet, incorporating information from the CDC draft regulations, clarifying and detailing every rule, regulation, guideline, procedure, and consequence. Then I held a joint meeting for residents and staff and attempted to facilitate a dialogue to review all the changes. The meeting was disappointing. Residents and most staff remained distrustful and angry, repeatedly describing the reasons that the changes were not helpful. However, I believed in the feminist approach I was trying to develop for the program. And I was familiar with the challenges of changing negative, entrenched norms and systems.

Varying degrees of resistance continued throughout that year and beyond as I worked to gain acceptance of the (in my view) minimal structural changes implemented during my first six months as manager. When I arrived in the CPMP, the facility did not

profess to be a treatment program, and was not seen as such by staff or residents. Neither of the previous two managers had focused on chemical dependency treatment or any kind of addiction recovery. The CPMP culture did not embrace Twelve Step recovery such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). Over 80 percent of women in prison report varying degrees of substance abuse. I had been hired to meet their needs by creating a comprehensive, multifaceted, treatment program with addiction recovery at its core.

I and other feminists have articulated problems with Twelve Step programs such as the outdated, sexist language and religious overtones in some of their publications (Harrison 1992, Kasl 1992, Rapping 1996). However, these programs are readily accessible to women in most communities and in fact, many aspects of Twelve Step programs are feminist in nature. Meetings cost nothing, are collaborative, have no formal leaders, and rely on mutual support, role modeling, storytelling, and witnessing in ritualized meeting formats. Twelve Step programs encourage same-gender mentors, called "sponsors," and women-only meetings are common.

AA and NA had been the early foundation of my own personal recovery from addiction, ultimately supporting the growth of my feminist consciousness. As an addictions treatment professional, I had experienced the efficacy of these programs and knew that the CPMP would need to incorporate reliance on AA and NA as part of our treatment approach. Unfortunately, none of the staff were recovering addicts or certified addictions specialists. As I began to require that residents regularly attend Twelve Step meetings, the staff appeared unable to support the process of incorporating addiction recovery as a necessary component of CPMP services and philosophy. Again, not surprisingly, there was continuing resistance to change. Essentially, the staff and residents were colluding in the denial of the residents' (and some staff members')

substance abuse and addiction problems. Nonetheless, I insisted that residents with documented histories of substance abuse attend NA and AA meetings.

Throughout that first year, struggling to maintain what seemed to be minimal progress, I continued the needs assessment and strategized for the coming year. One major problem was the lack of well-organized, supervised childcare. Mothers routinely kept their children with them during house meetings, parenting classes, Twelve Step meetings, and other programming activities. It was clear that in order for the mothers to focus and participate in regular on-site programming, the CPMP facility would have to provide childcare for the children during programming hours. None of the staff were experienced in early childhood education or daycare provision, and a staff childcare supervisor position had not been planned for or budgeted. Space limitations raised the question of where to locate childcare activities.

Another major problem was the difficulty with providing case management services. I had been hired to be case manager as well as program manager. Because of the disorganization within the program, I had to focus primarily on getting the facility stabilized that first year. I had developed case management forms for assessments, treatment plans, case notes, and discharge plans, and I did my best to meet regularly with the residents, but there was not sufficient time to provide effective case management. And there was the additional barrier of having my office located several blocks away.

Programming elements such as educational classes and process groups would need to be created and implemented on-site. None of the staff besides myself were trained or experienced in facilitating treatment programming. I did initiate some groups and classes, but the milieu was too disorganized to allow for consistency. Several individual facilitators who had agreed at my request to provide programming groups during the first year had felt so disrespected by the residents behavior that they became unwilling to

continue working with the population. Linkages with community resource providers would need to be reinforced and/or initiated for service provision on and off-site. Numerous procedures and systems, reasonably designed to provide structure, behavior modification, and learning opportunities for the residents would need to be developed, implemented, and refined.

Reviewing that first year of struggle, I returned again and again to my belief in the CPMP's radical potential to empower this essentially invisible population, imprisoned women. I sensed that the program had begun to stabilize somewhat, but prison culture remained entrenched as the dominant barrier to development of an authentic treatment milieu, feminist or otherwise. Throughout the year I was reminded repeatedly that the staff would have to be the key to replacing prison culture with a collaborative, women-centered space for healing and growth.

Staff

A feminist model of treatment is based on respect for women, a belief in women's ability to change through empowerment, and an understanding that women are relational and respond well to positive support and role-modeling. It is essential that program managers, clerical staff, case managers, and counseling staff reflect a diverse resident population in terms of gender, race/ethnicity, socioeconomic background, parenting status, and sexual orientation. A majority of staff should be in recovery from chemical dependency and some should have had experience in the criminal justice system. Program staff should be knowledgeable about, sensitive to, and supportive of meeting the specific treatment needs of women. Staff should demonstrate empathy, empowerment, honest and clear communication, and appropriate boundaries in their work with the residents. Staff must be aware and respectful of the importance of cultural and sexual

orientation differences, and be willing to scrutinize and deal with unresolved personal biases related to these issues.

In the summer of 1993 the Friends Outside CPMP was not a treatment facility. Staff had been hired in response to newspaper classifieds advertising for "community corrections workers." They were not hired or trained to be counselors. Often, according to my boss, J. Elizabeth Husby, the agency "had to hire the most likely candidates we interviewed, and we were sometimes desperate to find people to cover the shifts" (J. Elizabeth Husby, personal communication, May 1996). The program had been poorly managed, and in fact, the manager's position had been open for four months prior to my being hired. Essentially, the line staff had been hired to monitor the residents and facility. They earned low, entry level wages, and had no experience or understanding of the skills needed to work in a treatment setting, much less a feminist treatment setting.

The staff structure in the CPMP was simple and included only four positions: program manager, case manager, administrative assistant, and community corrections worker (CCW). The administrative assistant worked twenty hours a week (half-time), and there were eleven full-time CCWs who worked eight-hour shifts to provide for round-the-clock staffing of the facility. When I was hired, the case manager and program manager positions were combined into one, making me responsible for managing the facility and supervising the staff, and for providing comprehensive case management for the ten residents in the program. The CPMPs, like many non-profit human services programs, are underfunded, and staff salaries are typically low. Combining the case manager and program manager jobs was a strategy intended to enable the agency to offer a higher salary and recruit a program manager with expertise in addiction, who could also provide case management and develop a treatment program.

Husby had told me directly when she hired me that the CPMP staff was unskilled and that the previous managers had not provided the program with significant development or leadership. I knew very little about community corrections settings, women prisoners, or the CPMP. I did know that creating a feminist addiction treatment program under any circumstances would be an awesome challenge, and would require a quality, skilled staff. As a feminist committed to all women's empowerment, I certainly wanted the women on staff prior to my arrival to grow professionally and move forward with the program. I never planned to replace the existing staff immediately upon arrival. I hoped that most of the staff would want to be a part of a collaborative staff team and claim responsibility for the team process as we developed the treatment program. However, thinking about the staff's reportedly limited skills and some of the stories Husby had shared with me, I was especially apprehensive about staff overfamiliarity with residents.

Overfamiliarity can take a variety of forms. Some examples are: favoritism of certain residents over others evidenced by doing special favors, giving personal gifts, or protecting from negative consequences; development of personal friendships in which staff share detailed personal information with residents outside the purview of treatment; staff use of group process with residents to deal with personal issues; financial or sexual relationships.

Some treatment providers believe that professional boundaries require that they maintain a professional distance or assume an attitude of paternalistic superiority with residents or clients. Obviously, this approach would be antithetical to feminist treatment models that aim to empower women through partnership and alliances between residents and staff. Even well-trained program staff can be vulnerable to becoming ensnared in an overfamiliarity dynamic with a resident. Women-specific treatment settings can be

especially tricky where collaborative relationships between staff and residents are integral to the milieu. Working in a nurturing, homelike treatment setting can lead staff to relax appropriate professional boundaries and cross the line between caring support and overfamiliar personal relationships.

Overfamiliarity undermines the integrity of the treatment milieu, disempowering not only the individual resident and staff member but the entire treatment community. Jealousy, resentment, and divisions are generated between residents who should be actively supporting each other through the treatment process. Staff lose credibility and the respect of residents. Because it is a common problem in human services, overfamiliarity is repeatedly addressed in Friends Outside employee materials. Knowing how vulnerable even trained professionals can be in this area, I hoped the CPMP staff had been trained on this topic and committed myself to vigilance on the issue.

During the summer of 1993, I reviewed individual personnel files and performance evaluations written by the previous two managers. I discovered that only two members of the staff had experience working in a human services agency. The overall employment histories included a wide range of job experience: food server, security guard, moving company, crossing guard, retail sales, pet groomer. I was relieved to notice that the performance evaluations did not identify any major problem areas. After my review of the personnel files, I met individually with each staff member and tried to establish an initial connection. During these meetings I invited staff members to talk with me about their work, shared some of my ideas and hopes for the program, and asked for their feedback. The majority of the staff appeared to be open and willing to work with me, and several even expressed enthusiasm.

I initially felt relieved to find an all-women staff at the CPMP; however, the majority were Anglo/European American. Of a twelve-member staff, there was one

Latina and one African American woman. To my knowledge, none of the staff were lesbian or bisexual. One was a recovering addict and she was the only staff member who had served time in a jail or prison. None of the staff had been trained or certified in addiction treatment. None had group facilitation skills; they were not counselors. Only one was pursuing formal education in the related behavioral field of psychology.

During our first full-staff meeting that summer, I asked the staff to engage in dialogue and brainstorming about the situation in the CPMP. I listened for several hours to staff members discuss their thoughts and beliefs about the program, the residents and their children. The discussion started slowly, and most staff members were understandably hesitant to speak, considering that I was their new manager, they hardly knew me, and they were beginning to realize that I intended to change the program significantly. Several staff spoke up more readily and eventually the discussion heated up. The staff's comments articulated a wide range of attitudes and beliefs about the program's prisoner mothers and their children.

All but one staff member constantly referred to the residents as "girls." Many staff shared feelings of pity and sympathy for residents, and felt sad in their belief that the children would always suffer from what they viewed as the residents' hopelessness and inability to change their lives. Other staff talked about feeling angry that the residents even had the opportunity to serve their prison time in the CPMP, stating that they were not sure that the women deserved a chance to be in the program. These staff appeared to be very resentful of the residents, speaking sarcastically and derogatorily about the women and revealing racist, sexist, and homophobic attitudes. Some staff actually called residents "sluts" and "lazy" or "stupid." Discussion about drug addiction further indicated many staff's negative judgments and disgust regarding the residents as well as profound ignorance about chemical dependency. Staff members tried to speak appropriately when

discussing the residents, but since they themselves were unaware of the biases inherent in their comments, their underlying contempt for most of the women was obvious to me. I was sure it must also be obvious to the resident mothers in the CPMP.

Throughout the months, as I worked in the facility alongside staff and residents and observed their interactions, I found myself amazed at the dysfunctional, inappropriate and unprofessional dynamics in which staff engaged with residents. I expected that residents' communication styles would often be inappropriate, but staff were supposed, at least, to be community corrections professionals, if not counselors. However, it was not uncommon to find staff calling out to residents from one end of the facility to the other, yelling at them to "shut up," "you better finish your chore," or "hurry up or I'm going to leave you here." Staff often participated in lengthy arguments and/or low-key wheedling with residents, attempting to convince them to do their chores, attend to their children, get up, or go to bed.

Some staff routinely made assumptions about residents' behavior, accused them of infractions, and threatened unfounded disciplinary actions. Other staff responded to legitimate infractions by protecting residents from disciplinary consequences if the resident would "promise not to do it again." And individual staff members applied these styles of interaction inconsistently, depending on their stress level, and/or which resident they were dealing with. Regardless of how the staff approached them, with sympathetic permissiveness or punitive authoritarianism, the tone was paternalistic, and the residents were ultimately infantilized and disempowered.

The situation provided dramatic illustration of the staff's overwhelming sense of disempowerment, frustration, resentment, anger, and disrespect toward the program residents. This was certainly understandable. The program was chaotic and unstructured, the staff were untrained and unskilled, the residents were extremely difficult to deal with,

and the only tools for managing the situation appeared to be avoiding the problems or using the CDC disciplinary procedures. Because of the staff's sexist, racist, and homophobic attitudes and their demonstrated inability to use the disciplinary process consistently and appropriately, eventually I insisted that all 128s and 115s be discussed with and approved by me before they were written. Often I found myself overruling staff in their desire to document infractions and impose consequences. The confusion escalated, team work was impossible, and the milieu deteriorated.

Another major problem was the local parole agent assigned to the facility by the Parole and Community Services Division regional headquarters responsible for oversight of the CPMP. The RES is responsible for working in collaboration with the CPMP management and staff to ensure the custody and security of the facility and to administer the CDC disciplinary procedures. Additionally, she is expected to work with facility staff to support residents' appropriate participation in the required programming activities.

The RES in place for the CPMP when I arrived there quickly revealed herself to be the CDC system and prison culture personified. Her attitude was controlling and authoritative with myself, staff, and residents. She was uneducated about addiction, did not support the concept of developing a treatment program for the CPMP, and articulated her opinions in the presence of residents. She was not open to working collaboratively and routinely sabotaged all attempts to nurture a recovery milieu in the facility. Her behavior was antithetical to principles of feminist treatment such as emotional safety, respect for the women, partnership and trust between residents and staff, accountability from residents and staff, and role-modeling.

The RES reinforced the chaotic, dysfunctional environment in the facility by her utilization of typical parole agent work strategies in which she had been trained. The RES holds tremendous power over the residents because she is an armed parole agent and

has the capability to return them to prison at any time. She is, in essence, "the man." Women prisoners and parolees are well-versed in playing the subordinate role when dealing with police, prison guards, and parole agents. Many law enforcement personnel dehumanize and objectify prisoners and parolees in such a way as to justify their own use of manipulation and dishonesty in their work.

This RES, through routine interactions with residents, identified and cultivated informers or "snitches" among the resident community in order to gain knowledge of the underground activities in the facility and enforce custody and security rules related to drug use or other infractions on the part of residents. She would then protect her informers if they were found in violation of the rules. The RES would report confidential staff discussions about residents to individual residents to give them power over other residents. She often invalidated minor staff decisions about residents after the resident had been told of the decision. She gossiped about staff to residents. She believed in the "you scratch my back and I'll scratch yours" motto normative in prison culture.

I certainly needed knowledge of the activities occurring under the surface in the facility; the program was very dysfunctional, and the staff ineffective. However, I strongly believed that the best approach was to role-model honest, direct communication with the residents. I was aware that this might keep me ignorant in the short term, but I believed that in the long run, it would gradually instill honesty and respect in the future treatment milieu. I also believed that if the residents were to recover, become empowered, stay out of prison, and learn how to operate in the society successfully, they would have to learn more effective communication and relationship styles than those available in prison culture.

When I attempted to discuss my treatment approach (never using the word feminist) with the RES, she was not open or willing to work together on the plans. She informed

me that Friends Outside had the right to design the program, but that CDC did not really see the CPMPs as facilities for substance abuse treatment. When I went to my boss, Husby reported that this RES had always been a problem and that sometimes with CDC you just have to wait until people are promoted to deal with the problems they create.

As I tried to instill some structure and stability into the program and encourage staff to take some ownership of the process, I also began to document the major problems with individual staff. One staff person was discovered to have been purchasing items from a resident which were possibly stolen. Financial interactions of any kind with residents is clearly an aspect of overfamiliarity in addition to being illegal. Another staff came to work obviously under the influence of alcohol. There were indications that some staff had provided clean urine for several residents who had used methamphetamines so their urine screens would not show positive results. One staff member took a resident to her house and church, another instance of failure of professional boundaries and overfamiliarity. These staff had to be let go immediately as these issues were discovered. During the year I realized that most of the other staff members were not going to be able to work effectively in a treatment milieu and would eventually quit or be terminated.

Friends Outside personnel policies do not require a particular level of education or certification if an applicant can demonstrate experience and an ability to perform the job, a policy consistent with feminist principles of inclusiveness. Looking to the coming year, I knew we would need to hire new staff and hoped to build a more diverse staff team in terms of race/ethnicity and sexual orientation. I planned to recruit at local colleges and wrote new advertising copy asking for individuals "experienced in chemical dependency and related women's issues," aiming to attract more qualified staff. Additionally, I knew we would need to provide a significant amount of training and in-service for the entry-level staff who could be recruited at the salary level of the program. Specifically, we

needed one staff member with experience in early childhood education to create organized, supervised childcare for the CPMP. Working with Husby, I decided to create a new position which would be half-time CCW and half-time childcare supervisor.

The Resident Community

Although I had been working with addicted and recovering women for many years I had not previously been involved in corrections settings. I had worked in facilities and programs with groups that included women who were ex-prisoners, on parole or probation, but I had never experienced working with an all-prisoner population. I wanted to focus the majority of the time on providing case management services and programming groups and classes for the resident mothers. I did implement case management activities such as conducting individual assessments, developing written treatment plans, and writing regular case progress notes for each resident, but the process was inconsistent. I also attempted to implement some education groups, but the toxic level of confusion dominating the milieu, the lack of staff support, and the severity of all the various problems with the program prevented effective case management or programming during that first year. However, I was able to learn a tremendous amount about prisoners, prison, and prison culture from my daily interactions with the women.

The resident mothers in the facility essentially mirror the profile of women in prison reported in the literature. All of the women in the CPMP are eligible for placement in minimum security custody and were convicted of non-violent drug and property crimes related to their drug addiction. Most are young, single mothers of two or more dependent children. Most have not successfully parented their children, and have relied heavily on grandmothers and other female family members to care for their children during periods of drug addiction or incarceration. Some have lost temporary or permanent custody of

one or more children. The majority are substance abusers or have been addicted to drugs. Their "drugs of choice" are identified as crack, heroin, and methamphetamines, although most of the women have histories of poly-drug use which includes alcohol, marijuana, and prescription drugs.

The majority of women come from economically disadvantaged families and communities. Their families of origin have generally been unstable, chaotic, drug addicted, and often violent. Many were periodically abandoned as children by one or both parents, with most being raised in single parent homes by the mother, aunts, and/or grandmother. It is not unusual for the women to have been introduced at an early age to drug use and/or criminal behavior by parents or other family members. Some have served jail or prison sentences after having admitted to and been convicted of crimes committed by their parents or siblings. The vast majority struggle with trauma-related issues stemming from childhood abuse such as incest, molestation, and physical violence. Many experience abuse and harassment by prison guards while incarcerated.

The majority of women did not complete high school and, because of chaotic living situations, were essentially unable to learn well during much of their time in school. Few of the women have a significant employment history or marketable job skills because of their limited education and their drug use. Many were involved in the juvenile justice system from an early age. It is common for women to have spent time in foster homes, group homes, juvenile hall, and California Youth Authority (CYA) prior to serving jail and prison sentences in adult institutions.

Essentially, the CPMP resident mothers can be understood as suffering from long-term Post Traumatic Stress Syndrome (PTSS). Some the coping skills they have developed to survive the chaos, abuse, and oppression in their lives include extreme forms of manipulation, dishonesty, denial, avoidance, and blame. Behaviors stemming

from these coping skills relate both drug addiction and conflict with the law. The rules of life for most women prisoners have been the same from childhood into the street/drug life, prison and the CPMP: "Don't feel, don't trust, don't tell." They have not been able to develop life management skills required to function effectively as responsible adults capable of appropriate decision making, self-care, or maintenance of healthy relationships.

The feminist framework supporting the treatment approach is based on the understanding that a structured, supportive treatment milieu that incorporates comprehensive case management services and programming, best meets the needs of women prisoners. Further, within the milieu that offers women-specific culturally sensitive programming designed to address the women's multifaceted issues and facilitated by a skilled staff, it is the resident community itself that is the primary site of healing and empowerment. The most difficult barriers to establishing and maintaining an empowering treatment community are the effects of PTSS and prison culture on the resident participants. Treatment services provided by staff are useless if prison culture is allowed to flourish. The role of the CPMP residents in the treatment setting is critical to the process of minimizing and eliminating prison culture from the milieu. Staff must be skilled at supporting successful, positive, motivated residents as they struggle to deal with their peers and resist prison culture.

Most women in CDC institutions have responded in some ways to their own victimization by offending others during their time in the drug/street life and in prison. Though their crimes are primarily nonviolent, they certainly hurt others through their criminal behavior. The CPMP residents continued to maintain the chaos of their lives through their manipulations of staff and each other. It takes a very long time for these women to begin to lower the personal walls they have developed to protect themselves

from the oppression and pain in their lives. I knew that when the residents could begin to trust the program structure, the staff, and each other, these connections would allow them to trust themselves and their strengths. For this, they would need to feel a degree of safety from the program milieu. It was not possible to create this safety during that first year. The program was too unstructured and the staff were struggling in many ways with the same issues as the residents. The milieu was unable to support this magnitude of a shift from a chaotic, emotionally unsafe, prison culture environment, to a functional community that provides a space for healing and empowering relationships and experiences.

CHAPTER IV

CONNECTION

July 1994–June 1996

The feminist model of treatment I aimed to create for the CPMP would have at its core the belief that the women prisoners have the capacity for positive change through the process of empowerment. To support this process, the treatment milieu would need to provide respectful challenges to the resident's patterns of addiction, entanglement with the legal system, and other self-defeating behaviors, as well as opportunities to learn how to access systems of self-care in support of their long-term recovery.

The majority of women prisoners coming into treatment in the CPMP have developed an elaborate web of denial to protect themselves from the emotional shame and pain of their situation. To survive the dehumanizing conditions of their lives in and out of prison, most of the women rely to some extent on personal emotional walls to avoid the possibility of further betrayal and pain. The denial system supports personal walls and operates as an emotional survival skill by supporting the woman's belief that she is not to blame for the fact that she is in prison, or that her children have been taken from her, or that she is a victim of physical or sexual violence, or that she may also have victimized others while involved in the drug/street life or in prison.

However, on a deep emotional level, buried beneath their denial, the women know that their lives are intolerable, and this deep knowledge, along with the corresponding denial, is key to what drives the addictive process. Additionally, the oppression and dehumanization women prisoners have experienced at all levels have created a sense of shame and worthlessness which leads them to believe that they are powerless to change their intolerable lives. This belief is not completely unfounded. Most women prisoners

have not had access to the resources necessary to empower them to create positive, growth-enhancing lives. Racist, classist, and sexist social institutions have interacted to deny them the "American Dream." Most women in prison did not grow up in safety in a nice neighborhood with quality schools that prepare their children for upwardly mobile, successful lives. Deep feelings of powerlessness are a valid response when women have had no access to power.

Women use drugs, alcohol, and denial to protect themselves from the pain of oppression, abuse, and dependency. The addict's elaborate web of denial is perpetuated through her use of rationalization, minimization, and justification to avoid the truth of her situation because it is extremely painful to accept defeat. In the absence of more positive options, this denial system is a sophisticated, creative, survival tool deserving of some respect. Unfortunately, the web of denial operates to reinforce a woman's powerlessness and oppression by allowing her to avoid the truth about her situation. This, in turn, facilitates her ability to refuse to find ways to take responsibility for her life and allows her to remain stuck in addiction and/or imprisonment.

When a women prisoner/addict is able to let go of her denial and faces the truth about her reality, her choices are simple: begin to take responsibility for changing an unacceptable situation, or return to denial and use of drugs and other self-defeating behaviors. To ask a chemically dependent woman prisoner to let go of denial and take responsibility for her life is, in some way, like asking a drowning person to throw away her life preserver. Asking such a women to trust in the possibility of recovery and empowerment after a lifetime of oppression and betrayal requires that the treatment milieu convey respect for the enormity of this process and provide the support and assistance necessary for success.

In most traditional male-biased models of treatment, counselors routinely take a confrontational, controlling, authoritarian approach to breaking down the denial systems that are primary to maintaining addictive processes. The criminal justice system takes a similar approach to breaking down "criminal behavior" and preventing crime. The efficacy of such "rehabilitative" efforts is questionable in any case, but they are clearly inappropriate for most women. Many women prisoners who come to the CPMP have previously experienced various traditional drug rehabilitation programs and served multiple jail and prison sentences, without developing the skills necessary to maintain recovery and avoid conflict with the law. This kind of confrontational, controlling, authoritarian approach to changing women's behavior is abusive, oppressive, and merely reinforces their previous life experiences and their reliance on coping skills such as denial and drug abuse.

A feminist treatment model empowers staff to take a collaborative, respectful, non-controlling approach to challenging a women's denial, addiction, and other self-defeating behaviors. Over time, this approach allows the CPMP resident to feel safe enough to begin to trust her relationships with staff and, eventually, with other residents and herself. Rather than *telling* a resident what the truth of her reality is and how to "fix" the problems, staff in a women-specific milieu are able to take the time to dialogue mutually with a resident about observations, ideas, and experiences, and to role model solution-oriented thinking and behaviors that the resident can then test for herself. This approach can often be experienced as slow and cumbersome by staff and residents, whereas the more authoritarian approach may feel faster and more familiar, but the results are empowering for the resident as she is able to take more ownership in a collaborative process.

To support the process of empowerment which begins through staff's respectful, collaborative challenging of denial and related self-defeating behaviors, the CPMP treatment milieu must provide opportunities for the residents to learn how to access systems of self-care in support of their long-term healing, growth, and recovery. Many chemically dependent women, and especially those who are prisoners, have had limited access to resources and systems that provide for self-care and growth opportunities. A feminist treatment model provides such opportunities through a variety of groups, classes, and learning experiences aimed to address the multidimensional issues women prisoners are facing. Such groups and classes should deal with issues related to addiction and trauma recovery, physical and psychological health, families, and relationships, vocational and educational opportunities, and life skills such as financial management, and navigation of social services systems.

Moving into my second year as manager of the CPMP, I knew that further program development for the resident mothers would be impossible without an organized, supervised childcare program on-site. Once the children's program was established, on-site and off-site treatment groups could be implemented to address the multidimensional needs of the resident prisoner mothers. Ongoing recruitment and training of a skilled staff team would be required to effect the transition to a women-centered treatment program. I believed that with these elements in place, the resident community could gradually move away from prison culture toward the feminist model of connection and supportive relationships I aimed to establish within the milieu. This would all have to be accomplished without any additional funding.

Program

The CPMP had never provided childcare on-site and a staff childcare supervisor position had not been planned for or budgeted. In strategizing a solution to the childcare dilemma, J. Elizabeth Husby and I had decided to create one position for which the job description would be half-time childcare supervisor and half-time community corrections worker. Although I thought this plan would suffice in the short term, I was somewhat apprehensive about the possibility of finding an individual capable of balancing her work with the children with her monitoring role with the mothers.

In my experience, children's service providers sometimes take a negative, blaming view of the parents of at-risk children that can result in bias against the parents. Individuals who sincerely care about the well-being of children can sometimes allow bias against parents to inform a simplistic belief that the best solution for children in at-risk families is to remove them from the parents. The CPMP was created specifically to allow for at-risk children to be reunited with their imprisoned mothers. I was also concerned about the possibility of additional stigma deriving from the residents' status as prisoners. Any such bias would be antithetical to the goal of a feminist treatment model and clearly unacceptable in the childcare supervisor for the CPMP.

I anticipated that the childcare supervisor would be a key member of the staff team, not only in terms of providing the childcare program, but in working with the mothers to defuse their attempts to use their children to manipulate staff. She would have to be able to learn to recognize and cope with aspects of prison culture when working in the CCW role with the mothers, at the same time she is forming bonds of trust with the residents in regard to her work in the childcare program with their children. I needed an experienced childcare provider who could also conceptualize the debilitating effects of Post Traumatic Stress Syndrome and addiction on the mothers and support their growth and

empowerment as parents. I was amazed to find such an applicant responding to the newspaper advertisement I placed late in the spring of 1994. I hired her, and we began that summer to build the children's program.

California penal code 3416 establishes eligibility criteria that require that children of CPMP resident mothers must be no older than six years by the time the mother paroles and leaves the program (California Penal Code 3410 *et. seq.* 1979).

Children born prior to or during the mother's incarceration in prison are faced with more complex issues than those children born during the mother's stay in the CPMP, who benefit from the increased stability offered by the program and staff.

Prior to participating with their mothers in the CPMP, children have been placed either with family members or in the foster care system during their mothers' imprisonment. The physical and emotional health of children when they arrive in the program depends greatly on the quality of alternative care received during the mother's incarceration and the degree to which the child's physical, emotional, and developmental needs have been met by the caregivers during the separation. Beyond the basic need for appropriate food, clothing, shelter, and emotional nurturing, there are social and educational needs which are age-related. Children of all ages also have issues concerning bonding and/or separation and abandonment related to their mothers' incarceration and/or drug addiction. The ability of foster caregivers to provide age-appropriate support with these issues significantly impacts the child's condition upon arrival in the CPMP to join the mother.

If a child has received sufficiently good care, treatment for mother and child should focus on supporting their transition and assimilation into the program milieu. Case management begins with facilitating mother/child (re)bonding and supporting the resident mother in meeting her child's needs. This is accomplished through parenting classes and

other programming elements as well as informal interaction and connection with staff and other resident mothers, which provides role modeling, assistance, and encouragement.

For babies born after the mother's placement in the CPMP, assisting the mother through the remainder of her pregnancy, her delivery and the adjustment to a new baby is the primary focus in terms of the child's needs. If the mother has other children placed elsewhere, this includes helping her to understand and deal with the dynamics of guilt related to those children. Programmatic support for mothers of newborns delivered after arrival in the CPMP is accomplished through strategies described above.

For children who have experienced more severe forms of neglect and/or abuse beyond that directly related to abandonment issues resulting from the mother's history of imprisonment and/or addiction, a more intensive approach may be necessary. Depending on the age and needs of the child, therapy may be required to assist both mother and child to cope with emotional and behavioral difficulties stemming from abuse and/or neglect.

All resident children in the CPMP need developmentally appropriate activities, stimulation, and treatment, to enrich their experience in the program and to help foster feelings of safety, security, and stability for them. Obviously this is a complex task and requires a multidisciplinary approach combining the expertise of child development, medical, case management, and counseling staff as well as therapists. Thinking about future provision of a comprehensive children's development program, I could envision a case management model of treatment for the CPMP children that would incorporate formal assessment, written treatment plans, regular case notes and referrals to community resources. In the summer of 1994, we had to find a place to create a child care area and be satisfied with morning childcare five days a week.

With ten women and ten children living together in a 2,200 square foot renovated Victorian house, space is extremely limited. The only unoccupied area in the house was a

small room off of the central upstairs landing that was prohibited from having a door because the second floor fire escape opened out of the room. This space had been informally used by resident mothers as a playroom for the children since the program had opened, but it was too small to allow for simultaneous use by all the children. Strategizing with the new childcare supervisor we planned to use the playroom, the upstairs landing, and the two upstairs bedrooms to provide adequate areas for childcare during the mornings when the residents would be having their classes and groups. This arrangement would allow enough space for separation of infants from toddlers and preschool-aged children.

The childcare supervisor embodied wonderful qualities of creativity, energy, and love and understanding for the children which, along with her breadth of expertise, brought a much needed element of credibility and stability to the fledgling staff team. She immediately set to work to establish the maximum possible professional standards of service provision for the childcare program, given the limitations of the facility. She began training resident mothers to assist with childcare on a cooperative basis and established a rotating childcare assistant's schedule. We believed this would nurture connections between the childcare supervisor and the mothers and among the mothers themselves as they interacted with each others' children, in addition to providing the appropriate ratio of adults to children in the childcare setting. In 1995, I was able to develop a linkage with the Foster Grandparents Program to bring into the CPMP childcare program two foster grandmothers to assist the childcare supervisor with the children.

Once the childcare program was implemented in the fall of 1994, I was able to begin seriously to address the need for programming elements designed to meet the residents' multifaceted treatment needs. In order to accomplish significant program

development without an increase in the CPMP budget, I would need to rely primarily on linkages with other nonprofit resource agencies that could provide service delivery as a component of their existing scope of work as established by their service mission. My vision of feminist treatment reflects a tenet of community-based services that articulates the belief that communities should support the healing and growth of their members. Agency linkages intended to enhance service delivery among community-based service providers should be normative and should strengthen connections between funders, service providers, and clients or recipients.

In my years of personal and professional focus on women-specific addiction recovery, I had developed an extensive network of therapists, educators, counselors, and other women working in nonprofit agencies providing services to women. I hoped to be able to access this network of potential providers as I developed a wide variety of on-site classes and groups, as well as off-site referral resources to meet holistically the needs of the CPMP residents. Some service provision linkages had been attempted in the first years of CPMP operation, with minimal success. One reported problem was the resistant attitudes and behaviors of the women prisoner population, attributed primarily to prison culture. Previously established linkages were in place with Natividad Medical Center, Salinas Adult School, Family Resource Center, and the Women, Infants, and Children nutrition program.

The California Department of Corrections (CDC) is required to provide health care services to all prisoners in prisons and in community-based correctional settings. To meet this requirement for prisoners placed in the CPMP, CDC has established a contract with Natividad Medical Center (NMC) in Salinas, the local county hospital. When I became manager, the CPMP residents were routinely taken by staff to the emergency department at NMC for all of their medical or health care needs as they had been since

the program opened. These emergency room visits typically included a four to six hour wait for services for ailments ranging in severity from cold and flu symptoms, to chest pains, pneumonia, blood clots and liver disease. Clearly this was not a cost effective or otherwise efficient method of health care service delivery. Additionally, the long waits in the emergency room gave the residents unnecessary opportunities to deviate from their approved activities while away from the facility.

Upon my discovery of this situation in summer 1993, I had attempted to develop a linkage with the NMC Family Practice Clinic to provide non-emergency health care services to our residents and their children. I was informed that the waiting list for clinic services averaged from about four to six months. I resolved to check in with the clinic periodically to assess the situation. Finally, in winter 1994, a new coordinator was assigned to manage the clinic. When I described the CPMP to her she immediately recognized that the linkage was appropriate not only for the convenience of our facility's staff and residents, but also that from a public health perspective priority access to health care for residential facilities is standard.

The clinic coordinator and I developed a process which provides priority access to primary medical care for CPMP residents and their children that is personal and appropriate. NMC agreed to assign expeditiously a family physician to each mother and child as referred by CPMP, to schedule all appropriate preventive health care and "well checks" with the assigned doctor, and to provide priority access to non-scheduled healthcare services when needed by facilitating walk-in appointments with available medical staff in a timely manner. Obviously, this is a tremendous improvement over the emergency room and/or a six-month waiting list. The linkage with NMC solved many logistical and structural problems in terms of transporting and monitoring residents and supporting them in maintaining their accountability.

The CPMP's contract with the Salinas Adult School's parenting center provides for one weekly parenting class on-site in the CPMP facility. The teacher who provided this class had been working with the program residents for almost two years prior to my arrival. In speaking with her I got the impression that she felt that she was managing to deal with the residents fairly well, but she clearly stated that their attitudes and behaviors were often very negative and disruptive to her attempts to teach. She did not make overtly disrespectful statements about the women, but she consistently referred to them as "girls" and appeared to feel resigned to maintaining low expectations of their possibilities as a group. After I met with the parenting teacher and her supervisor, we agreed that we would continue the parenting class and try to bring more variety to its curriculum. Additionally, I made agreements with the teacher that I, and the CPMP staff as a whole, would make ourselves more available to support her with appropriate interventions when the participants in her class engaged in problematic behaviors.

The CPMP also had occasionally sent resident mothers to the Family Resource Center (FRC) for individual therapy with licensed clinical therapists who could work with mothers and/or children on serious emotional issues beyond the scope of counseling. Because most women in the CPMP resident population struggle with complex emotional issues related to long-term Post Traumatic Stress Syndrom (PTSS), I thought that the linkage needed to be enhanced to provide therapy to all residents who would be in program long enough to benefit. I worked with the FRC executive director and developed a formal Memorandum of Understanding (MOU) which insures the availability of therapy as a component of comprehensive services for CPMP residents.

The Women, Infants, and Children (WIC) program is a federally funded nutrition program through which impoverished women can obtain WIC food vouchers (similar to food stamps) for their children, and themselves when pregnant. Income-eligible women

must access this resource by making application at their local WIC office. After being accepted into the program, they are required to attend monthly nutrition classes facilitated by WIC nutrition educators in order to receive their food vouchers. The WIC food vouchers are exchanged for a precisely defined list of products such as milk, cereal, cheese, and peanut butter. The linkage between CPMP and WIC provides for WIC nutrition educators to bring services on-site at the CPMP facility monthly. This allows residents more efficiently to make application to the program, attend the nutrition classes, and receive their food vouchers, especially residents who are ineligible to leave the facility unescorted, such as those who may be in Phase I or those on house restriction for other reasons.

Access to standard social services has always been facilitated for CPMP residents through referrals to the Monterey County Department of Social Services (DSS) offices for AFDC, food stamps , and Medi-Cal for their children. Resident mothers are not eligible for these entitlements because of their inmate status—the costs of their incarceration must be paid by CDC. Because CPMP residents were referred individually to DSS offices, they were each assigned to a different eligibility worker there. This situation resulted in much confusion for CPMP residents and staff. Many of the eligibility workers at DSS were unfamiliar with the CPMP and routinely gave conflicting information to residents. Often when a new resident made her application, even with a CPMP referral letter explaining the program, the DSS worker would ask for rent receipts, utility bills, and other documentation that did not apply to CPMP residents. In fall 1994, I discovered, through networking, the "One Stop Services" unit of Monterey County DSS. I learned that the DSS had established a unit of staff providing "One Stop Services" for clients and agencies who require special needs or attention. I developed a process with the DSS "One Stop Services" unit whereby CPMP residents could apply for and receive

AFDC, food stamps, and Medi-Cal through a referral to a single assigned eligibility worker for processing of their applications in an expedited manner. Since we established this linkage the process has been much smoother, allowing for a more efficient and humanistic approach to service delivery to the CPMP residents.

As I began to develop additional programming for the CPMP, in 1994-1995, I knew that the first priority had to be substance abuse treatment classes and groups. In August of 1994, I attended a training sponsored by CDC for facilitators of a substance abuse curriculum titled "Framework for Recovery." This curriculum was created by Gordon Graham, an ex-prisoner who had been incarcerated in the 1960s and 1970s, and is widely used in CDC facilities. Graham has developed his substance abuse curriculum for prisoners and ex-prisoners in an interactive format which incorporates the use of video-based education classes.

Trained facilitators guide participants through twelve education sessions utilizing videos through which Graham discusses the "Framework for Recovery" concepts for each session. The facilitator and participants then review and discuss the concepts and conduct group and individual exercises and assignments which are explained in detail and recorded in a participant workbook. The process is intended to promote understanding of the dynamics of addiction, relapse, and recovery, and the building of recovery skills. While the curriculum is not designed specifically for women, it does address issues relevant to substance addicted prisoners in a respectful, non-shaming manner. CDC provided the curriculum materials to participating agencies free of cost. In the absence of a women-specific alternative, I decided to implement the program at the CPMP and began to facilitate the curriculum for the residents immediately.

In fall 1995, I was able to purchase the "Design For Living" addiction treatment curriculum developed by Hazelden Publishing, Inc. This curriculum is designed

specifically for women in conflict with the law and incorporates women-centered videos and printed materials for use with the residents. The curriculum focuses on identifying "strengths and stressors" and facilitates an empowerment model through written exercises and group participation. The discussion groups are designed to support the women in understanding the dynamics of their drug using behaviors and relapse triggers, and assists them in supporting each other to develop solution-oriented strategies for resolving their issues. "Design For Living" is divided into ten sessions which can be presented in a five-week or ten-week format and rotated with "Framework For Recovery."

To support the core substance abuse curricula, I developed a number of weekly focus groups which address addiction and recovery. In "Step I Group," residents study and present Step I of the twelve steps of Alcoholics Anonymous/Narcotics Anonymous. Residents use a worksheet to write out their story of addiction and are scheduled to share it in group with the other residents. Counseling staff facilitate the group process and support the group members to empathize with the resident sharing her story and to challenge respectfully any denial and/or minimization of the negative consequences of her addiction. This process can be effective in terms of intervening on prison culture and helping the residents to lower their defensive personal walls, see similarities in their histories, make connections, and develop trust amongst themselves. These empathetic connections strengthen the resident community by increasing accountability and supporting empowerment.

In "Problem-Solving Group," residents use a worksheet to identify problems, issues and/or concerns and set specific, achievable goals for the coming week, and they track progress on goals set the previous week. Most CPMP residents have been used to viewing their stressors and problems in a macro fashion. The problem-solving group process promotes the residents' skill in breaking down problems and issues into

manageable pieces and in conceptualizing more effective solutions. Facilitator and group feedback assist the residents in identifying problems that are specific and relevant to their immediate situation and in setting goals which can be reached in a week's time.

Attendance at NA and AA meetings is the most available and accessible community support for addiction recovery. CPMP residents attend twelve step meetings on-site in the facility and off-site in the community. Off-site meetings provide the opportunity for residents to connect with recovering individuals from diverse backgrounds and experiences. CPMP residents are able to develop a support system of recovering women in the community as they assimilate the concepts and practices of recovery.

To insure provision of culturally relevant support groups for the residents, I was able to link with two local agencies specifically established to provide services to African American and Latino communities. Sea*Rina Community Recovery Center is located about thirty minutes away from Salinas and offers culturally specific women's issues groups, NA, and AA meetings to African American women. I and the center director, a woman with whom I had previously worked, developed collaboratively a MOU to make these groups available to CPMP women even though they did not live in the center's service area. CPMP staff transported our residents to women's meetings and groups held at the Sea*Rina Center location. The center director also assigned an outreach counselor to come to the CPMP facility once a week to provide a group for all of our program residents.

Gente del Sol Community Recovery Center is located in Salinas not far from the CPMP facility and provides similar culturally specific services. An MOU with Gente del Sol arranged for a similar availability of women's issues groups and NA and AA meetings focusing on Latina issues and needs, which CPMP residents attended at the

Gente del Sol facility. An outreach counselor also conducted a women's process group in the CPMP facility weekly.

The culturally relevant women's groups were important for many reasons. They provided Latinas and African American women with role models, information, and support from facilitators and group participants from the community who reflected a shared race/ethnicity. These groups were not all limited to only women of color in the community and the CPMP. By participating in culturally specific groups which included Anglo/European women, residents were able to explore and process a variety of issues related to unacknowledged white racist stereotypes of non-white women, as well as issues related to the internalized racism of the women of color. These groups were often understandably difficult, but nurtured the process of understanding and empathetic connection among the women.

To meet the needs of CPMP residents who were survivors of domestic violence and/or sexual assault (80%), I developed a linkage with the Salinas Women's Crisis Center (WCC). The center offers individual counseling and support groups to women who have been incested, molested, battered, raped, stalked or otherwise terrorized as children or adults. I referred individual CPMP residents to the WCC facility which was located several blocks from our site. WCC also provided education series on domestic violence prevention on-site in the CPMP facility.

Not surprisingly, many of the CPMP residents were initially resistant to the enhanced programming elements I developed throughout my second and third years as manager. The milieu continued to be encumbered by prison culture, the staff was still undertrained, and the primary mode of operations continued to be crisis management. The residents often used complaints of illness, their own or their children's, to manipulate staff into excusing them from groups and class. The inconsistent attendance and rude,

argumentative, and otherwise disruptive behaviors of many residents created significant difficulty in facilitating educational group experiences.

However, as the programming groups continued over the months, the residents slowly began to relax and accept the fact that I and the other staff and providers were not going to give up on them. Over time, small signs of progress became visible. Some of the women began to share parts of their stories and feelings in the group. Sometimes women actually tried to challenge each other honestly, even at the risk of underhanded retaliation so endemic to prison culture. Providers bringing services on-site from linkage agencies began to notice occasional shifts in the negative attitudes in the resident community. In fact, this was significant progress compared to my first year of work in the CPMP, when I had attempted to implement programming activities and several volunteer facilitators had become so frustrated trying to manage the residents' behavior, that they refused to continue working with them.

Some educators and other providers who are inexperienced with the realities of prison culture and women prisoners, are not adequately prepared to work with this population. Maintaining a respectful, collaborative, non-controlling, yet challenging approach to treatment, in the face of a group of adult women who refuse to remain seated, or listen, or share their thoughts and feelings, or answer questions, or otherwise participate in the process, can be next to impossible even for experienced counselors. Some of the facilitators who attempted to work with the CPMP residents reacted to these kinds of problems with varying degrees of disrespect towards the women.

Naturally, disrespectful treatment from linkage providers reinforced the residents' tendency to justify blaming others, withhold trust, and avoid taking responsibility for their own inappropriate behavior. I learned to work with linkage agency facilitators to assess their understanding of the population and offer appropriate support with their

difficulties. However, some linkage providers, who routinely work with impoverished women and women of color, appeared to be truly biased against the CPMP women and could not be trusted to maintain the integrity of our program. Occasionally, I found myself speaking with program managers and supervisors from linkage agencies and attempting to sensitize them to the need for special attention to maintaining respect when working with the women prisoner population.

Staff

With the childcare supervisor in place and the childcare program operational, I focused my attention on the staff while continuing the development of facility programming groups. The recruiting efforts I had undertaken the previous year had begun to shape the development of a staff team reflective of the profile of the resident population. By May, 1995, nine of the original staff of twelve had either resigned or been terminated. The staff now numbered nineteen including myself and the on-call/relief workers. Of the nineteen-member staff, four were Latina, six were African American, nine were Anglo/European American, and three that I know of were lesbian. Six staff were former addicts in recovery, and five had been in conflict with the law. There were now three certified addictions specialists on staff and all staff had prior experience working in human services agencies.

Having recruited a sufficiently diverse staff to reflect the diversity within the resident population, I now needed to provide extensive training to empower staff to carry out effectively the aims of a feminist model of treatment. A well-trained staff should be willing to scrutinize their own personal, unresolved biases related to the sexuality, race/ethnicity, class, and prisoner status of the resident population. I believed that a staff team committed to this kind of growth would be the strongest foundation from which to

accomplish the long-term program development goal of replacing prison culture in the milieu with a resident community capable of holding its members accountable for their own recovery.

Although the CPMP staff team as a whole in 1995 was remarkably skilled in comparison to the staff in place when I became manager in June of 1993, they all continued to be overly vulnerable to manipulation by the residents. Staff reactions to residents' behaviors and attitudes often continued to fluctuate between permissiveness and attempts to control their dishonesty, avoidance of their responsibilities, pushy, confrontive behaviors, and/or overcompliance. Additionally, staff's interactions with each other evidenced similar struggles. Some staff appeared to be over-responsible and some appeared to be under-responsible for the work load they all shared. Again, this dynamic triggered fluctuating reactions from staff ranging from passive avoidance of the problems to aggressive controlling attempts to blame each other for the problems when the work did not get done.

Aiming to enhance service provision and empower staff to work more effectively as a team, I initiated two regular weekly staff meetings during the spring of 1995. The first, called "staffing," is a standard component of clinical treatment. In traditional treatment settings, staffing is attended by members of the multidisciplinary treatment team, which is composed of a relatively hierarchically stratified group of professionals. The treatment staff may be composed of medical doctors, nurses, psychiatrists, psychologists, case managers and counselors. With such a hierarchy of professionals on staff, the staffing decisions can often be informed primarily by the opinions of the high-status, high-paid staff members such as the medical doctors and/or psychiatrists, who actually spend the least amount of time with the clients.

My intention for CPMP staffing was to foster true collaboration among the staff team by supporting each staff member to participate fully in the process, giving equal attention to all opinions. The format for staffing allocates time for individual staff members to dialogue about each resident. Staff members share their perspective on experiences and observations concerning progress and problems of individual residents and/or children. As each resident is "staffed" the team brainstorms solution-oriented interventions designed to support her positive healing, growth, and recovery. The staffing process can be extremely valuable in that it facilitates exploration of the variety of differing perspectives by the whole staff team in order to obtain a fuller view of a resident's immediate situation and allow for more comprehensive treatment planning and interventions. Additionally, staffing can promote trust and respect among the staff members as they work together toward the common goal of quality services for the residents.

The second of the weekly staff meetings I initiated, was called "team building." A therapist with whom I was acquainted, and who had experience as an organizational consultant, agreed to my request that she come into the program once a week to work with the CPMP staff as a group. My hope for this weekly team building group was that staff would learn to take increased responsibility for their interpersonal communication. One of the barriers to team work that I had observed over time was the tendency of most staff to struggle with resentments and conflict with each other over the work load. My aim was to empower the staff to work together to generate solutions to their interpersonal conflicts, just as we were asking the residents to do. Not only would this improve staff teamwork, but it would also serve to foster empathy and a collaborative approach to working with the residents if the staff were reminded that their own challenges simply mirror those of the residents.

Staffing and team building both allowed for an excellent opportunity to assess staff training needs. During 1994-1995, after the staff had more or less stabilized, I provided most of the training myself. I worked with the staff in specific training sessions as well as in more informal situations, taking every opportunity to raise staff awareness of the issues involved in gender-specific treatment for women prisoners. Many staff trained in traditional treatment settings are unaware of gender role stereotyping in general and with respect to substance abuse and/or imprisonment in particular. I emphasized in our staff discussions the increased stigma and shame attached to being a drug or alcohol addicted woman as opposed to a man. I was particularly concerned about the possibility of staff biases or intimidation regarding the stigmas associated with incarcerated women. I shared all information I could find on the true characteristics and needs of women prisoners and their situations. I worked extensively with staff on developing professional boundaries and tried to sensitize them to the trap of overfamiliarity. We worked on issues related to sexual and physical trauma and discussed treatment approaches related to the need for the survivors to feel safe in the milieu and supported in telling their stories.

Creating a feminist women-specific treatment program is difficult because in such a milieu all staff must develop an understanding of and commitment to issues specific to the population of women prisoners. Some CPMP staff have had trouble accepting a women-specific approach to treatment because it challenges their own internalized biases regarding gender, race/ethnicity, socioeconomic class, age, and sexual orientation. Most treatment programs avoid anything more than superficial attention to these issues, if any. For staff accustomed to working in settings which address all clients as being the same regardless of these specific issues, looking at women's differences may be threatening. Additionally, some staff share the issues with which the residents are struggling. A staff member who has been a victim of physical or sexual violence may feel uncomfortable

working on these issues with residents. To be able to work effectively with residents who are trauma survivors, staff must be willing to explore and resolve their own feelings about sexuality, sexual abuse and/or partner violence.

Throughout 1995-1996, I continued to focus with staff on identifying and meeting their training needs related to the residents' specific issues as women addicts and women prisoners. In our regular monthly staff meetings, staff routinely engaged in discussion regarding topics about which we needed or wanted to be trained, and I did all I could to provide such training. I was able to utilize CPMP staff with particular expertise, as well as outside experts, to address the CPMP staff for training during monthly staff meetings on specific topic areas such as domestic violence, sexual assault, suicide prevention, and substance abuse.

As the staff continued to evolve and develop over time, I was able to offer more comprehensive training strategies, always without corresponding budget increases. I began to exchange cross-trainings with the CPMP linkage agencies, many of which also serve women's populations. Staff from the Salinas Women's Crisis Center; Family Resource Center; Planned Parenthood; the Monterey County AIDS Project; YWCA Monterey Peninsula; Natividad Medical Center; Women, Infants, and Children Nutrition Program; and Gente del Sol and Sea*Rina Community Recovery Centers have all exchanged cross-trainings with CPMP staff. I also arranged for staff to attend seminars, workshops, and conferences held locally to address general issues related to addiction treatment, treatment for women, and other issues regarding services for women. I and several CPMP staff have participated in planning for and presenting on panels at conferences addressing women and addiction and welfare reform.

Cultural knowledge, sensitivity, and competency concerning issues of diversity are particularly important to the design and provision of comprehensive women-specific

programming for the CPMP residents. In a feminist model of treatment, it is critical that residents are treated with respect and empathy, which can provide a milieu that is emotionally safe and supportive of healing, growth, and recovery. To achieve such a milieu, staff must be ever willing to question their assumptions and languages regarding issues of cultural difference, and to heighten their awareness that not all members of any one cultural group are the same. Racial/ethnic groups of women express diversity within the specific group in terms of socioeconomic background, personality, regional origin, religion or spirituality, addiction in the family of origin, and other factors. Working with cultural factors, it is important not to perpetrate racial/ethnic stereotypes unconsciously. In supporting staff to commit to the goal of cultural competency, I utilized a variety of strategies aimed to assist them to embrace rather than fear difference.

In my attempts to develop cultural competency in the CPMP staff, I wanted to promote an understanding of and respect for racioethnic differences in family structures, communication styles, child rearing, religion and spirituality, music, styles of dress, nicknames, celebration and ritual, hygiene, health care, birthing and funeral rites, among many other factors. I believe that staff must be aware of how their perspectives impact their approach to treatment and their relationships with individual residents and the resident community as a whole. To provide training in cultural competency for CPMP staff, I found members of the particular cultural group being addressed to facilitate the training process. Training for CPMP staff has addressed homophobia, racism, ageism, able-bodyism, prisoner stigma, and sexism.

To design a milieu that would support the process of embracing diversity, I obtained and displayed posters and other art which reflected women and children of all colors and cultures. I made sure that all educational materials were inclusive of diverse populations, and developed a library that included a variety of fiction and nonfiction

books and periodicals that reach lesbians, women of color, older women, and women with HIV/AIDS and other disabilities. At every possible opportunity, I ensured that I and members of the CPMP staff participated in culturally relevant groups, community activities, and diverse cultural celebrations.

CPMP staff trainings regarding the issues discussed here that were begun and expanded between 1994-1996 continue to be important to enhanced service delivery, and training on these topics is ongoing. As we have continued with these training activities, the CPMP staff increasingly has evolved and developed experience and skill in working with the residents and their children. The staff have worked hard to recreate themselves into a functional team capable of working together to create solution-oriented strategies to support the residents' recovery. Staff routinely demonstrate their ability to challenge respectfully the residents' self-destructive behaviors and to nurture and support their strengths and successes. The staffing and teambuilding processes, especially, continue to remind us as a staff that we must expect from ourselves no less than that which we expect from the residents.

Throughout 1994-1996, as the program milieu stabilized, I was able to continue to develop and improve case management services for the residents. In the fall of 1994, over a year after coming to the CPMP, I moved my office from its location several blocks away into the residential facility. I had wanted to move my office into the residential facility ever since I started the job and realized how cumbersome it was to be located away form the site. The problem was that the only logical room in the house to which to move my office, had been occupied for two years by the longest-term resident in the facility, and I did not want to put her out of her room. When she finally paroled from the CPMP, I took the opportunity to relocate my office, which was a major improvement. Being on-site at the residential facility made the entire scope of my work more efficient

and enabled me to become more of a member of the milieu rather than an off-site supervisor. I intended to be a member of the staff team, not simply a supervisor, and was relieved to be in a better position to provide more immediate support, role-modeling, and intervention for residents and staff. After moving, I was able to incorporate a much more accurate sense of the program's needs into my process of assessment and strategizing.

Having my office on-site allowed for increased consistency in case management service provision. The case management process relies on standard procedures of conducting the biopsychosocial assessment, developing a case summary and treatment plan, maintaining ongoing counseling sessions, and developing a comprehensive discharge/exit plan. The case management components are designed to provide the resident with a comprehensive, individualized treatment experience. The case manager should meet informally with each new resident to welcome her and make the initial connection, within seventy two hours of her arrival in the CPMP facility. The in-depth biopsychosocial assessment in conducted within fourteen days of the resident's arrival. This time frame allows for the woman to have an opportunity to make some adjustment to the program milieu and begin to (re)bond with and care for her child. It also provides an opportunity for the case manager and other facility staff to interact with and informally observe the woman as she begins to assimilate into the program by learning systems and procedures and by beginning to form relationships with the other residents.

The biopsychosocial assessment is the foundation upon which the resident and the case manager collaboratively develop the course of treatment for the resident. The assessment addresses all areas of the resident's history related to substance abuse/addiction, family of origin, current family/support system (including all children), medical and psychological conditions, abuse, education and work experience, sexuality, and self-assessment. Residents have different levels of honesty and willingness to self-

disclose, and the case manager should use the assessment process as an opportunity to support the woman in providing as much truthful self-disclosure as possible. The assessment process can be an important time of reflection for the resident as she explores her personal history and tells her story.

Many of the questions asked during the assessment can be very difficult and painful for the resident to consider and/or answer, and she may try to avoid her feelings and remain stoic, or she may experience sadness and cry. The case manager should approach the assessment with respect and empathy for the resident and gently support her as she begins to identify the issues and problems that have contributed to her current situation. The resident may at this time begin the process of ongoing personal assessment and gaining of insight necessary to develop a healthy, addiction-free lifestyle which will help her stay out of conflict with the law. The process also provides an opportunity for the resident to be educated about, to explore, and to understand the nature of the Friends Outside CPMP treatment milieu and the expectations regarding her participation in the program. Residents have often formed opinions and beliefs about CPMP placement which are based on discussions among the women in the prisons about the lack of structure and low programming expectations in many of the programs. These rumors have historically been true of the CPMPs, including Friends Outside prior to 1993. New residents are often surprised by the program structure and demanding level of participation required for their success.

After the biopsychosocial assessment has been completed, the case manager synthesizes the information obtained into a case summary which includes her impressions concerning potential barriers to treatment and a prioritized problems list. The treatment plan is developed from the problem list. The treatment plan is a written document which identifies major problems such as addiction, impaired parenting skills, and childhood

sexual trauma, and establishes interventions intended to assist the resident in healing and moving towards recovery in the identified problem areas. The treatment plan charts the resident's movement through her individualized treatment program. The case manager and the resident should collaboratively agree on the problems and interventions developed and should review and revise the treatment plan as needed.

All treatment plans include a variety of assignments designed to familiarize residents with twelve step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) and integrate residents into the addiction recovery process. Residents are required to attend NA and AA meetings in the community, read the literature, obtain a "sponsor," and "work" the twelve steps of the programs. All treatment plans also require that residents participate in the CPMP facility's on-site programming elements, including shared responsibilities for shopping, cooking food for the children and themselves, and maintaining the facility in a clean and sanitary fashion. All treatment plans include referrals to community-based resources to address individual programming needs such as therapy or vocational programs.

Because the residents' length of stay is not standardized, treatment plans must be flexible, adaptable, and highly individualized in terms of goals, objectives, and interventions. For example, a resident who is in the program for four months does not have the opportunity to complete a vocational program. And in most cases it is not appropriate to have her enter into an in-depth therapeutic process because the process will be interrupted when she leaves the program before any resolution of issues can occur. Residents with shorter terms must, of necessity, focus almost exclusively on addiction treatment, twelve-step recovery, and parenting classes for both on- and off-site programming, and rely on counseling.

A resident who has a slightly longer term of six to twelve months, who demonstrates progress in her substance abuse treatment and recovery and parenting skills development, should be supported to participate in more educational and vocational development activities. Obtaining her GED or completing a vocational certification program can become a goal and be incorporated into her treatment plan. Residents with longer terms also have the time needed to benefit from therapy.

Depending on her educational level upon entry into the program, a resident with a sentence of two or more years has the opportunity to complete more advanced vocational or educational goals. However, the primary treatment goals concerning addiction and recovery, parenting, and living skills continue to be the core of her program.

Regularly scheduled, one-hour weekly counseling sessions between the case manager and each resident provide for tracking of progress in reaching treatment goals. Residents' needs, successes, problems, and disciplinary issues are addressed in case management sessions. The resident and case manager work collaboratively to modify and/or expand the treatment plan according to the changing needs of the resident mother and her child. In addition to formal, scheduled case management sessions, the case manager is available to resident mothers and their children on a more informal basis throughout the week during classes, groups, and as requested by the resident, case manager, or other staff.

During Phase III-Reentry Phase, the final 120 days prior to the resident's parole from the CPMP, the case manager and resident work together to develop a detailed discharge plan. In fact, the discharge planning process begins when the resident first enters the program and is incorporated into the treatment goals. The case manager and the resident identify issues related to successful transition to parole during the initial biopsychosocial assessment. Throughout the resident's stay in the CPMP, she and the

case manager collaboratively explore and expand on transitional issues and develop exit plans to address re-entry into the community. During treatment, residents gain important insight into their behavior, problems, successes, needs, and issues which must be addressed. This discharge plan addresses the needs of the mother and child and aims to assist them in the transition to parole. An important focus is to reduce risk and increase healing and growth through gaining skills designed to find new solutions to old problems such as asking for help or going to an AA/NA meeting instead of using alcohol or other drugs.

Depending on the resident's length of stay, success in the program, and home situation, exit plans must be somewhat flexible and adaptable to the changing needs of resident mothers and their child(ren). Mothers who parole will have various levels of need in terms of housing, transportation, financial support, childcare, educational and vocational development, medical services, and emotional health care. Residents are supported by the case manager and other staff in assessing their individual situation and needs, and in realistically identifying and assessing options for meeting those needs. All discharge plans emphasize the importance of transitional support and, depending on the individual resident, referral to intensive day treatment or aftercare programs may be indicated. Other residents may be stabilized enough to rely on AA and/or NA groups to maintain their recovery.

As the resident's parole date nears, the exit planning process often becomes more intensive. The case manager and other staff must use the occasion to facilitate the resident's commitment to the need for ongoing recovery work and/or treatment. Many residents with shorter terms are not able to stabilize their recovery sufficiently to maintain sobriety after parole without intensive structure. These mothers are often understandably reluctant to commit to another program after being incarcerated for a year or more and

want to believe they can manage on their own. These residents, at the same time, have an inkling of the difficulty of paroling and periodically experience a great deal of fear when thinking about their parole date and beyond.

The discharge/exit plan includes all necessary referrals to community agencies which can offer resources to meet the needs of the released resident and her child(ren). These can include housing authorities, social services, educational programs, employment programs, childcare providers, NA and AA, Head Start, and substance abuse/addiction treatment programs. The case manager supports the resident in locating addresses, phone numbers, and contact names for these referrals, and in developing time frames and deadlines by which the resident agrees to contact these resources.

Most treatment referrals will require the woman to attend an in-person on-site intake appointment, making it difficult for residents paroling to other communities to actually follow up on the referral until she returns to her county of last legal residence, to which she is required to return upon parole. However, most referral programs will mail or fax literature and information for the resident to use in developing her exit plans. It is imperative to engage the resident in a collaborative process, encouraging her to make calls, request information, and develop time frames for implementing her exit plans.

In cases where the resident is paroling to the local community, the case manager should assist her in keeping her intake and other appointments with referral agencies and following through on activities related to exit plans.

Case management services essentially provide the framework within which the residents are empowered to make positive changes and move into healing and recovery. Women prisoners entrenched in prison culture are well acquainted with being controlled by authority. They are not so familiar with operating responsibly and making positive choices within a respectful, supportive, structured milieu. Residents often say that

placement in the CPMP is more difficult than serving time in prison because they are expected to make responsible choices, rather than take orders. Through the collaborative process of assessment, treatment planning, and progress tracking, the resident and case manager develop the supportive structure of scheduled groups, classes, therapy, assignments and other services. With this framework in place, the CPMP residents are able increasingly to take responsibility for making positive personal changes, and participating as positive members of the resident community. During my first year in the program I had developed and written the assessment, case summary, treatment plan, and discharge plan forms, but had not been able to utilize them effectively because of the chaos and disorganization in the milieu. Throughout 1995 and 1996, the case management services I established at the CPMP developed into an increasingly consistent, comprehensive process, with time frames being met and service delivery goals being achieved.

As the program milieu stabilized over time, I was increasingly able to balance my roles of program manager and case manager. With effective case management in place, with the childcare supervisor on staff, and with the entire staff benefitting from the infusion of experienced staff members and comprehensive training, staff efficacy remains consistently high. Staff are able respectfully to maintain clear expectations of residents, communicate with them appropriately, and follow through with solution-oriented interventions to problems. Disciplinary procedures are rarely necessary, but are handled appropriately when imposed. Staff members work together as a team and have learned to respond effectively when residents act out. Power struggles between staff and residents and among the staff team are unusual rather than routine.

The Resident Community

In my years of working with chemically dependent women, I have become increasingly convinced of the efficacy of grounding my understanding of women's needs in the theory of women's development articulated by researchers at the Stone Center at Wellesley College, which has been termed the "relational model." The relational model places women's development of identity and selfhood in the context of their relationships, and identifies relationship and connection as the primary motivation for women's development over a lifetime. Relational theory describes women's healthy development as being informed by mutually growth-enhancing relationships which foster empowerment, self-knowledge, self-worth, vitality, energy, and the desire for more connections. Women's psychological well-being derives from a sense of mutuality and connection grounded in relationships which are based on shared trust, support, creativity, and respect (Jordan and others 1991, Covington 1997).

Conversely, women whose relationships have been violent or otherwise abusive, or women who have been disconnected from others, experience confusion, low self-worth, diminished energy and creativity, and disempowerment. Given the relational model framework, it is clear that the profile of women prisoners, which includes a high incidence of abandonment, physical and sexual assault, and intergenerational cycles of addiction and criminality, provides insight into the challenges these women face. Having developed her sense of self and identity within abusive relationships, having learned her styles of relating and communication within a context of oppression, impoverishment, chaos, and violence, a woman prisoner cannot be expected to enter treatment and miraculously possess the skills to reverse a lifetime of socialization and successfully navigate the milieu.

Most chemically dependent women prisoners arrive in the CPMP with a variety of difficult issues related to their histories of addiction and trauma. Residents generally have trouble identifying, naming, and expressing feelings. They have generally learned to "stuff" feelings of anger, fear, sadness, and emotional pain, and have not been able to develop skills related to experiencing, understanding, expressing, or resolving their positive or negative feelings. Women commonly use drugs to cope with stressful feelings and relationships. Guilt and shame are primary in the web of confusing feelings that can often control a woman's perceptions, reactions, and choices. Women often feel responsible for the trauma and victimization they experienced as children and/or adults.

The lives of women entering CPMP have been highly stressful for long periods of time before and after being sent to prison and they have generally been separated from their children for at least four to six months by the time they arrive in program. Stress in the lives of imprisoned women is normative and they often deny that they are under stress and have few skills for stress reduction. The women typically try to cope with their stress by ignoring it or acting self-destructively and creating chaotic situations that create more stress. They often experience sleeping and eating difficulties, sleeping or eating either too much or too little. Women who have learned to ignore or stuff their feelings as a coping skill, often do not recognize physical and/or emotional signals that could initiate self-care activities. Many residents do not notice that they are overwhelmed, in physical or emotional pain, tired, or hungry. Women prisoners, as well as chemically dependent women in general, are known to neglect routine dental and other health care needs. CPMP residents also may have difficulty with their thinking processes and find it hard to concentrate for even brief periods on simple activities.

CPMP residents generally have difficulty developing and maintaining relationships. Because of their abuse histories the women have learned not to feel, not to trust, and not

to talk about their reality. They have trouble with accurate assessment of situations and often do not trust their sense of reality. Residents tend to be intolerant of their own and others' mistakes and think in rigid patterns, leaving little space for flexibility, difference or creativity. Trauma denies women the ability to experience mutually nurturing relationships which could ground them in a sense of self-worth, value, and safety. They often will create a crisis situation in order to get nurturing or attention needs met. Women prisoners often feel hyper-vigilant and are constantly aware of and ready to react to others' behavior, and often misinterpret interpersonal signals. Many CPMP residents experience the world around them as intrinsically threatening and are constantly being triggered to defensive reactions, which can manifest in aggressive angry acting out or in isolative, smoldering resentment.

During my first year as manager of the CPMP, I had made some early attempts to provide therapeutic groups and case management services for the residents, but the milieu had been too chaotic and disorganized to maintain any consistency or success. At that time the residents had been totally entrenched in prison culture, and the staff were not skilled enough to support implementation of significant treatment programming. The residents routinely utilized dysfunctional coping skills of manipulation, dishonesty, blame, avoidance, overcompliance, and aggressive acting out to maintain confusion in the facility.

Because of their chaotic, dysfunctional histories, most women prisoners have never experienced a sense of authenticity or control over their life situation. As children, they spent much of their time in survival-based reactive behaviors. As adults in the criminal justice system, they have periodically been under the authoritarian control of law enforcement and institutional personnel. In prison the women have no control over their daily lives. They are told what to do and where to be every moment. The most common

reaction to this environment is to find a niche in prison culture and attempt to gain a sense of empowerment through a variety of manipulative behaviors when interacting with guards and other prisoners.

CPMP residents bring these issues and behaviors into the program milieu. Residents typically manipulate staff with a variety of methodologies. "Staff splitting" occurs when a resident succeeds at pitting one staff member against another in order to advance the resident's agenda. Another common manipulation residents utilize is to adopt an air of extreme urgency and pressure staff for immediate answers to last-minute questions. Women prisoners also use a behavior which can be described as "attack by complaint" where they list the most insignificant to the most significant details and problems as if they all are equally important. They attempt to assert some measure of control over their environment by overwhelming staff with a barrage of complaints about the plumbing, the temperature, the food, the daily schedule, the children's diapers, the soap, the shampoo, and a vast array of other issues. These complaints are presented to staff as if staff should somehow be able to change every detail to insure universal contentment with each and every situation.

Residents manifest these behaviors sometimes in sincere reaction to their circumstances and sometimes with calculated intent. Either way, the desired reaction from staff is confusion, stress, and impaired thinking intended to allow the resident to advance her agenda. The resident who engages in these manipulative behaviors is attempting to get her needs met in the only way she knows. She is struggling with PTSS and her history of oppression, abuse, and disempowerment when she behaves in these ways. She has no experience with getting her needs met by addressing reasonable options and/or solutions from an empowered position. She has rarely experienced reasonable options.

The feminist treatment milieu I aimed to create would provide a structure built of clearly expressed guidelines, expectations, and options, within which a skilled staff team would support the residents in a process of redefining themselves and their relationship to life. The residents' manipulations can be very difficult to deal with, and staff must be skilled with patience, an ability to engage in teamwork, and a willingness to proceed methodically, within procedures, to maintain respect for the residents and stability in the milieu. By providing a space of emotional and physical safety informed by the nurturing of collaborative, mutually growth-enhancing relationships between residents and staff and among residents, the CPMP treatment environment could empower the residents to learn to take care of themselves and take responsibility for their recovery, individually and collectively as a resident community.

Throughout 1994-1996, as the treatment milieu stabilized and the staff team became increasingly more effective in working with the residents and their children, the resident community also began to stabilize. In the fall of 1994, when residents were first required to attend regular treatment programming Monday through Friday, most residents were initially extremely resistant. They found excuses for not coming to group, for being late, for acting disruptively, for refusing to participate, and for having to leave before group was over. And they complained incessantly. Staff were forced to develop detailed procedures in order to manage the residents' manipulations.

Eventually, over time, as the original group of residents were paroled, and as the staff's support and insistence on residents' accountability began to take root, the residents learned that they could trust us to keep our commitments. They began to believe that staff were going to be consistent and respectful in our communication with them and in our management of their behavior and the disciplinary procedures. Gradually, the residents realized that staff could not be manipulated as before. As the treatment milieu coalesced

and stabilized, the groups and classes and other treatment plan requirements began to have the desired effect on the residents and they were able to learn about the process of healing, growth, and recovery.

During this process, over the months and years, the results became more and more obvious. Residents began to follow their schedule, met their paperwork deadlines, and stopped making excuses for resisting the program. They were not perfect. But they began to struggle seriously with their issues in group, challenging each other's dishonesty, refusing to keep each other's secrets. They began to take ownership of their individual recovery and the recovery of the resident community. After women were paroled, they began to call the facility voluntarily for support and to keep us updated on their progress. This was a previously unheard of behavior. Before, women had perceived the CPMP merely as an extension of the prison and they had been so happy to leave, that they rarely would stay in contact. Now many were perceiving the program as a home, a place of renewal, and an ongoing part of their support system. Slowly the prison culture was being dismantled, and when it threatened to return, such as when we received several new women simultaneously, the resident community was capable of taking responsibility for its collective healing and recovery.

CHAPTER V

WISDOM

June 1996–January 1997

The Friends Outside CPMP contract with the California Department of Corrections was scheduled to be renewed in June of 1994. However, CDC was not prepared to enter into the contract renewal process at that time and had provided two one-year extensions on our CPMP contract. Late in the spring of 1996, CDC announced that all seven CPMP contracts statewide were due for renewal and issued a "Request For Proposal" (RFP).

The Contract Renewal Process

The "Request for Proposal" (RFP) process is a standard procedure used to award government grants and/or contracts. Typically, a funding source, in this case CDC, will publish and disseminate an RFP intended to attract service providers to compete for the available contract or grant. The RFP is the document that announces the maximum funding amount and budgetary guidelines and that precisely details the program services competing agencies will be required to provide, if awarded a contract. Agencies wishing to compete for the available contract must submit a proposal that provides narrative information about the proposed program and a budget, as well as other details concerning city permits and fire clearances for the program site, agency history, organizational structure, and staff qualifications, among other factors. RFPs for major funding are typically very detailed and are divided into several categories such as site suitability, programming elements, and budget, which are rated by a panel of experts according to a point system. Points are earned for proposals demonstrating the highest standards within each category combined with the lowest proposed annual budget. Agencies must follow

precise formatting guidelines and submission deadlines throughout the RFP process. Proposals that meet these deadlines and earn the highest point scores win the contracts.

J. Elizabeth Husby and I first learned of the upcoming contract renewal process from the regional parole staff responsible for the administrative oversight of our CPMP contract. When we received the RFP in May 1996, we realized that the CPMP contracting process and the contract itself were about to change significantly, and that the agency's board of directors, management, and staff would need to assess seriously the impact of these changes and develop a strategy to respond to this unexpected situation. Among the most significant of the changes was the fact that the overall contract administration for the CPMPs and responsibility for operational oversight of the seven CPMP sites, would be transferred from the CDC Parole and Community Services Division (P&CSD), to the CDC Institutions Division's Office Of Community Resources, which had established a new unit called the Women's and Children's Unit (WCSU) specifically to oversee programs in the prisons and in the community. The WCSU had been given responsibility for the contract renewal process. WCSU staff had written the RFP and would seat a panel of reviewers to rate the proposals and award the eventual CPMP contracts to new and/or renewing providers. For the first time, Friends Outside would have to compete for its CPMP contract. In reviewing the RFP, Husby and I were impressed with what appeared to be the improved standards and increasingly therapeutic approach of the new WCSU contract administrators.

Essentially, the new contract required that the Friends Outside CPMP would have to expand its available bed-space to house a combined total of 30 mothers and their children rather than 20. This expansion would include an increase in the annual funding amount from just under $400,000 to about $450,000. The RFP reflected significant changes for future CPMP service provision standards as well, establishing addiction treatment along

with parenting skills development as the primary components of treatment programming. Previous RFPs had stated a need for substance abuse education and parenting classes, but had not articulated minimum requirements or standards of service delivery in terms of these programming elements. P&CSD administrators had been satisfied if a CPMP provided two NA or AA meetings weekly for substance abuse programming. Additionally, on-site service provision would now be required for the majority of programming, whereas previously, off-site referrals for most services had been acceptable.

New standards for the CPMP facility staff structure would require a full-time program director, a full-time case manager, a full-time children's program supervisor, and a full-time administrative assistant. Additionally, staff who had previously been called "community corrections worker" (CCW) would now hold the job title of "counselor." The program director, case manager, children's program supervisor, and all counseling staff would now have to possess education, certification, and experience in their field of expertise. For the first time, in this RFP developed by the new WCSU administrators, CDC had articulated detailed programming elements and requirements, and staff qualifications that provided a structure for a legitimate treatment program.

After an initial review of the RFP, Husby, I, and the agency board, agreed that the future direction of the CPMP emerging from our reading of the RFP appeared to be positive. The other six contract providers had not been developing their programs and continued to operate at the level of CPMP service provision I had found upon my arrival at Friends Outside. The program development I had been engaged in for the previous three years had created a treatment program which could easily meet the requirements of the new contract. With the increase in funding, I would be able to expand existing staff positions and hire a full-time case manager. This would clearly improve efficiency and

enable the program to operate more consistently at a much higher level of service provision. Overall, the agency was in an excellent position to compete for contract renewal.

The one major barrier was the fact that, at 2200 square feet, the Helen McCaig House could not accommodate the increase in the number of residents and their children that a new contract would establish. To keep the contract, the agency would have to find a way to provide more space for the CPMP. Coincidentally, the property next door to the CPMP facility had been for sale for several months. This one property included two small, old Victorian houses that had been poorly maintained as multi-family rentals. I believed that these houses would offer the best solution to our problem. The board and management of Friends Outside discussed several other options, including moving the program to another location that could be leased or purchased.

After a thorough assessment of available properties in the area it was decided that purchasing the property next door to the existing facility would be the most effective plan. The other properties which could have accommodated the program needs for space were either out of reach financially or too institutional, or both. The property next door was affordable and would allow the program to retain its current location and maintain the facility's homelike environment, in the most cost-efficient manner available. However, the agency could not risk losing the property to another buyer, and would have to make the purchase without knowing if the CPMP contract would actually be renewed.

In June 1996 the Friends Outside board of directors, management, and staff gathered for a meeting to discuss the CPMP contract situation. The board announced its unqualified support for program staff and belief in the importance of keeping the program contract and continuing to provide quality treatment to the population of women prisoners we serve. A decision was made to move forward and purchase the property next door to

the Helen McCaig House facility. The board of directors would develop a contingency plan for utilization of the new property in the event that we failed to have our contract renewed. I would be responsible for writing the program design sections of the narrative for the proposal and Husby would write the sections detailing the Friends Outside organizational information, the facility siting issues, and the budget. Husby would develop and implement renovation plans for the new buildings once we owned them. I would manage the procurement process for equipping the new houses.

The deadline for proposal submission was August 13, 1996. The CPMP contract RFP was very complex and, in some places, difficult to decipher in terms of content and formatting requirements for the proposal elements. The proposal format required that I write narrative descriptions of the profiles of the women prisoner population and their children and of the program structure and service delivery elements that would meet the RFP requirements for the new contract.

Throughout the summer I maintained the CPMP treatment programming with the residents and staff while simultaneously writing my sections of the contract proposal. Looking toward the future, I was overjoyed to envision the improvements the new contract would bring. In the current CPMP facility, space was extremely limited. All of the CCW staff had to share the one front desk area for their work, and there was only my tiny office in which staff could meet with each other or residents in privacy. The childcare program was housed in the combined space of the upstairs playroom, landing, and two of the upstairs resident bedrooms. The dining and living areas of the house doubled as classroom and meeting space for the residents' groups and classes. The childcare supervisor and I both had double job descriptions, and the administrative assistant only worked twenty hours a week. Service provision under these circumstances was stressful and sometimes inconsistent due to the limited facilities and programming

demands on both myself as combined program/case manager, and on the half-time childcare supervisor. Because the mothers' programming depended on the availability of childcare, and because I was responsible for the on-site groups and classes, if either the childcare supervisor or I was away from work for any reason, programming had to be canceled or rescheduled. Program staff did an excellent job under the circumstances, but the situation created ongoing problems with the consistency and credibility of the programming schedule.

The additional staff provided for by the new contract would significantly alleviate this staffing problem. With a full-time children's program supervisor, the number of available childcare hours could be extended, which would allow for the resident mothers' programming hours to increase as well. With the addition of a full-time case manager, the case management services would be even more consistent, and the case manager and I would be able to share the responsibilities of facilitating individual and group counseling and education classes. Having a full-time administrative assistant on staff would allow for timely completion of clerical work and reassignment to the administrative assistant of other duties that had, of necessity, been shared by all staff. Attributing the title of counselor to the former CCWs would be appropriate to the current staff's skills and experience and add an additional and deserved sense of legitimacy to their work at CPMP.

With the purchase of the two buildings next door, the CPMP campus would consist of three renovated Victorian houses located directly adjacent to each other, surrounded by green lawns and trees, and a fenced area in back well-equipped as an outdoor playground. The original building, the Helen McCaig House, would continue to provide residential living space for the resident mothers and their children, the new case manager would move into the upstairs office, and the childcare area would be moved into a newly

remodeled space on the first floor stocked with all the equipment necessary for a quality children's development program. The first of the two new houses, the middle house of the three, would be devoted only to residential living space. The second of the new houses would be utilized for offices and classroom space. The renovation project would combine two rooms into one large classroom/meeting/conference room. Staff would have a small kitchen and a large utility room available for breaks, meals, and projects. I would have a larger office and the administrative assistant's desk would be in the large reception room. The outside grounds would provide enough area for therapeutic uses such as play and exercise, and planting of vegetable and flower gardens in which residents and their children could learn another way to nurture life. After the years of struggle the program would finally have a facility compatible with treatment goals to support the therapeutic milieu.

The Friends Outside Community Prisoner Mother Program contract proposal was submitted on deadline August 13, 1996. Expecting contract awards to be announced in November, agency management and staff continued program operations while the contractors continued with the renovations of the new buildings. The Salinas planning commission unanimously approved the agency's application for an expanded use permit, and the agency received fire clearances from the city, allowing for the expansion to provide bed-space for fifteen women and their children.

On November 5, 1996, CDC informed Friends Outside that the agency's CPMP contract would be renewed. Friends Outside was the only one of six competing agencies whose CPMP contract proposal and/or treatment program had earned enough points to complete the review process. The struggling little feminist treatment program for women prisoners and their children had won the approval of the largest paramilitary organization in the United States. The remainder of 1996 involved recruiting and hiring new staff and

preparing for the furnishing, equipping, and opening of the facility's new buildings so we could welcome the five new women and their children to their new home and continue the work of assisting women prisoners to heal and empower themselves.

Conclusions and Recommendations

My years of work in the CPMP have convinced me that most women in prison should not be there and that they, their families, and communities would be better served if women had access to treatment programs equipped to provide them with comprehensive addiction and trauma recovery services specifically designed to met the needs of women and their children. In my experience, most women prisoners get into conflict with the law because they have been victimized and oppressed in their families and by society. Most imprisoned women have not had the education and/or employment opportunities necessary to follow their dreams and goals. Many have never envisioned a dream or goal. They are simply trying to survive. They are dependent on drugs, alcohol, men, and crime because they know nothing but dependency.

Women prisoners are not simply victims; the abuse they have suffered has led them to offend. Generally they are guilty of the crimes for which they are convicted. I am not suggesting that we ignore or excuse their crimes out of pity or sympathy. I do advocate for a more reasoned approach to addressing the needs of the thousands of women incarcerated in California prisons and their children. We do not need more prisons. Imprisonment and the authoritarian, controlling, abusive oppression of prison culture does not help women take responsibility for themselves and their families. Prison reinforces dependency, depression, disconnection, and disempowerment for the women forgotten there. It gives them more of what they have always known: shame. This shame about their gender, their color, their size, their age, their sexuality, their intellect, their

being does nothing to convince them to change their lives. These women do not deserve to be thrown away and forgotten by society. We need them to be healed from their oppression and empowered to participate fully in their families and communities.

Community-based programs can offer effective alternatives to incarceration. The research on women prisoners demonstrates that the majority are convicted of non-violent drug related and property crimes. These women are chemically dependent and need drug treatment. They are trauma survivors and need trauma recovery treatment. The Community Prisoner Mother Program in California is a beginning and provides an opportunity for the correctional system to join in partnership with communities to offer healing to an almost invisible population of women.

After the Friends Outside CPMP contract was renewed, CDC's Women and Children's Services Unit repeated the RFP process and eventually awarded the remaining contracts to addiction treatment providers who had not previously held CPMP contracts and had not been involved in community corrections. The transition has not been easy for the WCSU staff or CPMP providers. The CDC culture and addiction treatment culture are in many ways incompatible, yet the WCSU and the CPMP providers are in the process of attempting to create a new model of treatment for women prisoners. Friends Outside is the only former CPMP provider that saw the need for, developed and implemented addiction treatment services, three years prior to its being required by CDC. The California CPMPs have improved significantly since the WCSU has assumed responsibility for contract administration and operational oversight of the individual programs, yet problems remain. My years of experience working with women prisoners and their children and with the CPMP procedures lead me to offer these recommendations:

Sentence women directly from the courts into community-based CPMP placement. The law that established the CPMP in 1979 requires that women must first be sentenced to

prison and have completed the reception process before they can apply to be placed in CPMP. This process can take up to four months and when a woman is approved for placement, she can be on the waiting list for several more months. Many women have already been incarcerated in county jails for months before being sentenced to prison. This system prolongs the mother/child separation. If she is pregnant when she enters prison, her baby may have to be delivered in prison, where it will be removed from her and taken to foster care within hours. Direct sentencing minimizes separation and bonding trauma for the child and mother and allows for treatment to begin immediately.

Standardize the length of stay in CPMP placement by allowing judges to offer a set term of two years to eligible women to do their time with their child. Current law allows for women incarcerated in state prison to be placed in CPMPs after being processed through the prisons. Once they arrive in a CPMP their length of stay is dependent upon the length of the remainder of their prison sentence. Some women come to CPMP treatment with two months left on their term, and some come with up to six years. A standard two-year term for all CPMP placements would provide accountability to the community for the crime committed. Two years would provide the woman with the long-term treatment needed for her to change her behavior patterns. Standardized length of stay would enable programs to manage better the treatment milieu, provide more equitable treatment opportunities and offer an improved quality of care to all residents placed in program.

Increase funding to allow for establishment of CPMP facilities in most California counties. An increase in the number of CPMP sites would allow more women prisoners access to the treatment necessary to prevent further conflict with the law, further trauma to their children, and perpetuation of generational cycles of crime. Currently, to access CPMP treatment, women must be placed long distances, often hours of travel time, away from their families and children not living with them in the program. Most CPMPs are not able to provide the family treatment component that is the standard of care in addiction treatment. More localized siting of CPMPs would facilitate essential family participation in the treatment process and allow women to participate in the parenting of all of their children. Continuity of care would be possible if the prisoners remained in an area local to the CPMP in which they received treatment and could attend continuing care programming which is the standard of care in addiction treatment. Localized CPMP siting would also enable the women who graduate from the program to continue to utilize the extensive community support system they develop during treatment.

Allow CPMP managers and staff from all sites to come into the prisons and facilitate the orientation process for prisoners who may be eligible for CPMP placement. Currently, prison staff who have never seen the CPMP facilities and know little of their services, conduct the orientations. Because prison staff are most often familiar with the previously inadequate quality of CPMP services and are not educated about the current quality of treatment available in CPMP, they often discourage women prisoners from applying for placement. Women prisoners report that the prison staff often cannot answer their questions accurately, and in fact that misinformation has prevented women from applying for placement.

Provide funding to implement management information systems capable of data collection and analysis. Empirical evidence to substantiate anecdotally supported knowledge that community-based women-specific treatment generates successful outcomes for women prisoners and their children is critical to insuring future development and replication of these valuable programs.

I have struggled to remain true to my vision of a feminist treatment community which focuses on women's ability to empower themselves through discovering their own strengths and value and through building connections with other women so they can find themselves. Writing the contract proposal that summer of 1996 gave me the opportunity to look back and review all that had been accomplished through the hard work of an amazing group of women. I was fortunate to have been hired by J. Elizabeth Husby to manage a program she believed in and wanted to nurture. Her trust and support have enabled me to create a model program informed by feminist values in the midst of a conservative political environment. I have enjoyed the challenge of bringing together a staff of diverse women who struggled through their own issues as we worked hard together under very difficult circumstances to bring respect and partnership to our work with the resident mothers and their children. And I have been grateful to work with the women prisoners who come to the program to be reunited with their children and in the process discover themselves. The relationships, commitment, and hard work of all of these women continue to enrich and inform the emergence of feminist values in the care and treatment of imprisoned women.

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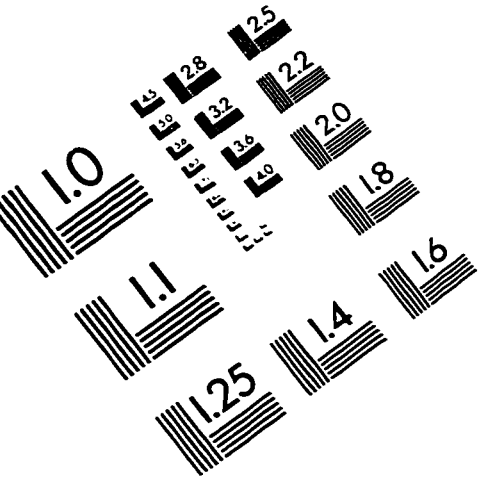
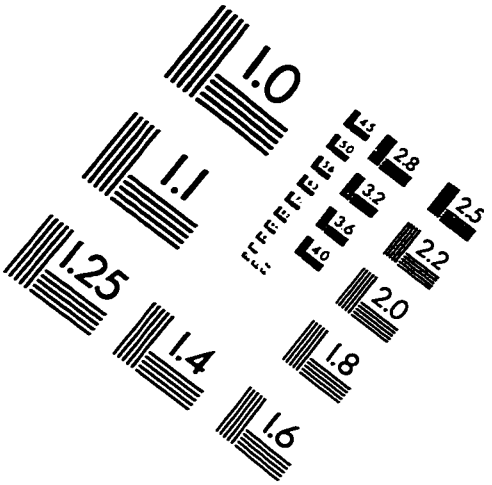
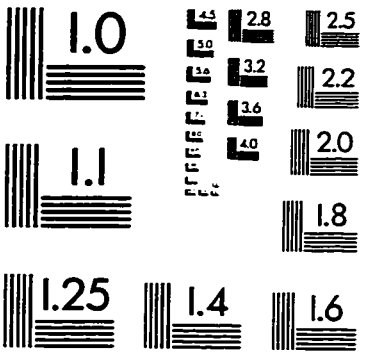
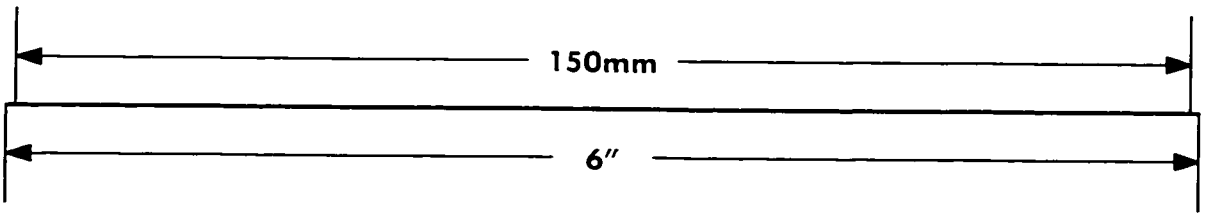
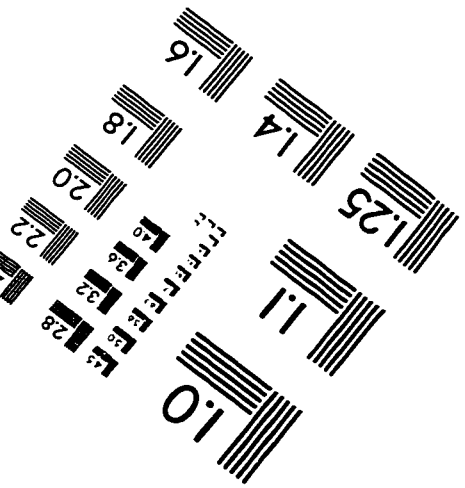
IMAGE EVALUATION TEST TARGET (QA-3)

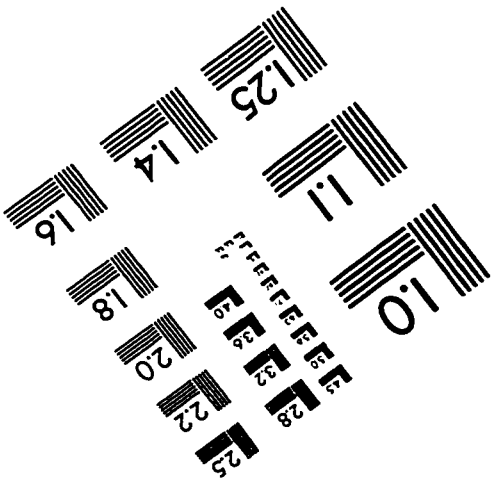












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