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Peer Recovery Services

New Hampshire: Community-Based Group Collaborates With State Corrections Agency to Provide Leadership Training for Incarcerated Women

by Niki Miller, M.S., C.P.S.

In July 2005, I stood in front of 40 women, their folding metal chairs crammed into a gray room at Shea Farm, New Hampshire's minimum security/halfway house facility for women. I was holding an outreach session for a peer-led organization of women in co-occurring recovery from alcohol and drug problems, trauma, and mental health issues.

Shea Farm's name always conjures a thousand images. For me, one of the clearest of them is of Sandy, a 23-year-old mother of three, with hair pulled back in a terse ponytail and a face like one of those drowned Pre-Raphaelite beauties. Sandy wanted to take our women's leadership training, a four-day series of peer-led empowerment groups that my organization was bringing into the facility. She would max out in February 2006, but her parental rights were going to be terminated in January. I wanted to get her into a leadership training in

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Incarcerated Mothers

Justice for All: A Mother's Day in Court

by Beverly McLeod Iseghohi

Few groups have been less visible—and more endangered—than incarcerated mothers. The legal challenges they face in order to protect their parental rights attract little or no media attention. Incarcerated mothers lack the allure or publicity of "celebrity moms" who challenge court orders that prevent them from spending time with their children. As the number of women in prison continues to explode, this problem should be a source of deep concern.

In 1997, approximately 80,000 women were incarcerated in the United States. As of 2006, in the aftermath of draconian sentencing laws introduced in the 1990s, the number of incarcerated women increased to more than 104,000. In June 2007, the Bureau of Justice Statistics reported a 4.8% increase for incarcerated women. (Sabol, Minton, and Harrison, 2007.) Their numbers rose at a faster rate than the rate for men. The majority of incarcerated women are mothers. The explosion in the number of incarcerated women has prompted the publication of several studies on the impact of a mother's incarceration on her children. (Conway and Hutson, 2007.)

Effects on Children

Studies show that children of incarcerated mothers experience anger, alienation, hostility, feelings of abandonment, and overall dysfunction. (Wright and Seymour, 2000.) These children are far less likely than their peers to excel in school and are much more likely to engage in activities such as gangs, sexual misconduct, substance abuse, and overall delinquency. The emotional devastation of parental termination to children and their mothers warrants the court's exhaustive deliberation and scrutiny before permanently severing the mother-child bond. Termination of parental rights should be a legal device used in rare cases. Instead, the number of cases involving parental rights termination of incarcerated parents more than doubled from 1997, when the Adoption and Safe Families Act was introduced, to 2002. (Margolies and Kraft-Stolar, 2006.) The Adoption and Safe Families Act requires states to move to end the rights of parents whose children have been in foster care for 15 of the past 22 months. The Act spurs fast-track adoptions, setting short, strict time limits for parents to comply with court orders.

Children's rights advocates view these time limits—and the placement of children in foster care—as problematic. A report published by the Brennan Center for Justice urges the federal government to provide states with guidance on how to meet the needs of children in foster care and their incarcerated parents. (Allard and Lu, 2006.) The proliferation of such literature establishes a strong

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the community she would soon re-enter. She was from the Lakes Region, a rural area where millionaires' summer homes and long-established prep schools flourish around the corner from communities with the highest dropout rates in the state. Sandy's Lakes Region was littered with barely insulated trailers that miraculously withstood harsh winters.

I asked Sandy if she could get a continuance, delay the termination hearing, or contact the judge. "Not this judge," she said. "He terminated my parental rights to my first two kids and put me in the system when I was seven." Leadership training was the best intervention our women's recovery support organization had to offer Sandy and other rural New Hampshire women with intergenerational vulnerabilities and needs.

Brief History

The New Hampshire State Prison for Women was established in response to a 1983 class action lawsuit that mandated the state to create a separate facility to house females and to ensure "conditions of confinement and programs and services on parity with those provided to male New Hampshire State prisoners." (New Hampshire Commission on the Status of Women, at 11.) In the late 1990s, New Hampshire's corrections commissioner requested a National Institute of Corrections (NIC) technical assistance site review of the facility. The NIC's report pointed out that the state was still open to potential legal liability due to inadequate programming, vocational training, and housing that was not on par with men's facilities. (National Institute of Corrections, 2003.) Shortly afterward, the women classified for work release were moved out of the halfway house at the men's facility and taken to Shea Farm along with minimum security incarcerated women from the prison.

Initial Needs Assessment. In 2002, our grassroots organization, the New Hampshire Taskforce on Women & Recovery (TWR), was established to improve the lives of at-risk and recovering women, girls, and families affected by alcohol and other drugs. The group's initial needs assessment identified numerous gaps in prevention, treatment, and recovery services for women in New Hampshire. The report designated women in the criminal justice system as a priority. (Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention, and Treatment, 2003.)

In 2004, the New Hampshire Commission on the Status of Women released their report, entitled *Double Jeopardy*, which brought widescale attention to the severity of the issues facing women in state custody, including mental health problems, single parenting, domestic violence, and poverty. There were still blatant disparities in services offered to incarcerated women and men, including the failure to provide adequate substance abuse treatment services for women. (New Hampshire Commission on the Status of Women, 2004.)

In June 2004, TWR applied for technical assistance from the National GAINS Center to bring in experts on women's correctional programming, including Dr. Joan Gillece of the Maryland Mental Hygiene Administration. She came to New Hampshire along with Warden Steve Williams of Maryland's Dorchester County Detention Center and Loel Meckel, L.C.S.W., director of Community Forensic Services from Connecticut's Department of Mental Health and Addiction Services for two days of conferences. TWR held two days of trainings and events. We collaborated with the Commission on the Status of Women to convene a breakfast with high-level corrections staff and public policymakers. The result was the beginning of an alliance between the NHDOC and women's advocacy groups.

Indictments Handed Down. But in 2005 all hell broke loose for dozens of victims living at the Shea Farm facility when numerous indictments for rape and sexual assault were handed down by the New Hampshire Attorney General's Office against a corrections officer who to date has been convicted of multiple counts of rape, felonious sexual assault, and assault. Currently, he faces 52 additional related charges. (Timmons, 2006.)

The Taskforce on Women & Recovery's involvement with Shea Farm increased as the trauma that resulted from this scandal reverberated throughout the justice-involved women's community. I met Sandy shortly after the officer assaulted, raped, and sexually assaulted

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Inspection Report

Independent Assessment of Mental Health Programs and Services at the Bedford Hills Correctional Facility in New York State

by the Correctional Association of New York's Women in Prison Project Visiting Committee

Editor's Note: *In the United States, the Correctional Association of New York has rare statutory authorization for a private organization to conduct regular inspections of state prisons. The particular inspection described in this article was conducted on January 9, 2007, in conjunction with the organization's Women in Prison Project. The article itself details some of the group's observations regarding the facility's mental health programs and services based on information gathered from both inmates and staff. The full report, which covers additional topics and includes footnotes and recommendations for various state agencies, is available at* www.CorrectionalAssociation.org/WIPP/prison_monitoring/Bedford_Mental Health_2007.pdf.

Mental Health Overview

Bedford Hills is designated as a mental health level one facility, which means that it has the capability to provide women with the most intensive mental health services available in the state prison system. The facility has a 16-bed Intermediate Care Program (ICP), a 15-bed Residential Crisis Treatment Program (RCTP) with nine dormitory beds and six observation cells (operated by the Department of Correctional Services with the Office of Mental Health providing clinical services), a 16-bed Therapeutic Behavioral Unit (TBU), a 50-person Mentally Ill Chemically Addicted (MICA) program, and a 60-person Network program. Bedford's MICA and Network programs, ICP, and TBU, are the only programs of their kind for women inmates in Department of Correctional Services (DOCS) custody.

Caseload Increase. As of January 2007, more than 50% of Bedford's total population (421 women) was on the Office of Mental Health (OMH) caseload. This figure represents an increase in the percentage of inmates on the caseload in July 2005 (42%). Of the women on the mental health caseload, 30% had been diagnosed with a major mood disorder (which includes depression, psychotic depression, and bipolar disorder) and 15% had been diagnosed with a psychotic disorder (which includes schizophrenia). A total of 44% of women on the caseload had an Axis I diagnosis. Just over 72% were taking psychotropic medication; nearly half were taking neuroleptic medication.

From January to June 2007, Bedford had 10 admissions to Central New York Psychiatric Center, an OMH-run secure psychiatric hospital located in Marcy, NY, with 17 beds reserved for state-sentenced women inmates. Nine of these admissions were from Bedford's general population and one was from the Special Housing Unit (SHU).

During that same time period, Bedford had 197 admissions to its RCTP, which provides short-term housing for inmates in psychiatric crisis and intensive monitoring for inmates on suicide watch. Thirty-five of these admissions were from SHU, 42 were from TBU, and 120 were from general population.

Extraordinary Challenges. The challenges facing OMH and DOCS in providing adequate care to the hundreds of women suffering from mental illness at Bedford Hills are extraordinary. In recent years, both agencies have taken constructive steps, which we strongly support, to expand the facility's mental health program. Nevertheless, it is clear that serious deficiencies in the facility's mental health services persist and that substantial improvements are needed to ensure that the women in Bedford's custody receive appropriate mental health treatment and support.

The positive aspects of the facility's mental health program include the following:

- The opening of the TBU, the diversion of a number of otherwise SHU-bound inmates to the unit;
- The opening of the MICA program;
- The continued operation of the ICP and Network program;
- Positive feedback from inmates about the quality of many mental health staff members;
- Improved mental health assessments of women in the SHU;
- Reports from inmates that psychotropic medication is distributed in a timely fashion and that medication side effects are explained by mental health staff;
- The maintenance of a solid medication contraindication/reconciliation system; and
- Aggressive recruitment of new staff to fill vacancies.

Our main concerns include the following:

- Insufficient mental health services for women in Bedford's general population;
- The confinement of women with serious mental illness in SHU and inadequate mental health services for SHU-confined inmates;
- Flaws in the TBU model, including requiring inmates to remain in SHU, ticket-free for at least a month before being transferred to the TBU unit and having return to SHU as a potential consequence for misbehavior;
- The underutilization of the TBU and ICP;
- The absence of a mental health component in MICA and the lack of adequate mental health staff for the program;
- Mistreatment of inmates by certain correction staff assigned to the TBU and to the MICA and Network programs;

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- Inadequate staffing for the Network program; and
- The lack of a gender-specific, culturally sensitive, and trauma-informed approach to Bedford's mental health-related programming and services.

Gender-Specific, Culturally Sensitive, and Trauma-Informed Mental Health Services

Bedford Hills has a long history of offering inmates abuse counseling services through its Family Violence Program, a 12-week program for survivors of domestic violence. Unfortunately, there has been a dramatic drop off in participation in this important program. According to a 1994 DOCS report, there were 137 women in the Family Violence Program in December 1993; at the time of our visit, there were only 13 women participating. The program had a capacity of 32 and was staffed by three social workers. These numbers call for an examination of the reasons for the decrease and the creation of a plan to revitalize the program.

A critical need exists not only for courses like the Family Violence Program, but also for mental health services that are developed and implemented with an understanding of the consequences of trauma, the particular mental health issues facing women inmates, the varied experiences of women from different racial and ethnic backgrounds, and the linguistic and cultural barriers individuals may face in accessing treatment and support. An estimated 82% of women at Bedford Hills suffered severe physical or sexual assault during childhood and an estimated 90% have experienced violence in their lifetimes. Being incarcerated, surviving in the prison environment, and being separated from children and other loved ones are often highly stressful, regardless of an individual's personal history. In addition, we also urge that any staffing needs assessment include an evaluation of whether the facility has sufficient Spanish-speaking mental health staff.

The DOCS has recently taken the positive step of creating an executive level taskforce on issues facing women inmates. This taskforce represents an opportunity for the Department to initiate an effort to ensure that all women's facilities offer effective abuse counseling programs and gender-specific, culturally sensitive, and trauma-informed services. Such services would not only allow women inmates to more effectively access assistance and support, they could also help to reduce recidivism rates and improve facility safety and efficient overall operations.

Mental Health Services in Special Housing Unit

At the time of our visit, 22 of Bedford's 24 SHU cells were filled. OMH staff estimated that 14 of the 22 women (63%) in SHU were on the OMH caseload. Six of the 14 had applications pending for the TBU. OMH staff informed us that all inmates admitted to the SHU are assessed by mental health staff within 24 hours and that OMH conducts rounds in SHU seven days per week.

This taskforce represents an opportunity for the Department to initiate an effort to ensure that all women's facilities offer effective abuse counseling programs and gender-specific, culturally sensitive, and trauma-informed services.

The women in SHU we spoke with confirmed the frequency of rounds and that they had been seen by OMH within a day after being transferred. OMH also reported that SHU inmates on the mental health caseload meet with counselors about twice per month and with a psychiatrist once per month, though the frequency varies on a case-by-case basis. These meetings are held in one of two private rooms in the SHU building. There are no group sessions for inmates with mental illness in SHU.

Mental Health Conditions Worsen. Most women in SHU had positive remarks about the quality of mental health staff members they met with. Even with these counseling services, however, many women told us that their mental health condition had worsened since being placed in SHU. Two situations warrant particular attention: One woman who had been diagnosed with depression and post-traumatic stress disorder reported having tried repeatedly to harm herself while in SHU; she had an application pending for the TBU, but had not yet been approved for transfer. Another woman, diagnosed with manic depression, reported that she had recently been transferred back from the facility's observation cells after trying to kill herself. This woman reported having met with mental health staff only a few times per month before the incident. In general, she seemed disoriented and was unsure if anyone had spoken to her about the TBU.

Restrictive Setting Aggravates Conditions. There is widespread recognition by mental health experts that inmates suffering from serious mental illness should not be placed in SHU. The unit's restrictive setting aggravates most mental health conditions and can cause inmates to decompensate, even if they are able to meet with counseling staff on a regular basis. In the beginning of 2007, one woman at Bedford who had been diagnosed with mental illness committed suicide while she was in disciplinary confinement. In 2006, Bedford reported two Unusual Incidents (UIs) concerning self-injury in SHU. That year, four women from SHU were admitted to CNYPC. From January to June 2007, one woman from SHU was admitted. During that same time period, there were 35 admissions to Bedford's RCTP from SHU.

Some inmates in SHU communicated that the lights inside their cells were too bright and disrupted their ability to sleep. Members of our visiting team observed that many SHU cell lights were half-covered by sanitary napkins—an attempt on the part of some inmates to make the room darker at night. The superintendent explained that the lights allowed officers to check

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on inmates to make sure they were "still breathing." Although these concerns are understandable, sleep deprivation can have an acutely adverse effect on any individual, especially one already suffering from mental illness.

Women in SHU and in general population also reported that although some correction officers maintained a professional attitude, others verbally harassed inmates in SHU with mental illness. Reports of harassment included officers using degrading and derogatory terms and taunting or provoking inmates with mental illness to misbehave.

Therapeutic Behavioral Unit

Created in June 2005, Bedford's TBU is a 16-bed unit jointly run by DOCS and OMH for mentally ill inmates who have chronic disciplinary problems and who would otherwise remain in disciplinary confinement. The unit's target population are inmates who have:

- An Axis I and/or Axis II diagnosis;
- A demonstrated pattern of Axis II behavioral traits;
- A "disciplinary pattern of disturbed, disruptive behavior with self-control deficits and violent or disruptive impulses"; and/or a pattern of "instrumental assaults on staff/inmates" and "custodial management challenges"; and
- A profile that matches the "therapeutic mix of currently admitted inmate-patients for a balance of patients modeling appropriate behaviors with those needing more intensive treatment."

Case-by-Case Evaluations. When we inquired about which SHU inmates would be considered ideal candidates for TBU placement, staff explained that they look for inmates who need intensive mental health services and who have the potential to succeed in the program.

After conducting an initial assessment, the psychologist assigned to SHU can recommend that an inmate be evaluated for TBU placement. The OMH unit chief and other clinical staff evaluate the recommended inmate and, with the superintendent and other DOCS staff, make a final decision about whether to transfer the inmate to the unit. Evaluations are done on a case-by-case basis and it seems that no inmates, even those without formal Axis I or Axis II diagnoses, are automatically excluded from consideration for TBU placement.

Model Phases. The TBU model is comprised of three phases. The first begins while inmates are still in SHU. Once an inmate is accepted into the program, Phase I consists of informing that inmate about the TBU and the expectations of inmates in the program. In order to move to Phase II—and be transferred to the TBU—an inmate must have at least 30 days of "outstanding behavior," including remaining ticket-free during that time period. After the 30-day period, staff estimated that it takes about two weeks to be transferred to the unit.

During Phase II, inmates are transferred from SHU to the TBU, where they remain "on probation" for the first two weeks, meaning that they are allowed to attend certain groups but are required to remain in their cells for most of the day, including meals. Phase II inmates must maintain good behavior and remain ticket-free during the probationary period to earn "privileges," including the ability to participate in additional therapeutic groups, recreation on a different floor in the building, and meals with other inmates on the unit.

Meetings, Groups. TBU inmates meet at least once per month with a psychiatrist and more often with psychologists and social workers; determinations about frequency are made on an individual basis. For inmates who have successfully completed the Phase II probationary period, these one-on-one meetings are held either on the unit in a private office, on the unit's main area outside of the cells, or off the unit in an OMH office. In addition, each TBU inmate is evaluated every 30 days by a Case Management Committee consisting of DOCS correction staff, DOCS medical staff, and OMH staff. For inmates transferred to the TBU from other facilities, weekly telepsychiatry meetings are held with mental health staff from Bedford Hills and the transferring facility. Staff explained that inmates who decompensate in TBU are transferred first to Bedford's RCTP and then to CNYPC if necessary.

In addition to the individual meetings, Phase II inmates participate in therapeutic programming for four hours per day, five days per week. Two hours per day are spent in "core groups"—therapeutic community, relapse prevention, communication skills, medication education, anger management, positive changes, poetry, spirituality, change, and art. The other two hours are spent in "leisure groups," which consist of yoga, current events, bingo, and art therapy.

Phase III, Discharge. TBU inmates must remain ticket-free to earn their way into Phase III. Inmates in this phase are allowed additional out-of-cell time and can continue earning "privileges," including the ability to participate in certain programs with general population inmates. The Case Management Committee decides on an individual basis when Phase III inmates are ready to move off the unit. Inmates can be discharged from the TBU to the ICP, to the MICA program, to the general population at Bedford Hills, or to the general population of the facility from which they were initially transferred. Inmates can also be transferred back to SHU for more serious disciplinary infractions. If an inmate "maxes out" (finishes her sentence while in the TBU), she can be sent from the unit directly back to the community.

Time spent in the TBU is considered part of an inmate's SHU sentence and inmates can earn time off of their SHU sentence for good behavior. Tickets can also be given to inmates in the TBU. If an inmate receives a ticket, the circumstances of the ticket are evaluated by a team consisting of both mental health and DOCS staff. OMH staff reported that decisions about ticket penalties are made on a case-by-case basis and that no one entity or individual "overrides a decision" about what to do with a TBU inmate who receives a ticket. If the offense is serious, the inmate might accrue additional SHU time, lose TBU "privileges," or be sent back to SHU. Minor offenses carry penalties that are less severe. OMH declined to give us specific data about whether any women in the TBU had accrued additional SHU time or earned time cuts, and, if so, how it was accrued or earned. OMH stated that this information would be available in the agency quarterly reports required by the recent settlement of a lawsuit on behalf of Disability Advocates, Inc., concerning people with mental illness in DOCS custody.

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Program Evaluation

Some women we spoke with had been in the TBU for a few months; others reported being in the unit for over a year. Women had positive feedback about the quality of mental health services in the TBU, described the OMH staff as caring and accessible, and reported that, unlike their experiences in SHU and general population, they met with counselors in the TBU as often as they needed. Inmates' main concern regarding mental health staffing focused on their anxiety about interacting with and trusting new OMH staff members. Women also had positive remarks about the TBU's group sessions, especially because the groups allowed them to leave their cells without restraints and to interact with other inmates.

Overall, we hold the view that incarcerated women, DOCS, OMH, and society at large would be better served if women with serious mental illness were removed from the prison context altogether and placed in secure community-based facilities designed specifically to manage and treat their conditions. Nevertheless, the more intensive mental health services, ability to participate in individual and group therapy, increased access to OMH staff, and additional out-of-cell time for therapy and recreational activities clearly make the TBU a substantially better place than SHU for women with serious mental illness.

Our concerns about the program fall into five main areas:

1. Requirement to remain in SHU;
2. Heavy reliance on the threat and/or use of disciplinary sanctions to motivate compliance with prison rules;
3. Underutilization;
4. Staff screening and training; and
5. Lack of comprehensive discharge planning services.

Requirement to Remain in SHU. The program's goals are undermined by requirements that inmates remain in SHU for more than a month even after they have been deemed an appropriate TBU candidate and that they maintain "outstanding behavior," including remaining ticket-free, during the time in which they are waiting to be transferred to the TBU unit. These requirements are highly problematic: Spending an extended period of time in SHU's restrictive environment can be severely detrimental for inmates with serious mental illness. Particular behavioral traits associated with certain mental illnesses are symptomatic, not willful. Without more intensive treatment and services, certain mentally ill inmates may not be able to refrain from engaging in the same type of behavior that led them to violate prison rules in the first place or may decompensate before they meet the requirement for transfer.

Ultimately, these regulations decrease the chance that some inmates in dire need of more intensive treatment will receive that treatment. That six of the 14 women in SHU on the mental health caseload had applications pending at the time of our visit and that the TBU's estimated average census (14) is lower than its operating capacity (16) may be, in part, a result of the difficulty inmates have in overcoming this barrier to transfer. Additionally, characterizing the month an inmate spends in SHU preparing for transfer to the TBU unit as "Phase I" is a misnomer. As SHU inmates do not receive the more intensive services offered to inmates in the TBU, time spent in SHU should not be considered part of the TBU program.

Heavy Reliance on Threat, Disciplinary Sanctions to Motivate Compliance. The TBU model relies too heavily on the threat and/or use of disciplinary sanctions to motivate compliance with prison rules. Even with individual assessments, the TBU's disciplinary system is likely to be ineffective and demoralizing for many of the inmates the unit was developed to aid. While the possibility of punishment might deter a healthy inmate from engaging in inappropriate behavior, certain mentally ill inmates may not be able to perform the same action/consequence calculus or stop themselves from engaging in inappropriate behavior even if the consequences are well understood. It is telling that every woman with whom we spoke had received multiple additional tickets since being placed in the TBU. Additionally, the TBU's disciplinary system, which retains transfer to SHU as a potential punishment, is misguided. From a mental health perspective, sending an inmate from TBU to SHU is counterintuitive: A person who is unable to conform to appropriate modes of behavior even in an environment like the TBU is a person in need of more help, not less. Sending that person to SHU, where there will be fewer mental health and other support services and more time in isolation, will likely cause her mental health condition to deteriorate and increase the chance that she will violate even more prison regulations.

Underutilization. The TBU is underutilized. The TBU's intensive services and supportive environment are highly beneficial to the otherwise SHU-bound inmates who live there. We question why more women are not applying for, being accepted into, or being put on the waiting list for the unit. The often-disproportionate representation of mentally ill inmates in disciplinary confinement indicates that more women should be appropriate candidates for TBU placement.

Staff Screening and Training. Staff assigned to the TBU are not appropriately screened or trained. On the positive side, inmates commented that many officers treat TBU inmates in a respectful and reasonable manner. On the other hand, every TBU inmate we spoke with communicated serious distress about the treatment from certain officers assigned to the 7:00 a.m. to 3:00 p.m. shift. They described these officers as verbally abusive, taunting and provoking inmates to misbehave. Mental health staff explained to us that all TBU officer positions are "bid positions," meaning that more senior officers have the ability to pick whether they want to be assigned to the unit. Even though officers assigned to the TBU participate in additional mental health training, using a bid system ultimately makes it difficult to ensure that officers assigned to TBU posts are those best suited to work in the unit's difficult and sensitive environment.

Lack of Comprehensive Discharge Planning Services. The TBU lacks comprehensive discharge planning services. At least five inmates have been released directly from the unit to the community. OMH reported that inmates who "max out" receive basically the same discharge planning as other inmates, with additional emphasis on con-

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necting them with community-based mental health services. OMH staff also noted that they do not collaborate very closely with Bedford's transitional services staff. Without comprehensive discharge planning services, TBU inmates are more likely to experience disruptions in the continuity of their care and to recidivate.

Mentally Ill Chemically Addicted Program

Bedford's MICA program is the only one of its kind for women in the state prison system. The MICA program was staffed by one supervisor, three DOCS correction counselors, and one senior corrections counselor. At the time of our visit, no OMH staff were assigned to the program and DOCS MICA staff did not have a regular meeting schedule with OMH personnel. Although an OMH counselor had been assigned to MICA for a few hours each week to conduct 30-minute individual sessions with inmates, this counselor had left the facility a number of months prior to our visit and her position had not yet been filled. MICA counselors informed us that if a situation requiring additional mental health assistance arises, they ask OMH to intervene. A three-day OMH training course for DOCS MICA staff does exist, but had not yet been implemented because of staff turnover.

No Participation Restriction. To be accepted into MICA, an inmate must be on the OMH caseload and have ASAT completion as a requirement of her DOCS work and treatment plan. Inmates who complete the program are considered to have fulfilled their ASAT requirement. If an inmate has already successfully completed ASAT, she is generally not allowed to participate in MICA as well. Women can fill out a MICA application themselves or be referred by DOCS or OMH staff. There is no participation restriction for inmates with more serious mental health diagnoses and inmates are not required to have a particular diagnosis to gain entry into the program.

MICA has a 39-week curriculum set by DOCS central office. The counselors we spoke with explained that the goal for MICA is to have the program operate like a therapeutic community (TC), although the TC model had not yet been fully incorporated into the program structure. The program has two groups, each of which was comprised of about 20 inmates at the time of our visit. One group participates in MICA programming for three hours during the AM module; the other participates during the PM module. As of January 2007, programming consisted of one group session five days per week and brief individual sessions on an ad hoc basis. MICA inmates are allowed to participate in programs with the general population during their non-MICA modules.

The group of inmates in MICA at the time of our visit was the second group to participate in the program since it opened in 2005. Thirty-six out of 50 women in the first group to be assigned to MICA completed the program's full course. Counselors reported that inmates were most commonly removed for disciplinary infractions.

Program Evaluation

OMH staff estimated that approximately 80% of women on the mental health caseload also had a substance abuse diagnosis. We strongly endorse the concept of integrated treatment—a model proven to be more effective than separate substance abuse and mental health treatment (either "sequential" or "parallel") for individuals with dual diagnoses. At the time of our visit, the program had a number of serious deficiencies and problems, including an insufficient mental health component, the lack of both OMH staff and specially trained DOCS staff, the absence of a substantial residential component, and poor treatment from some correction officers. Overall, the program seemed to be operating as an ASAT program with a MICA population.

The inmates we spoke with generally praised the quality of the MICA counselors but expressed considerable disappointment with all other aspects of the program. In fact, during our tour, inmates were frustrated that MICA counselors had agreed to spend an entire meeting discussing the program's shortcomings and possible solutions—a conversation which members of our visiting team were grateful to have the opportunity to observe.

Officer Treatment. A primary concern for inmates was that certain officers on the unit called inmates derogatory names, made degrading comments related to their mental health status, and seemed loathe to respond when women requested to see mental health staff. Many women reported that officer treatment was worse in MICA than in general population. Others mentioned that some women preferred to stay in their cells as a result of feeling unsafe around officers. One woman explained that she had not left her cell for the entire weekend (when there were no MICA programs and no civilian staff assigned to the unit) because she did not want to interact with one of the officers on duty.

Women also reported that they met with OMH only about once every month (the same meeting schedule for most general population inmates on the OMH caseload) and were unable to discuss mental health issues in group sessions because of the lack of trained staff. Many explained that group sessions lacked structure and that there were few other activities on the unit aimed at creating a sense of community and support among the inmates living there. That 15 of the 51 women in MICA's first group did not finish the program's full course and that several women from the second group had also been removed may be due, at least in part, to the program's inadequate mental health and support services and problems with officer treatment.

Restructuring Needed. Both the superintendent and the OMH unit chief agreed that more could and should be done to build MICA's mental health component. The superintendent informed us that Bedford Hills was planning to hire a full-time DOCS psychologist who would be assigned to MICA for at least some of his or her hours. The unit chief also mentioned that OMH hoped to reassign a staff person to work with the program. While we support these efforts, to provide truly effective services, Bedford must take additional steps to restructure the MICA program. Such steps involve the incorporation of principles of evidence-based treatment for individuals with dual diagnoses, including the "cross-training" of mental health and substance abuse staff, the provision of comprehensive mental health and substance abuse services, and the implementation of other services aimed at strengthening program participants' "immediate social environment" and support networks. ■

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the women living at Shea Farm. TWR asked the office of the New Hampshire Attorney General to fund technical assistance to determine the effects of this victimization on the women at both facilities. Dr. Bonita Veysey of Rutgers University came to New Hampshire and interviewed victims and staff. Her report recommended increased mental health services, a re-examination of the liberal use of psychiatric medication, and programming and staff training based on trauma-informed principles. (Veysey, 2006.)

Peer Recovery Support Services

In New Hampshire, the estimated rate of substance abuse among incarcerated people is as high as 85%. (Minard, Merrow, Stapleton, and Gagnon, 2002.) Most corrections staff agree that the number is higher among women offenders. Research in the field of women in corrections suggests that increases in rates of women's incarceration are driven by substance abuse and addiction. (Grella, 2007.)

Over the last 10 years the Substance Abuse and Mental Health Services Administration (SAMHSA) has funded peer-to-peer recovery services organizations throughout the country with both mental health and substance abuse treatment funds. They have supported the creation of recovery community organizations (RCOs)—not to be confused with self-help groups—as an essential part of transformation to a recovery-oriented system of care. (SAMHSA, 2007.)

In the beginning, these organizations were initiated as advocacy groups. They then moved to fill some of the gaps that professional services could not fill. Women's peer-to-peer services grew out of the specific needs of recovering women who tended to have a high rate of co-occurring issues such as mental health problems, justice involvement, trauma, and single motherhood. (Governor's Commission on Alcohol and Drug Abuse Prevention, Interventions, and Treatment, 2003.) Until recently the treatment system's approach to women was at best fragmented and at worst retraumatizing. Effective women's peer recovery services can be more culturally responsive if they are built around the issue of trauma. A strength-based approach that returns a sense of safety and autonomy and a sense of authority over past adverse experiences has been effective. (SAMHSA, 2007.)

Peer recovery services for people involved with the justice system are part of this recovery movement. The Winner's Circle, a peer recovery services program spearheaded by an RCO in the African-American community for men re-entering from the justice system, has been highly successful in the Chicago area. (Treatment Alternatives for Safe Communities, 2007.) A gender-specific model of peer recovery services organizations also has precedent among recent federal grantees; some of them have ministered to the justice system-involved women. (SAMHSA, 2001.) The NH Taskforce on Women & Recovery grew out of this new movement and other advances in the field of women's integrated recovery.

Leadership Training

Leadership training was our organization's initial strategy. Rather than place a bandage on the hemorrhage of needs through direct services, TWR chose to put its very limited resources to work at forging the passionate voices of recovering women and their allies into a powerful instrument of change.

We reviewed information developed by the Center for Substance Abuse Treatment's *Women, Co-occurring Disorders, and Violence Study.* (SAMHSA, 2005.) Each of these federally funded sites were part of a five-year study to develop and evaluate gender-specific services that attended to the full range of issues for women recovering from addiction or substance abuse, trauma, and mental health problems. The sites used an integrated approach to treatment; all of them were charged with incorporating strong recovering consumer/survivor leadership in planning and evaluating services. Two of the sites caught our attention: the Maryland site, directed by Dr. Joan Gillece and the only one situated in a correctional setting, and the Boston site directed by Dr. Hortensia Amaro of Northeastern University.

Boston Site. The Boston site had developed a manualized curriculum, the Women's Leadership Training Institute, which was delivered by recovering women for recovering women. Its goal was to teach women to use their own experiences to advocate for needed services. It covered topics such as boundaries concerning disclosure, the system of oppression, how to work as a team with other women in recovery, and the connection between recovery from trauma and from addiction. TWR members made several visits to Boston to observe the leadership groups.

Initial Training. In 2004, TWR obtained a small grant from the New Hampshire Charitable Foundation to train an initial group of volunteer peer facilitators in the 16-hour leadership curriculum with the help from staff of the Boston site. The generosity of Dr. Amaro, and of Rita Nieves of Boston Public Health, who sent two excellent trainers, Iliana Ojeda and Brenda Marshall, to New Hampshire in the dead of winter for three long days, must be acknowledged. An initial group of facilitators was selected from applicants from all across the state.

Since then, TWR volunteers have transported women on probation, parole, and work release to these leadership workshops in local communities. The facilitators completed the New Hampshire Department of Corrections (NHDOC) volunteer training and obtained clearance to enter the state's correctional facilities. The first series of leadership training sessions took place onsite at Shea Farm in January 2005, with support and cooperation from the NHDOC. It was so successful that TWR was invited to do the same at the nearby New Hampshire State Prison for Women. We have recently begun to bring our peer facilitators to other states to hold trainings onsite for justice- involved women and women in long-term treatment. Leadership training is usually reserved for the promising, privileged, and accomplished. The paradox is the dramatic impact it seems to have on women who are hopeless, disenfranchised, and perceived as failures.

Graduation

Upon completion of the four-day training, women receive certificates at a graduation ceremony designed by the participants themselves. The warden attended the graduation ceremony of the first group of women completing

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Worth Reading

by Russ Immarigeon

Diverting Women—Connecticut

The Development and Implementation of Two Women's Jail Diversion Programs in Connecticut: Part I
by Rocio Chang, Loel Meckel, and Jessica LaRosa
21 (4) American Jails 17-23 (Sept./Oct. 2007)

Evaluation of a Gender and Trauma Specific Jail Diversion Program for Female Offenders: Part II
by Jessica M. Pollard, Jennifer Schuster, Hsui-Ju Lin, and Linda K. Frisman
21 (5) American Jails 53-63 (Nov./Dec. 2007)

The Connecticut Jail Diversion Program started in 1994 and by 2001 was present in all of the state's 20 criminal arraignment courts. At the time, diversion program staff noticed that women with co-occurring disorders (mental health and substance abuse) were being incarcerated repeatedly. At the time, too, research was showing that women were often victims of physical abuse, sexual assault, and other forms of trauma. In 2002, supported by federal and state grants, Connecticut launched two jail diversion programs specifically for women.

Connecticut has a strong tradition of academic-governmental collaboration. In this two-part article, practitioners and researchers from state agencies and local universities describe the development and implementation of the Women's Jail Diversion Program, results of empirical research on program outcomes, and lessons learned from the program's experience to date.

Admission Criteria

Screening for the program occurs at "court lockup" or as soon as a person enters the criminal justice system. According to the authors:

> The criteria for admission into these three- to six-month intensive outpatient programs is a history of trauma, current or past history of substance abuse, and being at risk for incarceration. Each program provides a gender-specific, culturally appropriate case management, trauma treatment, and integrated mental health and substance abuse treatment services, as well as psychotropic treatment. The goal is to provide comprehensive outpatient behavioral health treatment and community support services within one program to minimize fragmentation of care and create a center of safety and support for the [program's] participants.

Program Implementation

Implementation of the program raised a number of important "more-than-expected" issues and concerns, namely:

- Women entering the program manifested greater substance abuse problems;
- Women had "more complicated" social, economic, and psychological profiles;
- Women's trauma affected their ability to receive benefit from their treatment;
- Initial case management models proved insufficient;
- Women felt that spirituality and "connection to a higher power" were especially important; and
- Informal contacts and supports were necessary.

Connecticut's women's prison holds a significant number of women who are returned to prison for probation or parole violations and for alcohol- and drug-related offenses. Accordingly, as these authors note:

> [T]he Women's Jail Diversion Program staff worked to adapt the program's services to the clients' needs rather than expecting the clients to adapt to the program's needs. The program recognized that recovery is a process, not an event, and that drug and alcohol use are often coping skills for dealing with stress and continued use indicated a need to develop healthier coping skills.

Within this context, the program made important efforts not only to use flexible approaches to treatment, but also to continue working with women who have "complicated needs in treatment." In other words, the program made a concerted effort to work with harder cases, rather than resting on its ability to manage easier cases. Program staff found, for instance, that the initial approaches, curricula, or models the program intended to use were insufficient and they substituted more appropriate interventions. Staff added such dimensions as "topic-specific groups" that addressed such matters as interpersonal relationships, relapse prevention, and coping with trauma. Staff also invited community service providers and caregivers to come and share relevant information with women in the groups.

Lessons Learned

The research conducted on this program identified a series of "lessons learned," including the following:

- Women continue to have "traumatic events" during the course of their treatment;
- Women and their service providers must form healthy relationships with one another;
- Holistic models are appropriate for a more comprehensive effort to reach "different learning styles, different preferences, and lifestyles";
- Women's basic needs should be addressed first and foremost;
- Women are experts at identifying their own needs, but advisory or steering committees can help bridge gaps between women and community-based services;
- Women's needs should be at the center of treatment plans, not program needs;

See WORTH READING, next page

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- Programs should allow themselves approximately three months in which to "conceptualize service delivery, develop policies and procedures, access training, and introduce the new program to the court and to the community before recruiting participants"; and
- Start developing future funding as soon as the program starts.

Perhaps the most important lesson, and one worth repeating, is that program staff, as well as the courts and other official decisionmakers, should acknowledge that:

> [N]oncompliance with services should trigger a review of client needs and the "fit" of services to the client rather than an assumption that the client is not motivated for services.

Finally, the extent of the program's ability to actually divert jail- or prison-bound women into the program is an especially important concern, although it was not adequately covered in these articles. The authors report that the women had histories of prior arrests and "nights spent in jail." However, little else is indicated in terms of assuring that these women would have otherwise been imprisoned. And, even trickier, little is mentioned about the program's impact on the state's overall women's prison population.

Available from: American Jails, American Jail Association, 1135 Professional Court, Hagerstown, MD 21740-5853; (301) 790-3930. $48 annual membership; $15 per issue.

Diverting Women—Chicago

Co-occurring Mental Disorders Among Incarcerated Women: Preliminary Findings From an Integrated Health Treatment Study

by Doreen D. Salina, Linda M. Lesondak, Lisa A. Razzano, and Ann Weilbaecher
45 (1/2) J. of Offender Rehabilitation 207-26 (2007)

Women are sent to prisons and jails largely for nonviolent offenses. However, many of these women have co-occurring disorders, including serious substance abuse and mental health problems. These conditions are becoming increasingly evident as academic researchers, community agencies and activists, and correction professionals increase their individual and collective focus on the plight of incarcerated women, a trend that gained momentum in recent decades.

In this article, Chicago-area researchers Doreen Salina, Linda Lesondak, Lisa Razzano, and Ann Weilbaecher report preliminary results of an "integrated health" study they have been conducting with assistance from incarcerated women in a residential program operated by the Cook County Sheriff's Department of Women's Justice Services (DWJS). In this study, the researchers, who are affiliated with Northwestern University, the Chicago Department of Public Health, and the University of Illinois at Chicago, rely on data obtained from 283 women on mental health, substance use, and HIV/STI risk behaviors. The women in this sample are largely African-American and they are all participants in a jail diversion program that hopes "to divert women with substance abuse and other mental health disorders from the criminal justice system to appropriate treatment and comprehensive services within their communities." The women in this sample are largely pretrial detainees, although it is unclear whether the program intends to facilitate their release from custody before or after sentencing (or even after serving a full jail or prison term).

The results reported in this article focus largely on the women's mental health and substance abuse. Significant findings include the following:

- More than 75% of the women were diagnosed with primary Axis I posttraumatic stress disorder;
- Major depression was often a secondary Axis I mental health diagnosis;
- DSM-IV criteria for substance disorders were met through both substance abuse and substance dependence, especially sedative-opioid dependence; and
- Women were subject to many issues related to community psychosocial and environmental functioning, including legal/criminal, employment, and social/community support dysfunctions.

Salina and her colleagues argue:

> Methods must be found to effectively and economically treat women with co-occurring disorders while involved in the criminal justice system if the human and financial costs are to be contained and rehabilitation efforts are to be successful…While women are still actively involved in the criminal justice system, additional focus should be placed on obtaining accurate, comprehensive substance abuse and mental health diagnoses and developing multidimensional treatment planning that includes relevant data on all five axes of the DSM-IV.

The latter, they conclude, "can inform both the appropriate treatment strategies and the expected prognosis and outcomes if all factors identified on the multiaxial format are considered and incorporated in discharge planning."

An important question, left largely unaddressed here, concerns the relative balance, or share, of the organizational responsibility for providing the most effective treatment. Does this reside within the criminal justice system's various parts (jails, probation, etc.) or within community-based institutions from families through community support groups to mental health centers and substance abuse treatment programs? Salina et al. note the following:

> Currently, DWJS has extended the use of this model in collaboration with a local community-based hospital outpatient psychiatric department. While still under the jurisdiction of the diversion program, women in the day reporting diversion program (a furlough program) are assessed and then linked for psychological services at the community hospital. Detainees are able to see a psychiatrist for medication evaluation, receive appropriate medication and medical testing, and then participate in a psychotherapeutic group focusing on depression, trauma, and recovery.

But there is more to say about this evolving dynamic.

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the program in the prison and was kind enough to have the kitchen crew bake a cake. The women were allowed to invite their friends within the prison community to the ceremony. As the warden looked around at the flip chart pages the inmates had posted on the walls, he commented, "This is the stuff we learn in team building and management workshops."

At graduation, after four days of working as a team, the women share poetry, inspirational and spiritual writings, and unique perspectives on their learning, and demonstrate their ability to tell their stories with a point. This particular group also had musical gifts, and, while an older woman played the guitar, the crystalline, angelic voice of a young incarcerated woman rang through the hall, raising the hair on the back of necks and bringing tears to eyes. For the facilitators, the graduates, corrections staff, and all of us in the audience, this was an extraordinary moment; it was the moment we knew the prison could heal if we all worked together.

After graduating from the series of groups, most justice system-involved participants (85%) report an increase in their ability to identify their own strengths and 79% report more positive feelings about other women in recovery. (Miller, 2007.) Peer-led recovery services for women are not designed to treat deficits. Instead, increased self-efficacy and unity better equip recovering women by building on inherent strengths. When these new recovering leaders in the prison system found their voice, the first thing they asked for was a role in developing more responsive services. The second thing was a way to get involved in girls' prevention programs.

Post-graduate Activities

Many incarcerated and re-entering women who have taken the leadership training in correctional facilities have joined TWR. There are leaders who trained in prison, stay involved when they get to Shea Farm, and continue with TWR when they settle into their new lives in the community. TWR volunteers help them locate resources and connect them to the recovery community. Their biggest needs are transportation, securing prescription medications, and housing. Some women just call the office and talk to another recovering woman when they feel shaky in their recovery. TWR helps others locate substance abuse treatment. Many of them repeat the leadership training on the outside and connect with women in their communities; some have become training assistants and help facilitators with handouts and setting up. One woman became manager of a local restaurant when she re-entered a community in the western part of the state. She was able to donate lunches for the leadership training when it came to her community. This year we plan to train a group of new facilitators that will include some of the women who began their leadership journey in the prison.

Child Reunification. Justice-involved members speak at TWR meetings and events. A carful from the halfway house always attends. Although the Taskforce does not get involved in individual criminal cases, it has become a strong advocate for child reunification. Some of this work is supported by a small grant from the New Hampshire Children's Trust Fund. This is extremely helpful since the funds TWR is fortunate to receive from the state substance abuse block grant are restricted from helping people with more than six months left to serve. Volunteers have transported members to parental rights hearings and staff has testified on several occasions. A Shea Farm bimonthly empowerment group meets regularly and a similar group has begun at the prison. The group members recently met with the chief administrator of the state's Division of Youth, Children, and Families (DYCF) and presented written examples of issues they had with the department, such as inadequate treatment resources for women, and limited visitation and contact from children. A similar meeting took place at the prison. Not only did some of the women immediately receive pictures of their children and correspondence, but also a working relationship with the department is now in place. TWR is working with the DYCF to broker and remarket voluntary parenting support services for re-entering mothers.

Impact on Attitudes. Since the training equips women to speak with authority about their experience, a number of justice-involved graduates have served as panelists at several conferences and trainings for TWR. Panels of justice-involved women have spoken at the statewide domestic violence conference and at the child abuse conference. The NHDOC has graciously allowed women on work release to participate in some of these events. This fall seven of the women helped train over 100 child protective workers, home visitors, and early childhood professionals. Three women on work release attended a presidential forum on recovery issues and posed questions to the candidates' representatives about their stand on parity and the Second Chance Act. In almost every case the women received a small cash stipend for their participation. The impact of these panels and events on the professional community cannot be overstated. Minds and attitudes are changing; many influential allies and advocates have been won over in a variety of disciplines, including law enforcement, the judiciary, mental health, and state government. TWR calls on them regularly. The NHDOC has encouraged the women to accept other speaking engagements as well, including speaking at juvenile diversion programs and to civic groups.

Lessons

Abraham Maslow must not have met any women like those in our program. Leadership, intellectual creativity, and a commitment to a higher purpose are not exclusively the domain of those whose basic needs have been met. Many recovering women report their moments of highest inspiration took place at their lowest points.

Prison is an opportunity for women to capitalize on their highest hopes and most noble dreams: to change the world, their lives, and the lives of their children. The lesson here is that people continually underestimate recovering survivors with multiple vulnerabilities. Their ability to survive, navigate social services and the justice system, and to provide insight and prioritize reforms is prodigious. They have information no one else has. They can also teach each other what they have learned. Empowerment for female offenders does not mean throwing them into situations for which they may be unprepared and entirely in alien territory,

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because those in power think they ought to be at the table. This can set them up for failure, disempower them, and keep them on the outside. Empowerment means women are at least given some of the training and preparation the professionals get. Then they can hold their own quite nicely.

Other lessons from the inclusion of peer recovery services and leadership training in women's correctional facilities include:

- Recovering peers can win the trust of most incarcerated women in a very short time.
- When women see the prison administration supporting their leadership and input, they are more willing to partner with them to work toward common goals.
- When the women learn the skill of reframing grievances as recommendations, people listen.
- When women are challenged to come up with a better way, they often do.
- The women's recovery community and its allies are a powerful tool for women re-entering communities.
- Peer recovery service organizations can broker effective alliances across systems.
- When corrections is approached with a resource, rather than a critique, they are happy to help women access it.
- When recovery advocates understand the budgetary and administrative constraints under which even the most enlightened women's corrections officials must operate, they can help generate low-cost, creative solutions.
- When corrections supports leadership and gives women valued roles in engineering reforms, the institutional culture changes.

Every Recovering Woman Has a Role in Healing the System

In 2006, the Commission on the Status of Women spearheaded a legislative initiative that resulted in the passing of Senate Bill 262, sponsored by State Senator Sylvia Larsen, which created an administrator of Women's Services within the Department of Corrections and an Interagency Coordinating Council (ICC). At the bill signing, with the cooperation of the NHDOC, two graduates of the Women's Leadership Training program read a list of 20 recommendations for reforms to Governor John Lynch and his executive council in chambers. Then they returned to Shea Farm.

Input Needed for Effective Reforms. These recommendations were formulated at empowerment groups that TWR peer volunteers regularly facilitate at Shea Farm and at the state prison for women. The groups prepare a monthly written summary of current issues and recommendations for the ICC. Currently and formerly incarcerated women attend council meetings and work directly with the commissioner of corrections and the Senate president. The new warden, Joanne Fortier, and the commissioner, William Wrenn, have both supported the involvement of these women in improving services. TWR has tenaciously maintained that the ICC needs the input of the women themselves in order to plan effective reforms. So far, everyone is listening.

Targeted Prevention for Girls. One day in July 2007, I left the women's prison after conducting Targeted Prevention for Girls, a three-hour seminar for the women. This training is delivered to prevention professionals all over the state. The amazing thing about presenting information on gender-specific risk factors to women who have lived all them is watching them trace their own trajectory into addiction and gain an understanding of exactly what they can do to make it different for their daughters. Six of the women in the prison who took the Targeted Prevention for Girls training have gone on to create personal digital media narratives, thanks to a grant from the New Hampshire Endowment for Health. With the cooperation of the NHDOC, the Taskforce on Women & Recovery has brought donated laptops and a series of workshops on creating digital narratives into the prison. The participants burn DVDs of first-person narrated images and sounds that represent the story they must tell to young girls in high school. The DVDs are almost completed and will be available in early 2008 under the name "Shared Straight" as part of TWR's Targeted Prevention for Girls curriculum. (For more information about this project visit *www.NHTWR.org.*) This is happening because of an investment in the leadership of recovering women inside and outside the criminal justice system and recognition of their incredible capacity to take care of their own. I have seen the complexity of the issues of women in the prison system overwhelm commissions and councils of policymakers made up of the some of the brightest people I know. However, women in the recovery community, including those who are in prison, are usually undaunted by the complexity of the multiple vulnerabilities they live with on a daily basis and are well prepared to roll up their sleeves and dive in. Because of their energy and passion, we have learned that no system is capable of healing every recovering woman, but every recovering woman has a role in healing the system.

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foundation for advocates who seek to change existing parental termination laws containing unclear standards and unreasonable time periods. A subtext of this problem, however, is the lack of adequate protections enabling a mother to navigate the legal process leading up to and including a parental termination proceeding. On this topic there is scant legal and policy literature.

This article will address two points: the need for policies requiring protocols and procedures to ensure incarcerated mothers are informed of their rights, including but not limited to legal representation, and the incarcerated mother's lack of access to administrative and court proceedings.

Legal Background

As early as 1923, the United States Supreme Court recognized a parent's right to raise her children as a fundamental right. (**Meyer v. Nebraska,** 262 U.S. 390, 399 (1923); **Skinner vs. Oklahoma,** 316 U.S. 535, 541 (1942).) Several decades later the Court ruled that parents are entitled to raise their children without any interference from the state. (**Stanley v. Illinois,** 405 U.S. 645 (1971).) In 1982, the Supreme Court went on to rule that parental rights do not cease because a mother has been convicted or because she has lost temporary custody of her child to the state. (**Santosky v. Kramer,** 455 U.S. 745, 753 (1982).)

Fundamental Liberty Interest. While parents have a fundamental liberty interest in the custody and care of their children, the state can infringe on a parent's rights if there is a compelling interest. (U.S. Const. amend. XIV.) When parents jeopardize the health and safety of their children, through abuse or neglect, the state may intervene to protect the children. (**Santosky,** supra.) The legal framework for infringing on constitutionally protected parental rights is a combination of state and federal laws.

An incarcerated mother may be particularly vulnerable to having her parental rights terminated. For example, some state legislatures include incarceration among the "aggravated circumstances" that justify making no efforts to reunify families. (Lee et al., 2005.)

Right to Legal Counsel. Consequently, the decisions that child welfare agencies and courts must make about the type of services to provide and the length of time a child should remain in foster care before they move to terminate parental rights can be difficult to overcome for imprisoned mothers who are likely to have been the sole caretakers for the children before their imprisonment. The lack of legal counseling and information for incarcerated parents has contributed to the inclination of courts to approve parental terminations. (Gabel and Johnston, 1995.)

An overview of the right to counsel in civil cases must begin with **Lassiter v. Department of Social Services**. (**Lassiter v. Department of Social Services of Durham County, North Carolina,** 452 U.S. 18 (1981).) In this 1981 case, the Supreme Court ruled that an indigent parent facing termination of his parental rights in a state-initiated proceeding has no categorical due process right to counsel. (**Lassiter,** supra, at 31-32.) Since the indigent litigant in **Lassiter** did not stand to lose his freedom, he was not entitled to due process protection. In other cases, this decision was tempered by a due process standard used in a case decision handed down prior to **Lassiter.** "When physical liberty is not at stake the court should consider the private interest at stake, the government's interests, and the risk of erroneous decision in the absence of the desired safeguard." (**Mathews v. Eldridge,** 424 U.S. 319, 335 (1976).)

Representation at Dependency Proceedings. In the wake of the **Lassiter** decision, advocates have attempted to show a heightened interest on the part of the indigent litigant and to equate the litigant's interest with physical liberty. They attempt to show that the government's primary interest is saving money, or that it aligns perfectly with the litigant's interest. They also try to show that the factors in their cases, such as the factual and legal complexities, the education and skill of the opponent, and the handicap of the litigant, result in an exceptionally high risk of erroneous deprivation of a fundamental right.

As a result, state courts have drawn widely varied conclusions about the circumstances under which a constitutional right to counsel in civil cases attaches. While this due process protection is essential, it also is important for incarcerated mothers to receive legal representation in the dependency proceedings leading up to the parental termination hearing. The mothers' presence at these proceedings enables them to demonstrate an interest in their children's welfare long before the child welfare agency files a petition to terminate parental rights.

Legal Services Gap Created. Until 1997, incarcerated parents were eligible to receive representation from the Legal Services Corporation (LSC), which represented—in both criminal and civil cases—people who were incarcerated in federal, state, or local prisons. In 1997, LSC was prohibited from representing this class of individuals in civil cases. This created a significant gap in legal services for incarcerated mothers.

One of the fundamental tenets of the democratic system is that people will have equal access to justice under the law. To give meaning to this promise,

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those who are indigent should receive legal representation in civil matters. In 1963, the Supreme Court ruled that it is a violation of the Fourteenth Amendment to leave a criminal defendant without a lawyer. (**Gideon v. Wainwright,** 372 U.S. 335 (1963).) The **Gideon** baseline for due process should extend to those who cannot afford to pay for legal representation in civil cases.

Outcome Altered. Having an attorney can substantially alter the outcome of a case, even in civil court. A study from the 1980s in California showed that unrepresented mothers won physical custody of their children 49% of the time, compared with 86% when they had representation. (Maccoby and Mnookin, 1992.) Stanford University sociologist Rebecca Sandefur analyzed many of the studies on civil case representation and found that people represented by attorneys were up to 14 times more likely to receive a favorable outcome than those who represent themselves. (Sandefur, 2006.)

Statutory Requirement Needed

During the early stages of incarceration, a mother can avoid countless problems regarding the placement of her children if she is armed with legal advice and assistance. Most importantly, she needs to be informed of the consequences of inaction. If the mother cannot participate in the child welfare case reviews, her attorney should be present to ensure that the agency is in compliance with its own standards.

There should be a statutory requirement for legal representation of incarcerated parents in child protective proceedings to ensure that mothers receive consistent and competent legal services.

Just as rehabilitation services are needed to facilitate self-improvement in preparation for family reunification, legal counsel is needed to help parents initiate and respond to time-sensitive documents related to their parental rights in preparation for family reunification.

Educate Incarcerated Mothers on Rights

The lone advocacy program receiving state funding to educate incarcerated mothers on parental rights is the Pennsylvania Prison Society, a private agency that partners with legal services. This program is invaluable because legal advice in the early stages of incarceration can be critical in ensuring that families can be re-established upon the mother's release. For example, parents whose children are in foster care are required to follow a plan and complete various tasks before they can regain custody. Numerous obstacles exist which prevent parents from completing these tasks. Educating the parents during their incarceration about these requirements can help to prepare them to complete the tasks.

Grounds for Termination. An incarcerated mother who is unfamiliar with the law and the child welfare system does not know the grounds for termination of parental rights. She does not know failure to communicate with the child or agency, failure to plan for the child's future, or failure to make progress toward reunification, are all grounds for termination of her rights. Many mothers are unaware that they have a right to have visits with their children while they are incarcerated. The lack of regular contact with their children and the foster care agency, or the failure to keep records of their contact, can result in the termination of their parental rights. Additionally, disaster can result from incarcerated mothers signing documents they do not understand. To make informed decisions about their children, incarcerated mothers need access to legal counsel and education about the law.

State laws define abuse and neglect and the procedures for intervening in families' lives. Equally important, states, through their child welfare and corrections department agencies, should set policies requiring protocols and procedures to ensure indigent incarcerated parents are informed of their parental rights.

Self-Help Tools. The minimum standard used should require state agencies to inform mothers of their rights, provide them with self-help tools, and grant them access to all dependency proceedings. Self-help tools, while not a substitute for legal representation, can place the mother in a slightly better position when she attends a proceeding without counsel. Mothers who are unable to afford legal counsel, but who are successful at obtaining transport orders to attend administrative and court hearings, are at a disadvantage because legal proceedings involve complex concepts, requiring the ability of skilled tacticians. The majority of incarcerated mothers in the United States do not have a high school diploma. Despite the disadvantage of a mother who has no representation in a dependency proceeding, it is better for her to attend the proceeding, as her presence can help to support her assertion that she is concerned about her children's welfare.

Attending Proceeding

If the only representative attending a proceeding that involves the welfare of an incarcerated mother's children is the child welfare agency, there is a defect in the system that needs to be addressed. Mothers do not realize they cannot rely on receiving hearing notices in time to get to administrative and court proceedings. Nor do they know that they should ask their social worker to inform them of any changes in hearing dates. If they have an attorney, they can tell him or her they want to be present at the hearings so the attorney can ask the court to issue an order to have the incarcerated mother transported to court. If they do not have an attorney, they can write to the judge and ask to be transported to the hearing.

The hearing administrator or judge may be unaware that the mother is incarcerated and, if she fails to appear, has no duty to find out if incarceration was the cause. Even when the administrator or judge knows a mother is incarcerated, has taken steps to determine her location, and issues an order to produce her in the correct manner, numerous other breakdowns can occur, such as delayed arrival of the order sent to the correctional facility or transfer of the mother to another facility prior to receipt of the order. By the time the order is forwarded to the new facility, the court date may have passed or been adjourned. If the order reaches the facility in time, correctional staff may fail to inform the mother of the order, clear her for transfer, or place her name on the list that designates inmates to be transported and transferred to the custody of a facility closer to the court. The production order is just one example of the challenges incarcerated mothers face. These challenges are best tackled by legal tacticians.

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Assignment of Counsel. If the mother does not succeed in overcoming the navigational barriers to appear in court, she could lose her only opportunity to receive legal representation. In states where there is a statutory requirement for legal representation of incarcerated parents in parental termination proceedings, generally counsel cannot be assigned until the mother appears in court.

Resources for Counsel. Further, the challenges facing incarcerated mothers do not necessarily end when the judge appoints counsel. If the mother is assigned counsel and different lawyers are assigned for each phase of her case, she is still at a disadvantage. This inconsistency is problematic as the incarcerated mother may have little or no time to consult with her lawyer before proceedings begin. Additionally, lawyers representing incarcerated mothers are usually independent practitioners with limited resources. Without adequate resources and support, these lawyers are often unable to provide effective counsel in complex cases that involve numerous participants throughout each stage of the case. To avoid creating an unfair advantage for state agencies and to decrease the possibility of unnecessary terminations, representation should be statutory to ensure that attorneys for parents have sufficient resources to secure expertise such as investigators, social workers, and legal support staff.

Legal Services for Incarcerated Parents

Despite prevailing authority, mentioned earlier in this article, that prohibits state-funded legal services for incarcerated parents in civil cases, the Pennsylvania Prison Society partners with legal service agencies to educate incarcerated mothers about their rights and advocate for better communication between the prison and the Department of Human Services to facilitate mothers' participation in dependency hearings. This is an isolated example of an advocacy program funded indirectly by the state. The Prison Society's program needs to be replicated in other regions of the country.

In the absence of state-funded programs, incarcerated mothers rely on pro bono legal services to assist them. Legal Services for Prisoners With Children, in California, was the vanguard pro bono legal services program for incarcerated parents. In 1978, they began providing legal advice and referrals to prisoners on family law matters. They also conduct workshops on family law in California prisons.

Chicago. Chicago Legal Advocacy for Incarcerated Mothers (CLAIM), founded in 1985, provides legal and educational services for incarcerated mothers. They represent incarcerated mothers in domestic relationship cases and they represent the mothers' family members seeking to establish guardianship during the incarcerated mother's absence. CLAIM also advocates for policies and programs that benefit families of imprisoned mothers and reduce incarceration of women and girls.

Georgia. For the past eight years, the Civil Pro Bono Family Law Project (CPB-FLP), in Georgia, has gone to women's prisons across the state to provide legal seminars, brief consultations, and legal representation for incarcerated mothers seeking to remain connected to their children. When a woman is sentenced to serve prison time in Georgia, she must complete a six- to eight-week diagnostic program before she begins serving time at a designated facility. The only diagnostic program for women in Georgia's corrections system is located in Atlanta. The CPB-FLP presents bimonthly seminars at this location to intervene early in the mother's incarceration.

New York. While direct legal services remain the exception to the rule, legal advocates for incarcerated individuals continue looking for ways to assist incarcerated parents with maintaining their parental rights. In New York, the Center for Family Representation provides training for criminal lawyers to make family law court appearances for their clients.

Missouri. In Missouri, the legislature has considered a bill that would introduce new protocols and procedures, allowing teleconferencing for custodial placement meetings so that incarcerated parents can participate in the decision-making process about the future of their children. (Black, 2003.)

States' Cost Concerns. States would argue that the cost of providing legal counsel for incarcerated parents at all dependency proceedings is prohibitive. As the lack of civil representation is a pervasive problem for the indigent, there are models used by local governments to help address the problem for individuals who are not incarcerated. San Diego's Family Law Facilitator Center is a model, which, if modified, is capable of serving the needs of those who are incarcerated. The Family Law Facilitator Center has a small team of lawyers and paralegals. They spend, on average, 30 to 60 minutes per session, providing individuals with technical advice. They guide people in filling out forms, explaining where everything has to be filed, and instructing people in legal etiquette and how to dress when appearing in court. Unlike a personal lawyer, the facilitators cannot provide strategic or tactical advice. Self-help programs such as the Facilitator Center can offer a less costly alternative.

Correction Department Programs

Additionally, corrections departments can help to inform parents of their rights. In the past, the common prisoner re-entry program areas of focus included job skills, mental health, and parenting (how to care for children). The Federal Prisoner Re-entry Initiative, a law providing funding for prisoner re-entry programs in both federal and state facilities, has enabled re-entry program designers to expand the scope of topics. Some of the topics now include housing, health care, mentoring, money management, and substance abuse treatment. Certainly, these topics have great value in preparing incarcerated mothers for their return to the community, but these mothers need more. They need instruction on parental rights. Fortunately, there are forward-looking corrections agencies such as Oregon's Department of Corrections, which provides inmates with classes on the rules and practices related to their children. This is a first step.

One would hope corrections department programs will fully utilize the money received from the federal government to help prepare incarcerated mothers for family reunification. This level of preparation should include a program component on how to protect their parental rights.

Further, there should be in place policies establishing a threshold of protocols and procedures in correctional facilities and child welfare agencies to inform

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incarcerated mothers of their rights and provide them with access to dependency proceedings prior to the termination of parental rights hearing. This effort should be coordinated between the two agencies.

Protect Children by Protecting Mothers' Rights

While it is possible that many of the children of incarcerated mothers would fair better in foster care, with adoptive parents, or with a relative who could provide the child with a safe and loving home, it is questionable whether more than 50% of incarcerated mothers are not capable of fostering a parental relationship. The question becomes whether it is in the best interest of every child to have his relationship with his mother severed because of his mother's status. This is a difficult question, but it can be better answered if the mother is given an opportunity to be heard regarding the placement and care of her children. The best way to ensure the child of an incarcerated mother is protected is to zealously protect the mother's right to have her day in court.

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