

IN THE DECADE OF THE CHILD

**ADDICTED MOTHERS, IMPRISONMENT
AND ALTERNATIVES**

By

Jim Murphy, Nancy Johnson, Wanda Edwards

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Coalition for Criminal Justice/Center for Justice Education
Albany, New York

1992

We gratefully acknowledge a grant from the Daniel and Florence Guggenheim Foundation that enabled this research. We hope that the lives of the many women and children and their families who have struggled against all odds to overcome addiction, poverty, and racism might be significantly improved as a result of public attention and concern.



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U.S. Department of Justice
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ACQUISITIONS

New York State Coalition for Criminal Justice/Center for Justice Education
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A horizontal strip containing approximately 40 small, identical square icons arranged side-by-side.

[illegible]

- ▣ in 1980, one in five New York children lived in poverty; by 1984 the proportion had grown to one out of every four; for minority children, one out of two are poor;
- ▣ over 500,000 children have no health coverage;
- ▣ approximately 700,000 children have inadequate food and are at risk of nutritional deficiencies;
- ▣ over 760,000 young adults are believed to be functionally illiterate.

With that in mind, we must make a commitment to our children in every conceivable way. Not just this year, not just next year: we must make the next ten years the Decade of the Child!

Governor Mario Cuomo,
State of the State, January 1988

The cost of providing necessary health, mental health, housing, social and educational services to pregnant alcohol and drug abusers and others is almost beyond comprehension or estimation.

*The Governor's Statewide Anti-Drug
Council 1990 Strategy Update*

After three years and with massive deficits at the state and federal levels, the Decade of the Child is mostly a slogan. The 1980's were extremely hard on the poor. The new economic hard times meant budget contraction, especially for those who could afford it the least. The poor are continually growing worse off, while positive initiatives remain pilot programs at best.

Any discussion of drug-addicted women in the criminal justice system and their children needs to begin with these painful reminders of the state of life for so many poor people, single mothers and young children, many of whom are minority in New York State.

begin with these painful reminders of the state of life for so many poor people, single mothers and young children, many of whom are minority in New York State.

Following an overview of our findings, we provide a context for analysis: We look at the extent of drug and alcohol abuse, issues of treatment and aftercare (kinds, costs, access), and special concerns regarding women and addiction and women and imprisonment. We then review specific programs both inside and outside of the prison system and evaluate which features we believe offer the best opportunities and hope for the women participating in them. We conclude with recommendations for future research.

away but now are totally disintegrating the family structures of primarily African-American and Latino peoples by locking up the mothers also. Drug addiction is being looked at as the disease, while the underlying problems of poverty and poor daily living skills that contribute to the continuing crises of dysfunctional families are being overlooked. We must begin to take a holistic view of all the problems an addicted person presents. Future generations are at stake.

After analyzing the social and economic context in which substance abuse and responses to it occur in New York—with particular reference to addicted women who are pregnant or with children—we reviewed twenty-three prison and community treatment programs and visited seven (see “Research Methods and Program Reviews,” p. 18). Our recommendations are codified in our “Model Program” following our Findings.

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It is impossible to determine if a woman has signed up for a drug-treatment program because she finally decided to kick the habit or is merely trying to impress the Parole Board. A woman may also sign up with a program because she thinks she will get better housing conditions; some programs operate in separate housing units. All programs are supposed to be voluntary, but in effect, they are not when the reward may be time off a sentence. All prisoners are anxious to leave, but women, especially, are eager to get home to their children.

The Riker's Island and Bayview's Stay'n-Out programs were impressive in spite of the conditions under which they had to operate. They had the fewest resources and facilities. Yet the women we interviewed seemed to be committed to their programs and appeared to be determined to succeed. The women at Riker's Island clearly felt that the staff cared about them and that, for the first time in their prison experiences, they had someone to advocate for them.

The most remarkable finding of our interviews with addicted women in community programs was that, no matter how limited the services offered by a program, responses from the women were overwhelmingly positive.

We found that most of the women in prison had not been offered any drug treatment programs that were alternatives to incarceration, even though their arrest histories made it plain that they were drug-abusers. This pattern included first-time offenders.

The issue of children in a residential program is ambiguous. Separation from newborns seems to cause more anxiety among mothers than separation from older children.

Better AIDS education and comprehensive post-test counseling is called for.

All the community-based programs we visited had a parole and probation release program.

All were satisfied with their programs. They had few complaints. This indicates that women have the potential to do very well in overcoming substance abuse problems if there are enough programs available to them. It also suggests that if women were offered alternative-to-incarceration programs, they would successfully complete them in most cases.

Due to “get-tough-on-drug” policies, women are spending more time in prison on indeterminate sentences without receiving the help they need. Once in prison, they are rarely offered drug-treatment programs and often have to find them for themselves. Although some women said they needed the “shock” of prison to help them realize they needed to do something about their drug problem, the “shock” of being remanded to a residential drug-treatment program with the threat of going to jail should accomplish the same purpose. A residential program would be able to keep tabs on the women to make sure they complete their programs and satisfy corrections officials. We recommend against Shock Incarceration Camps as effective sites for treatment programs for women (not only because of conflicts of purpose inherent in all prison settings, outlined on pp. 15-16, but because women, who have often been the victims of abuse, do not respond well to such programs).

However, mothers felt at ease when they knew that their older children were being taken care of by relatives and not lost in the foster-care system. Also, family counseling sessions were called for where the whole family could sit down and discuss the mother's addiction and how to deal with it. Education sessions were not enough. Women felt that they had to work on their own problems before they could help their children, that they couldn't quit drugs for their children—they had to do it for themselves. While it eased the anxieties of women with newborns considerably to have them with them in a residential program, it was not because of the newborns that they did well in their programs: they did well because they had made the decision to quit.

Women in prison are seeing more and more of their sister inmates test positive for AIDS and it doesn't look to them as though anyone is doing anything about it. Prisoners who test positive for AIDS need sympathetic counseling.

The conditions set on these programs included the parolees/probationers having to finish the program or go back to jail or prison and redo any time spent in the program plus their regular parole/probation period. Most people finished their programs. Although some women “con” their way into these programs, once in they often benefit from them and actually become drug-free. Most of the women seemed to possess little or no education about the nature of addiction and substance abuse. Once armed with a little knowledge, they tended to do well.

Residential program clients tended to do better than non-residential clients.

The reason for this appears to be that residential programs have more control over the daily lives of clients. Most offer a broader range of services. However, some women reject entry into a residential program due to the loss of control over their lives. K. H. of Riker's Island was willing to do more time in jail than go to a residential program. She feared the loss of her child and the loss of contact with her siblings and grandfather. She currently is in Riker's Island's nursery program. Residential programs that take children are almost non-existent. Catholic Family Center's Liberty Manor does and has a long waiting list.

Women in community residential programs seem to progress faster and have better attitudes than women in prison programs.

Residents have only their programs to concentrate on—they don't have a myriad of other concerns. Taconic recognizes this and is trying to correct that problem by instituting the therapeutic community. In this program, clients will be in treatment all day with no other responsibilities. However, Taconic is becoming a forensic facility, and there will be an influx of prisoners with all but the worst psychiatric problems. Taconic's therapeutic community grant was not written with this possibility in mind.

Arms Acres is funded primarily through insurance agencies. The agencies track each client's progress and continue or stop payment depending on whether they think the client is making progress or not. Partridge House is funded through federal and state grants. It has a huge waiting list and needs more personnel.

Clients at Partridge House (a Native American facility) stated they needed the cultural component: it gave them something to belong to, to be part of a group. They got a better understanding of who they are and where they came from as a people. It gave them a sense of identity. Elsewhere, Latina women said that they needed Spanish speakers in their programs. Some women could only speak Spanish when they entered their programs. Because Partridge House is the only program that is for only one racial/ethnic group, this component is difficult to measure. None of the other programs offered classes in African-American or Spanish culture. This is something that needs to be explored more thoroughly.

When a woman is ready to enter a program, it is imperative to take her as soon as possible.

D.J. of Partridge House: "I had to wait two weeks to enter Partridge House. It was the hardest two weeks I had to do. It was just lucky they had an out-patient clinic I could go to for that time." Most places don't have out-patient clinics to complement their resident programs.

Lincoln Hospital, a non-residential program, takes everyone who comes in for an emergency acupuncture treatment. Because they can only do five intakes a day, they make a list of everyone treated and catch up on the intake paperwork at a later date; this way no one gets turned away when they seek help. G.T. of Lincoln Hospital said, "It was important that they took me right away. It made me feel someone cared. It gave me courage and something to look forward to tomorrow."

Most community programs only took clients who had been de-toxed at a hospital or some other facility, while the prison program clients had usually been de-toxed at Riker's Island. It appeared that most of the women did not go through "detox" programs; once having made the decision to quit, they stopped by themselves "cold-turkey." The programs they entered reinforced the decision and educated them as to why they were addicted and how to stay drug-free.

All the programs (with the exception of Lincoln Hospital Clinic) were by referral only. Referrals came through the courts, parole and probation, doctors, lawyers and Indian chiefs.

Most of the substance-abuse programs had referral services to non-residential maintenance programs, but clients are not tracked by the program itself. Only Catholic Family Center's Liberty Manor and Partridge House had comprehensive follow-up programs that lasted a year after the client's discharge as a part of the residential program.

Two reasons women frequently gave for being in a community program were that their children had been threatened by the child protection agency or their children had been taken away at birth.

An interesting result of the “get-tough-on-drugs” policy was pointed out to us by the director of one of the programs: “Children who are born with a ‘positive tox’ for methadone treatment are allowed to go home with their mothers. We still don’t know what the effects of methadone addiction are on these babies; yet the babies addicted to crack and cocaine are taken away from their mothers at the hospital. What is the difference between methadone and crack? One was invented by a Rockefeller and the other was not.”

Once these women lose their babies, they frequently lose all incentive for trying to live a straight life.

Addicted women may “maintain” for years, working, taking care of their bills, using drugs only when they know their children are being taken care of by relatives or friends. The loss of the babies gives them an added incentive to run the streets; this is particularly true with first-time mothers. Then not only do the women have to deal with the problems of addiction, but also with the guilt of losing their children. Once the women begin sobering up, the pain and guilt of what they have done to their children makes it harder to maintain their program.

Catholic Family Center's Liberty Manor (hereinafter, "Liberty Manor"), Taconic ASAT ("Alcohol and Substance Abuse Treatment") and Riker's Island have nursery programs, which seem to help the women tremendously. The women in prison have a three-fold problem: they are addicted; they have to face or have faced criminal charges; and they have lost their children. With the nursery programs, the anxiety over the loss of their children is less harsh. They have a better attitude about working in their drug-treatment programs and the children give them incentive to work hard. In addition to treatment for their drug problems, they get hands-on parenting counseling, something that they might never have had out on the streets.

At Liberty Manor, the clients learn to be responsible for their appointments, child-care and treatment. Being in a residential setting, they have other mothers and counselors to talk to about child care. They learn behaviors to cope with anxiety caused by cranky

babies. The childless women in the program learn how to help their fellow women with child-care duties. They learn how to cooperate as women. At Taconic, for example, S.K. became the god-mother of R.L.'s child.

Women in Partridge House and Arms Acres said that they thought their programs would not have worked if they had had to take their children with them. However, they had older children, whereas the women in the other programs had newborns. The women in the Lincoln program said that they wished for child-care while they were in group sessions. One woman at Liberty Manor said it was distracting at times to have children in the program.

A major difference noted between programs was that women in prison programs were far happier with having a nursery program than women in residential programs outside.

Women in prison who have older children spend a lot of time worrying about them and have a harder time concentrating on their programs. The reasons for this are clear: the women in the residential programs could see their children soon after they entered the program (usually in about four weeks), whereas women in prison have no way to control contact with their families. Many women are sent far away from their home city, and it is difficult for their families to come to see them. They also have the stigma of having their children see them in prison. When the children visit their mothers in residential programs, they know mother is there to help herself. When children of women in prison go to visit them, they know their mother is there because she committed a crime. Often, visitors of prisoners are treated like criminals themselves by correctional staff.

In addition, women in residential programs know how long they are going to be there; they know they are going home when their program is through. The women in prison—due to indeterminate sentencing, parole rules and regulations—often have no idea when they will be seeing their children again. This creates an anxiety that interferes with their program.

The special needs of addicted women's children in the two-to-twelve-years age bracket are being overlooked by most programs.

These older children aren't being serviced at all by any group; they aren't old enough for Al-a-teen. They are at the curious age where they think nothing affects them. They are "too young" to know what is going on. If their mother is in prison, they are being shuffled around to live with grandparents or are lost to foster homes. None of the programs we visited had a counselor for these children. C.D. (Partridge House) said, "My son didn't understand my addiction problem. He began to act out"—as did D.J.'s (Partridge House) children. D.J. said that she had attended a session in a Canadian substance-abuse treatment program that her husband was in where the family members confronted the addicted person and talked about what his addiction was doing to the family. She felt it was helpful for the whole family. Children learn by what their parents do. These children need drug-abuse prevention education and treatment more than the average child.

Most programs had a medical center that they worked with if their clients needed medical assistance. At Liberty Manor, the clients were

Group counseling is a place where women can sort out their domestic relationships and get a healthier self-image.

All programs had problems regarding funding sources.

Lack of time was also a consideration in a successful program.

Most of the programs worked on a twelve-step Alcoholics Anonymous model, which seemed to meet the needs of most of the women.

After-care support is vital to a woman's successfully completing a drug-treatment program. Many women go back to the same communities in which they became addicted.

responsible for their own appointments and most of the women were on Medicaid. The prison programs depended on correctional facilities' medical services.

For most programs it was due to lack of funding, while at Arms Acres, it was because of constricted control over the program. Fundamentally, there aren't enough programs. All programs have waiting lists, capping off with three hundred people at Lincoln and Taconic. At Riker's Island, the one group that exists is overcrowded with many women waiting to get in. Riker's Island is only a twenty-eight-day program with minimal services provided, yet it produces dramatic changes in the women who participate, as evidenced by the striking difference between K.H. and the three women we interviewed.

If prison administrators were serious about drug-treatment programs, they would have women concentrate on their drug treatment. As it is now, the women only get a few hours a day scheduled for treatment squeezed into the daily prison routine.

They enjoyed doing the reading and homework required. Sponsors are also obtained for the women once they leave the programs; they felt this is a good connection to community. A.J. at Liberty Manor thought that she could do her recovery maintenance with her sponsor. At Liberty Manor and Arms Acres, clients must have an A.A./N.A. sponsor and have attended A.A./N.A. meetings in the community before leaving the program. At Bayview and Riker's, women make contact with their sponsor and are given an address for A.A./N.A. meetings.

Drug addiction is a learned behavior (though a medical problem with a chemical component). When the women go back into the community, their addiction is often triggered by learned responses; in short, they relapse. Finding housing for women in a non-drug-infested area would be ideal but often is not possible. The women want to be in the same neighborhoods as their families. One solution might be shared housing space. A group of apartments could be shared by women with children who have completed their residency programs.

They could live together, give moral support to each other, share child-care responsibility and provide each other with a clean, sober environment. Requirements for this type of housing arrangement

would only be that a woman stays drug-free while she is in the apartment. This type of housing arrangement could be subsidized by HUD or a federal grant.

It is imperative that intensive family planning counseling (including information in prenatal care, birth control, adoption and abortion) be an integral part of any meaningful, long-term rehabilitation.

The vast majority of women drug-abusers who are frequently involved with the criminal justice system have children, are pregnant, or are of child-bearing age. For whatever reason, many women drug-abusers are ignorant of the deleterious effects of drugs on fetuses and seem not to be cognizant of the unhealthy and potentially dangerous environment a drug-abusing parent creates for a child. An awareness of their responsibility beyond themselves must be a part of the totality of treatment.

Model Program

THE MODEL PROGRAM SHOULD:

- ☐ Be an alternative to incarceration.
- ☐ Be a residential program.
- ☐ Be for women only or, at the very least, have a women's program.
- ☐ Have group counseling as well as individual counseling on an as-needed basis.
- ☐ Have a program for mothers with new-borns; have family counseling sessions in which the whole family has a chance to talk about the addiction problem with older children.
- ☐ Have dedicated administrative personnel and staff. This is often the difference between a mediocre program and a successful one. The women do better if they know someone cares about them.
- ☐ Have AIDS education.
- ☐ Have vocational training.
- ☐ Have a comprehensive follow-up program that lasts one year after release, which may include shared living space with other recovering addicts and their children.
- ☐ Include a strong support component for women in their home communities, particularly in known drug-infested areas.
- ☐ Be sensitive to the cultural/ethnic/language back-grounds and concerns of clients.
- ☐ Include intensive family-planning and counseling.

The Women's Perspectives

Although clients' perspectives were included in our general findings and recommendations above, we think it important to give voice to the women whose lives are most centrally affected.

Overall, we found that the women we interviewed were ready to relinquish the life of substance abuse.

There were different reasons given: G.T. of the Lincoln Hospital program said, "I just got tired, tired of having no money, tired of having no food. Just tired of the life." M.L. in Bayview said, "Having to go to prison shocked me. I couldn't have done it on the outside alone. I didn't see myself as having done anything wrong. Everyone lives this way." P.L. of Liberty Manor said, "My sister took over custody of my kids." D.J. of Partridge House said, "I hadn't gotten over the grief of my brother's death. I didn't realize what I was doing to my kids until my neighbors started saying things to me. My daughter was staying out late and my son was constantly acting up." They believed that no one would succeed in any program until they were ready to give up drugs. Once these women made the decision to enter a program, they tended to stick to it, no matter what the obstacles, and do well.

Most of the women thought that an all-women's program was beneficial to them.

They learned how to make friendships with other women, learned how to be supportive and felt free to talk about any problems, including domestic relationships. They did not have to compete for male attention or to form relationships. Most programs discouraged the women from forming relationships while in programs: the emphasis is on recovery. Group sessions did not focus primarily on drug addiction but covered a variety of areas such as self-esteem, domestic relationships, social skills and daily living skills. In the group sessions the clients began to work on their whole selves and not just their drug addictions. At Lincoln Clinic, the women formed their own rap group in response to the need for group sessions. At Riker's Island, the group sessions held by the counselor were filled to the walls, with more women waiting to get in. Individual counseling was not seen as being as indispensable as group counseling, but some women preferred it when talking about personal issues such as incest.

All the women we interviewed said that group therapy made a big difference in their programs. They became a group and started to experience responsibility for the group. They were able to talk over problems, find similar problems to share and form bonds that they would not have formed on the streets.

Group sessions did not focus primarily on drug addiction but covered a variety of areas such as self-esteem, domestic relationships, social skills and daily living skills. In the group sessions the clients began to work on their whole selves and not just their drug addictions. At Lincoln Clinic, the women formed their own rap group in response to the need for group sessions. At Riker's Island, the group sessions held by the counselor were filled to the walls, with more women waiting to get in. Individual counseling was not seen as being as indispensable as group counseling, but some women preferred it when talking about personal issues such as incest.

Women felt that being treated immediately when they came in for help was an inducement for success.

Women who had to wait to get into a program had a lot of difficulty holding on. Women in programs with comprehensive follow-up and companion out-patient programs tended to do well with fewer relapses.

For the women interviewed, the twelve-step A.A./N.A. program also seemed indispensable to success.

The women realized that they cannot depend on welfare for the rest of their lives.

"Group counseling" was the overwhelming response when the clients were asked what makes a successful substance-abuse program.

Women did not seem to have concerns over their health, and health care was provided at most places. However, women were concerned about the health care of their infants.

AIDS education was a big issue with the women in prison programs, as well as in Liberty Manor and Lincoln Hospital.

Women in all programs—with the exception of Partridge House and Arms Acres—expressed a need for vocational training of some sort.

The readings and the homework the women did gave them a wider understanding of their problem. They responded favorably to the structure of the A.A./N.A. The readings and the homework the women did gave them a wider understanding of their problem.

They wanted to make a living for themselves, but they can't do it without training. They realize they face serious problems when they are ready to go back into mainstream society. They need job skills. They want vocational training.

All the women said group counseling helped them the most. They expressed fears at first about participating in group counseling; but once in, they saw that it was beneficial. K.H. (Riker's Island) had not yet attended a group counseling session, and she was the most negative of all interviewees. She said she wasn't going to attend group because she thought she didn't need any help and she didn't want everyone to know her business. J.J. (Bayview) had expressed similar sentiments when she first entered treatment [as did D.J. and C.D. (Partridge House)] but said once she accepted that she had a drug problem and got over denial, she liked the group sessions. There was a remarkable difference between K.H., who had only been in the program at Riker's Island for a week, and the other three women we interviewed who had been for longer periods of time and had participated in group sessions. They seemed calmer, confident with a knowledge that they had a problem and were working on it. They also appeared to be more trusting. The change was dramatic. This suggests that women respond well to treatment however rudimentary its basis.

G.T. (Lincoln Hospital) was pregnant with twins and informed her health-care worker that she had a drug history. When the twins were born, they were taken away from her although they tested 'negative tox'. She now tells other women not to reveal their drug histories to health care workers for fear of losing their children. This can have potentially dangerous repercussions for infants as well as for the mother's health.

They feel that not enough pre- and post-testing counseling is being given by correctional staff. It is apparent that AIDS is on the rise in prisons and among women as a population. It is extremely frustrating for women to enter substance abuse programs and to get free of drug addiction only to learn they are dying of AIDS or are HIV-infected. Although one counselor (Riker's Island) told us that when one woman was informed she had a fifty per cent chance of survival, she said it was the best odds she have ever been given.

Women in prison programs stated that they were not getting the type of training they need to support themselves when they returned to the streets. Lack of meaningful employment and an excess of leisure time is an inevitable route back to using drugs, as A.M. found out when she became involved with drugs once out of work due to the telephone company strike.

[illegible]

Among the most alarming statistics are those for women with children, particularly crack-abusing pregnant women. New York's Department of Health reported 4,989 neonatal drug-related discharges in 1989. This amounted to 33.3 such discharges for every 1,000 births in New York City, and 5.6 for the rest of the state for an over-all neonatal drug-related discharge rate of 18.1 per 1,000 births.³

These statistics point to the severe problems facing low-income minority city dwellers. They represent the popular images of the drug-abuser. As we will see, however, estimates from the Division for Alcoholism and Alcohol Abuse (DAAA) and DSAS, as well as the figures for drug and alcohol treatment programs, paint a different picture.

¹ The Governor's Statewide Anti-Drug Abuse Council, *The First Anti-Drug Abuse Strategy Report*, 1989, Albany, N. Y.

³ New York State Department of Health, Statewide Planning and Research Cooperative System, *Neonatal Drug Related Discharges per 1000 Births New York State 1986-1989*, 1990, Albany, N. Y.

⁵ New York State Division of Substance Abuse Services, *The Statewide Household Survey of Substance Abuse, 1986*, Table 10, 1989, Albany, N. Y.

We . . . found that in hospitals serving primarily non-Medicaid patients, screening for drug exposure was even less prevalent. . . . One recent study has found that . . . drug use during pregnancy is just as likely to occur among privately insured patients as among those relying on public assistance.⁶

The level of serious abuse among men and women affects people of every race: **the disparity comes in the access to treatment and the use of imprisonment.**

▣ TREATMENT

The purpose of treatment is to arrest the debilitating personal and social effects of drug abuse.⁷ Aside from methadone treatment, which controls heroin and other opiate addiction, treatment aims at a "drug-free" life through abstinence. There are four main types of treatment modalities:

Detoxification is an entry point for the heavy drug user and an absolutely essential element in a number of cases. It provides time and support to end the immediate use of drugs so that longer term treatment can start. "Detox" services can be found in a hospital or residential outpatient setting. Costs can range from \$500 per day in a hospital setting to \$60-\$120 per day in a residential setting to considerably less in an outpatient clinic.

Therapeutic communities (TC's) and residential treatment are based on the Synanon program originally established in California. They are long-term (6-24 month) programs with a confrontational style that are meant to force addicts to face their addiction and to change their behavior so that they can live without drugs. Because of the long time commitment, the demanding schedule and the confrontational approach, many participants drop out of the programs. Studies have shown that drug use and criminal behavior is reduced for those who stay longer than three months. The cost of TC's varies from \$1,200 to \$2,500 per month. There have also been a number of programs adapted from the TC model that use a less confrontational style and include more traditional counseling techniques. The length of stay (6-12 months) and cost are diminished. Earlier phases of the TC movement allowed alcohol use for participants, causing strong disagreement with the Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) movements. Today, TC's have generally linked avoidance of both the use of alcohol and other substances to successful treatment.

The Minnesota model is a treatment style named after the program started in the 1950's at the Willmar State Hospital in Minnesota. Generally consisting of three- to four-week-long residential programs based on the 12 steps of Alcoholics Anonymous, the programs aim to break the avoidance and denial of addiction and provide supportive counseling and coping skills and follow-up to participants. Some are based in a hospital setting and most are run by for-profit organizations that depend on private pay or third-party insurance coverage for the \$10-20,000 fee for a month-long program.

Outpatient treatment is used extensively in New York, particularly through the extensive alcoholism treatment programs. Participants are expected to participate in day programming and maintain a schedule of AA or NA meetings. These are less costly.

⁶ United States General Accounting Office, *Drug-Exposed Infants: A Generation at Risk*. A Report to the Committee on Finance, U.S. Senate, 1990, Washington, D. C.

⁷ Office of National Drug Control Policy, *Understanding Drug Treatment*, An Office of National Drug Control Policy White Paper, 1990, Washington, D. C.

▣ TREATMENT IN NEW YORK

New York has a large delivery system for treatment. There are private, for-profit hospitals and clinics, such as Seafield Center on Long Island and Conifer Park upstate. These are insurance-paid and cost \$12-20,000 for a 4-week program. New York also has the largest state-funded system of treatment in the country. The Division for Alcoholism and Alcohol Abuse (DAAA) and the Division of Substance Abuse Services (DSAS), with 1990-91 funding just under \$600 million, provide a range of prevention and treatment programs. In 1989 DSAS programs included a mix of residential, outpatient, and methadone maintenance, serving about 52,000 people. In the same year, DAAA served some 60,000 people.⁸

TREATMENT	RACE				TOTAL
	Black	Hispanic	White	Other	
Methadone (Detox, MMTP) (50,881 total)	31	34	34	1	100
Drug-Free (drug free, medically supervised, chemical dependency) (19,557 total)	39	13	47	1	100
Methadone to Abstinence (1,761 total)	23	51	24	2	100

A 1990 Update of the Governor's Anti-Drug Council reports that 35% of cocaine admissions and 31% of heroin admissions were for females.⁹ DAAA reports 1989 admissions of 22,477 women, 76% white, 19% Black and 4% Hispanic.¹⁰

▣ TREATMENT CONCERNS FOR WOMEN

Alcoholism is like two different diseases for men and women; it's just caused by the same monster.¹¹

⁸ New York State Division of Substance Abuse Services.

⁹ The Governor's Statewide Anti-Drug Abuse Council, *Anti-Drug Abuse Strategy Report, 1990 Update*, 1990, Albany, N.Y.

¹⁰ New York State Division of Alcoholism and Alcohol Abuse, *1990 Report on Special Programming for Women*, 1990, Albany, NY.

¹¹ *Idein.*

While addiction destroys lives regardless of race, creed, or sex, there are different barriers and treatment strategies for different populations. This is particularly true for the treatment of addicted women.

Sr. Mary Nerney of the STEPS to End Family Violence and the Incarcerated Mothers Programs of the Edwin Gould Services for Children in New York City spoke of the mixed success of the traditional male-dominated treatment programs in treating women. For some, these traditional approaches work well. For women with long histories of subservience and abuse, experience has shown that confrontational-style programs fail. (Again, this argues against Shock Incarceration Camps for women.)

A similar point of view is expressed by Ann Grasso of Conifer Park in Scotia, New York, a for-profit treatment program that is part of Mediplex, Inc. She was puzzled by the failure of women to speak up and truly engage in the co-ed treatment process. She was also disturbed by the greater rate of failure for women on completion of Conifer Park's 28-day residential and subsequent follow-up aftercare program. With time, she was able to convince Conifer Park to establish a self-contained Women's Program, which now serves 24 women. Ms. Grasso directs the unit and identified a number of blocks to treatment that women face, including:

- ▣ They are expected to be caregivers and the calls of parents, children, husbands or significant others serve to strengthen the avoidance and denial pattern which characterizes addiction.
- ▣ They have almost always been victims of sexual abuse with high percentages of rape and incest victimization and have trouble "opening up."
- ▣ They tend to suppress their anger and have difficulty in acknowledging their angry feelings about loved ones, which often leads to severe depressions centered around issues of abandonment and loss.
- ▣ They also tend to become co-dependents in their dealings with loved ones who are addicted.

The recognition of the unique needs of women in treatment has led to a greater level of networking. A Women's Issue Caucus of Treatment Providers has been formed for mutual support and "to discuss modalities, problems, and outreach directed at women." The New York State DAAA has also identified blocks to treatment. The 1990 Report on Special Programming for Women noted:

The first issue involves the *stigma* attached to women who are alcoholic, the relationship of stigma to denial, and the impact of stigma and denial on the ability of family members and significant others to recognize a woman's alcoholism and to be supportive of her decision to enter treatment. The second issue relates to the *complexity of women's problems* and the responsibility women feel for managing these problems prior to their entry into treatment. The third relates to *how women perceive alcoholism within the context of their lives*. All of these issues are further complicated by the heterogeneity of women in regard to many factors, including age, race and ethnicity, socioeconomic status, sexual orientation, other drug use, urban/rural residency, and HIV serostatus.¹²

These unique needs and obstacles in overcoming addiction also produce programmatic tensions between drug/alcohol treatment and continuing child support which need to be recognized and accommodated, particularly in the early days of treatment. Being a mother and caregiver can be used

¹² *Idem.*

by the addicted woman to avoid or deny the importance of making treatment a priority for her life and the need to continue in aftercare upon release.

Most treatment providers insist that the program and the treatment plan must come first. Short- or long-term support for the children is essential until the woman is ready to resume major responsibilities for her children.

▣ ADDICTED WOMEN AND IMPRISONMENT

The impact of addiction, drug abuse, and drug offenses on New York's criminal justice system and particularly on women with children is both evident and dramatic:¹³

- ▣ Over 60% of women in prison in New York State are substance abusers.
- ▣ 68% did not complete high school.
- ▣ 75% have at least one child.
- ▣ 94% are Black or Hispanic.
- ▣ 80% come from New York City;
- ▣ 57% are under 30 years of age;
- ▣ 46% are sentenced as second felony offenders, thereby requiring imprisonment under current law.

A second 1990 Department of Correctional Services' (DOCS) study notes:

The proportion of the male commitment population imprisoned for drug offenses rose from 32.0% in 1987 to 43.7% in 1989. The growth in female drug commitments has been even more striking, increasing from 42.4% of the 1987 new court commitment population to 66.4% of the 1989 new court commitment population.¹⁴

Crack or cocaine were the drugs the women reported as responsible for their commitment, although 52% of those committed in 1988 and 30% of the 1989 commitments denied that they used drugs.

The impact of New York's mandatory sentencing laws on the system are seen in the characteristics of sentences:

- During 1987-89, the greatest growth in commitments was for D and E felonies. They amounted to 34% of the 340 commitments in 1987 and 43% of the 1059 commitments in 1989.
- Sentences for second felony offenses also increased. There were 108 second felony drug commitments in 1987 (32% of total) and 479 in 1989 (45% of the total).

¹³ Department of Correctional Services, "Identified Substance Abusers NYS," March 1990, Albany, N. Y.

¹⁴ New York State Department of Correctional Services, "Female Drug Commitment Population 1987-1989," March 1990, Albany, N. Y.

Commonly, the profile of both adult and juvenile imprisoned women contains the following characteristics: minority, comes from a broken home, substance abuser, victim of abuse, including sexual abuse, with a low self-image and history of educational and job failure.¹⁵ In the case of an adult imprisoned woman, she was a single parent living alone with one to three children; others of her family members were or had been incarcerated.

PROGRAMMING FOR WOMEN AND CHILDREN

Special programs for women offenders and their children are beginning to appear across the country. Anne McDiarmid, Adult Manager of Dakota County's (Minnesota) Community Corrections, cites five reasons for such programming:¹⁶

- ▣ To intervene in the cycle of crime, poverty and poor parenting that charts the lives and life-styles of women offenders. The real payoff of this kind of programming will come when their children fail to appear in the criminal justice system in future years.
- ▣ To increase self-sufficiency of women offenders and to decrease their involvement in the criminal justice and welfare systems.
- ▣ To avoid family disruption and the interruption of the security of the mother/child relationship.
- ▣ To provide an alternative to prison and help diminish overcrowding in the institutions.
- ▣ To avoid lawsuits (i.e., parity). (Parity refers to a Minnesota statute that mandates: "Adult women . . . shall be provided . . . a range and quality of programming substantially equivalent to" those for men. It further includes the special needs of women in programming.)

The National Institute of Corrections in Boulder, Colorado, maintains an Information Center on Female Offenders; they do not yet have an inventory of the states with such programs.

WOMEN/CHILD PROGRAMS IN NEW YORK

Both Bedford Hills and Taconic Correctional Facilities maintain nursery programs for infants born to women while imprisoned. Each of these nursery programs is a self-contained unit with a capacity of 30 nursing mothers. These programs are limited to women who were pregnant when committed to DOCS. Mothers can live with their child for up to 18 months, although the average time is one year. The Bedford program, housed in a maximum-security prison, is not specifically for drug offenders. On the other hand, Taconic's program, in a medium-security prison, is for drug-offending women.

There is other programming for mothers and children, including those run by the Children's Center housed in Bedford Hills' school building and the Incarcerated Mothers Program that has already been mentioned.

¹⁵ The American Correctional Association, *The Female Offender: What Does the Future Hold?*, 1990, Washington, D. C.

¹⁶ Anne McDiarmid in *IARCA Journal*, published by the International Association of Residential and Community Alternatives.

▣ TREATMENT IN A PRISON SETTING

Over the past few years, New York State DOCS has established Alcohol and Substance Abuse Treatment (ASAT) programs throughout the system. The 1990-91 fiscal year has seen the greatest growth for authorized ASAT programs with staffing at 280 (up from 90 in FY 1989). Currently, there are programs at 60 of the 63 facilities, including the programs within the facilities for women.

**ASAT Programs for Women Offenders
in NYS DOCS as of January 31, 1991¹⁷**

FACILITY	STAFF	PROGRAM CAPACITY	ACTUAL CASELOAD
Albion	2	80	79
Bayview	2	80	112
Bedford Hills	2	80	119
Groveland	2	40	40*
Parkside**	1	75	91
Summit***	1	81	81
Taconic	3	12	130

* Groveland has two programs.

**** Parkside is a work-release facility with larger caseloads.**

*** Summit Shock Program had 2-1/2 staff for both men's and women's programming.

While earlier studies of ASAT participants have shown lower recidivism rates upon release than those who have not participated, the quality of ASAT programs has varied dramatically from facility to facility. Some have been criticized as a waste of time. Others, however, have included separate tiers or units with intensive programming. In particular, the Stay'n-Out program begun in Arthurkill has received high praise and has served as a model for other states and been expanded to include a women's program at Bayview.

Along with the program growth in the 1990 fiscal year, DOCS is also attempting to establish a continuum of treatment, starting with classification, continuing through an existing ASAT unit, graduating into one of the ASAT prisons (McGregor and Livingston for men and Taconic for women). These prisons in turn will serve as "feeder facilities" for the Comprehensive Alcohol and Substance Abuse Treatment (CASAT) Program. CASAT has authorized five 200-bed treatment annexes providing intensive treatment programs both to prepare inmates for community reintegration and to provide one year of aftercare services upon release to parole supervision. Although intended to be run by nonprofit treatment providers, only Phoenix House was approved to run a facility (Marcy Annex). Three others (Chateaugay, Butler, and Johnstown) are being run by DOCS itself, and the fifth program has not yet started.

¹⁷ New York State Department of Correctional Services; information supplied to author.

Parole Relapse Prevention programs have also grown with DOCS' emphasis on treatment. In 1990, the Division of Parole was providing more than 600 parolees at any one time with residential or outpatient treatment. Except for 57 "slots" authorized for women and a similar number for men, relapse programming is open to parolees of either sex. These programs have been provided through not-for-profit organizations.

▣ PROGRAM INTEGRITY IN A PRISON SETTING

While such programs exist, DOCS faces enormous—and perhaps insurmountable—difficulties in establishing successful treatment programs within the prison setting.

First, there is role conflict:

- ▣ Treatment programs are based on a philosophy that is therapeutic. The goals and objectives, the planning and staffing are meant to encourage self-worth and personal responsibility, thereby helping an individual remain drug- and crime-free.
- ▣ Prisons, on the other hand, have no consistent philosophy; and the public mood, as perceived by policymakers, favors punishment over rehabilitation. Inmates are sentenced to serve time, not to change and grow. No doubt there are hopes that they will learn their lesson and remain drug- and crime-free, but the goals, objectives, planning, and staffing are dominated by security concerns, not by the self-worth or responsibility of inmates. This security focus creates a climate and daily schedule which hinders and complicates programmatic needs.

Second, a range of budgetary, bureaucratic, and political interests further complicate treatment integrity:

- ▣ On the one hand, lay-offs and the projected \$6 billion deficit in the 1991-92 budget are likely to compromise ASAT programming and staffing. These kinds of compromises are almost inevitable with the ups and downs of politics.
- ▣ On the other hand, prison and program siting decisions have been made to aid the economy of local communities, rather than on a more therapeutic basis. For example, even though 70-80% of the substance-abusing inmates come from New York City, the closest CASAT Annex is 250 miles from New York.

These kinds of concerns prompted treatment providers and advocates to prepare a paper entitled, "Program Recommendations: Drug Treatment 'Annex Facilities.'"¹⁸

Citing studies completed by the Narcotic and Drug Research Inc. (NDRI) and the NYS DSAS on a variety of treatment programs within prisons, the paper identified the following problems that have plagued such programs:

- 1) The correctional environment and personnel have been unwilling or unable to support program staff and programs.

¹⁸ A number of treatment providers and advocates prepared a Paper entitled, "Program Recommendations: Drug Treatment in 'Annex Facilities,'" which was adopted in 1989 by the NYS Catholic Conference.

- 2) The program staff is overburdened with unrealistic expectations and unrelated goals.
- 3) Inadequate funding of staff and equipment.
- 4) Bureaucratic and/or political constraints.

The paper identified the following key issues in the development and management of successful programs:

- 1) Successful treatment will be "intolerant of antisocial codes and behavior, encourage . . . communication, minimize distortion of reality, enhance individual initiative and development and consistently reinforce constructive behavior."
- 2) A prison setting must be an environment where the emphasis is on treatment and where there is cooperation between custodial and program staff.
- 3) Treatment requires "a continuity of care in the community after release and . . . strengthening of existing community-based networks."

Program objectives must include:

- 1) Creating an environment which provides health experiences and the opportunity for relearning and growth which is also flexible enough to be client-specific.
- 2) Developing ongoing program orientation, training, and evaluation to insure the program's effectiveness.
- 3) Developing a follow-up program especially with parole and community service agencies to ease reintegration.

Program issues revolve around:

- 1) Administration and custodial staff—central and facility administrators must be explicitly committed to treatment and, after selecting proper custodial staff, must also provide training and orientation for all staff. The program start-up time is particularly important.
- 2) Program staff—there should be a mix of professional and para-professional staff selected by the treatment provider. Training and orientation will be ongoing and interfaced with the custodial staffs.
- 3) Program participants—the intake and release procedure should be the responsibility chiefly of the program staff with obvious consultation with prison authorities.
- 4) Program content—the program must meet the standards in staffing, scheduling, and aftercare that are expected within the treatment community as funded by DAAA or DSAS. It must be firm and consistent in approving positive behavior and rejecting negative behavior. It will have a variety of educational and counselling components and will make provisions for family involvement where possible and aftercare support.

NEW YORK PROGRAM DEVELOPMENT

In the substance abuse treatment part of his 1991 State of the State message, Governor Cuomo announced:

Target Cities, a joint effort between New York City and the State to develop a comprehensive and coordinated system of substance abuse services in South Bronx and Northern Manhattan; and Project Connect, a program to provide a continuum of health and social services to women and children in three New York City communities.

In addition, New York's Anti-Drug Abuse Task Force, chaired by Lieutenant Governor Stanley Lundine, in its 1990 Update claims:

alcohol and drug abuse service delivery systems . . . are striving to serve greater numbers of women, pregnant women and women with small children. Currently, over 275 . . . programs provide services specifically for addicted women . . . discrete women's counseling groups . . . parenting groups . . . referral . . . case management and placement services . . . medical care . . . educational services.

Despite the past and current budget problems and deficits, New York's treatment programs have not been hit as hard as other human services or other state programs. The same Update of the Task Force outlined a new multi-service model for alcohol and substance abusing women with small children. This program was included in the 1990-91 Capital Budget and authorized the establishment "of at least 8 facilities (6 upstate and 2 in New York City)." Under the model:

treatment centers will combine drug and alcohol treatment with family support services ranging from housing to training and skills development to health and child care. The model will also work with children, providing necessary educational, developmental, health and alcohol/substance abuse prevention services. The Family Support Communities will offer a continuum of treatment services designed to keep the family unit intact while providing needed prevention, early intervention and treatment services for adult women and their children.

These initiatives have been included in the 1991-92 budget despite the serious proposed cuts and staff reductions. However, given the budget constraints, these proposals can only be models for the much greater efforts that are required. The 8 treatment centers, for example, would provide only 450 new treatment slots.

POSSIBLE PROGRAM MODELS

The programs most promising for individuals seem to be ones offering the profiled woman offender a strong community of support after an intense treatment program—most particularly, group therapy under the guidance of therapists who really care—that builds on self-worth and responsibility. The final section of this report reviews and evaluates seven New York programs that seemed particularly promising.



IV. RESEARCH METHODS AND PROGRAM REVIEWS



RESEARCH METHODS

In this phase of the project we analyzed the written descriptions of twenty-three substance abuse programs selected from preliminary research as possible program models. We researched four aspects of each program to get an accurate picture of the how each program succeeds or fails in meeting the needs of addicted women with children and addicted pregnant mothers. We constructed a program to meet these needs. Then, using the research data that we gathered, we illustrated whether and/or how each of these criteria could be met. This model, along with the research data, can be used for advocacy by the New York State Coalition for Criminal Justice. In order to carry out this goal, we first developed a research method to differentiate the programs in the initial research. We divided the project into three parts:

- 1) We surveyed the twenty-three programs recommended by a preliminary review. We ranked each program according to the services it offered, judged from a review of the written material as well as speaking to staff members about what services their program offered. From this review, we feel that we obtained enough information to differentiate the programs according to services.
- 2) We visited selected programs from the original twenty-three and interviewed at least two women from each program. These interviews were anonymous and provided a third view of the program. At this time we also interviewed administrative staff. These administrative interviews were confidential and provided a critical fourth view of the project.
- 3) From an analysis of the written materials, telephone calls, client and administrative interviews, we developed an overview of each program. In the summary, we propose a program that can be used as a model and provide data for further research and advocacy on behalf of female substance abusers.

We developed a chart (see p. 39) that included a broad spectrum of services and separated the services into six categories:

- 1) Type of program: Probation and/or parole; community and/or the prison, in-patient and/or out-patient, drug and/or alcohol, "detox" and/or treatment, follow-up and/or full release, referral services and/or only the program.
- 2) Family services: Mothers only, mother and children only, holistic family approach, "other" relationships (lesbian).
- 3) Criteria for admission to the program.
- 4) Basic services: Health, counseling, housing, vocational, educational.
- 5) Funding: Public, state; public, federal; private.
- 6) Special Needs: Race and ethnicity; developmental disability; age.

We visited seven based on the services that each program offered. Because each program we chose to visit had something unique to offer and its services were widely differentiated, it became possible to compare each program on services.

We also felt that it was necessary to interview administrative staff to discern what outside forces—political, funding community, insurance, governmental regulations—influenced the operation of programs.

The programs visited were:

- ▣ Partridge House at Akwesasne, Mohawk Nation
- ▣ Arms Acres in Carmel, New York
- ▣ Bayview Correctional Facility, Stay'n-Out Program, Manhattan, New York
- ▣ Riker's Island Correctional Facility near Manhattan, New York
- ▣ Taconic Correctional Facility, Bedford Hills, New York
- ▣ Lincoln Hospital, Bronx, New York
- ▣ Catholic Family Center's Liberty Manor, Rochester, New York

PROGRAM REVIEW/S

▣ Partridge House

Partridge House was chosen for the study because it is the only residential program with a strong ethnic component: it is for Native Americans only. While they have no specific program for women, we felt that it was important to see how a program worked that was specifically tailored for one racial or ethnic group.

FACILITIES

Partridge House is located on the Akwesasne Reservation near Malone, New York. It is a medium-sized structure with a large dining room, three offices, a large living room/meeting room and fairly large rooms that are adequately furnished. They offer ten beds; usually four are set aside for women and six are for men. (These numbers are flexible, however.) A van is available for transportation to activities or for doctor's appointments.

SERVICES

Partridge House is an eight-week residential program. It takes referrals from the criminal justice system; and while it is not an official "alternative to incarceration" program, people have had their sentences reduced for participating in the program. Partridge House accepts Native Americans from all over the East Coast and Canada. The only way into Partridge House is through referral. A client must be referred by some institution. They do not do "detox." Clients requiring detox are sent to a local hospital; if from Canada, they are sent to Ottawa.

They offer group sessions and individual sessions. They have family sessions for families of the clients (but there is no housing available for family members). These sessions are mandatory and four must be attended by family members before they can have interaction with the clients; in addition, the clients are not allowed to see any of their relatives until four weeks into the program. The programs are educational and do not refer to specific client problems.

There is no counseling offered to whole families. Partridge House maintains a list of five people, "family" or friends, who may visit the clients.

Partridge House offers daily living skills classes. They invite community speakers who have proficiency in a variety of skills to come in and give lectures.

They deal with sexual abuse and other contributing factors. They have a counseling program tailored to meet each client's individual needs. Clients' primary assessments determine what areas will be worked on during the eight-week module.

Partridge House, in conjunction with the out-patient substance-abuse program, has a co-dependency program that is basically female. This program is run on a non-residential basis because it is considered a secondary problem.

CRITERIA

Residents must be 18 and above. There is a program for Native youths in South Carolina and most younger people are sent there. A packet of information is given out when clients are admitted into the program which explains the program, rules and regulations.

There have been pregnant women in the program, but they usually cannot complete it because the day is very structured; all clients must participate in each program and there is no time to lie down and rest. One woman was six months pregnant and simply could not take the program physically. Because there are only ten clients in the program at a time, there would be no way to restructure the program for the benefit of one person.

Clients must be diagnosed as having a primary problem with alcohol abuse in order to be accepted into the program. All other addictions are treated as secondary. They are licensed by the state as an alcohol treatment center.

Partridge House is not set up for anyone with disabilities but the non-resident staff will go into the homes of anyone who cannot make it into the program.

Any medical problems are referred to the Mohawk Nation clinic. A substance-abuse assessment is done, as is a physical exam, upon entering Partridge House.

ADMINISTRATIVE VIEW

We met with the interim director of the Partridge House.

The program has twelve staff working with the residential program and six with the non-residential follow-up. Non-residential follow-up is done through the Mohawk Nation clinic. The director felt that there are not enough counselors, particularly for the out-patient clinic where it is not unusual for the staff to carry a case load of two hundred people at any given time.

Partridge House has a strong cultural component which includes language, crafts, sweat lodges and ceremonies as part of the program. A new director (non-Native) was hired at the beginning of 1990. He didn't understand the Native part of the program. He took out all of the ceremonies and sweat lodge meetings. He has subsequently left the program. The interim director, who is a Native person, said that she would bring back the language, culture and craft programs but would keep out the "religious" things. She said that there was community pressure¹⁹ to keep them out. The director felt that the cultural component was necessary in the recovery of the clients, but it was clear that she had to answer to the community as well as the clients. She felt that the language and craft classes were enough.

¹⁹ Akweesasne has three controlling governments which have fragmented the community. There are two elected governments, American and Canadian, and a traditional Longhouse government. The elected officials complained that Partridge House brainwashed clients for the Longhouse. Since the funding source is controlled by the elected officials, this may be a reason for keeping out "religious" aspects.

The program has to meet three sets of guidelines. The community in which the program is based has an unwritten influence: the program cannot offend the community. The program also has to meet state and federal guidelines and regulations.

The administrator did not feel her staff was overburdened with paperwork, although the women we interviewed felt that there were times the counselors were not available because of record-keeping duties. A file is maintained on each client. Observation notes are written each day by staff counselors and kept in confidential files. The administrator felt that the paperwork was her duty and that the counselors had enough time for all their duties.

The administrator felt that there was a need for expansion as they have a large waiting list.

The program does involve parolees and probationers. Admissions are strictly by referral. They try to make their program as accessible as possible, however, and to take referrals from courts, judges, and lawyers. A portion of a client's sentence can be served at the Partridge House.

The administrator appeared to be remote from the clients, but the staff counselors seemed to enjoy a closer relationship with clients. The administrator depended on clients who had been through the program to volunteer services as well as work with current clients.

CLIENTS' VIEWS

Two women were interviewed who participated in the program. The first woman, D.J., completed the whole program, 8 weeks of residency and 1 year follow-up, in 1989-90. She is an alcohol- and marijuana-abuser with two children. The second woman, C. D., participated in the eight-week residency but did not do the follow-up non-residential program, in 1986. She also had a relapse for a about a year, but has now been drug- and alcohol-free for two years. C.D. is a cocaine- and alcohol-abuser with two children. C.D.'s relapse was a result of the death of one of her children. Since the women participated in the program at different times, they had different ways of looking at the program.

These interviews revealed that the programs are always changing, particularly ones that have been around for awhile. Programs change under different directors, political pressures, and funding requirements/

sources.

When asked about the enforced separation from their families for eight weeks, both women felt it was necessary. They felt that they couldn't deal with their problems and their families too. D.J. felt that it was beneficial because her husband had to take care of the house, the children and work while she was gone. He had a better understanding about what it is she does. He had trouble fitting everything in that she made look so easy.

C.D.'s mother-in-law looked after her children for her while she was gone. She said it was hard to leave them, but she agreed that she couldn't have gone through the program with them. Both women wished there was more family counseling. The family night is structured on an educational basis, but there is no time when the whole family sits down together with a counselor and talks over substance-abuse problems. Both women felt that their children would understand

better if this happened. They felt the children's problems were also being overlooked, and whole family counseling sessions would help. D.J. said her husband had gone through a program in Canada. That program had a night when family members were invited to come and talk about what D.J.'s husband's substance abuse was doing to their family structure and life.

D.J. said that program made her (and him) realize how harmful substance abuse was to her family. C.D. said that she was released back into the community too fast: One day she was in Partridge House safe and secure, and the next day she was at home having to cope with everything she left behind. She said the follow-up program helped with the insecurity and anxiety she felt, but she wished for a more gradual release. D.J. agreed.

Both women were asked if they felt a stigma was attached to attending Partridge House. D.J. said the first few weeks she hid

out. Whenever the group had to go out into the community, she hid in the van seat.

But after the fourth week, she felt she finally understood and accepted her substance-abuse problem; then she no longer felt stigmatized. She felt proud that she was doing something to help herself. C.D. had

no comment.

Both women felt that the removal of the cultural component was the worst thing that could have happened to the program. Both felt that it had helped (was indeed essential), to their recovery. D.J. felt that it gave her a recognition of a higher power. C.D. looked forward to

going to the sweats²⁰. She felt they purified her and made it easier to cope with what was going on around her.

When asked what they felt a successful program should contain, they said, "group counseling, residency, cultural understanding and education, staff you can trust, and follow-up."

Arms Acres

FACILITIES

Arms Acres is located approximately 50 miles upstate from New York City. It is in the town of Carmel, New York. The program is located in a complex that houses a women's program, an adult program and an adolescent program. The complex is very plush and very nicely furnished. We were not offered a tour of the facilities.

SERVICES

Arms Acres is a private substance-abuse program based in the community of Carmel, New York that is funded primarily through insurance companies. It is a 28-day residency program. Arms Acres takes both alcohol and drug abusers. Although it remains unclear if "detox" is done at Arms Acres, clients we interviewed said they "used" the day before they were admitted to the program.

They do not offer a parenting skills class, nor do they have family counseling for the whole family. They maintain a flexible visiting list. Children are allowed to visit with their parents, but there does not seem to be any type of program for them, either educational or counseling.

Arms Acres offers both individual and group counseling in a variety of situations. They have a number of sub-sets within their whole program which include a women's program, an adolescent

program, a men's group and a psychological group for people who "are not sick enough to be committed but have borderline problems."

Their substance-abuse program is based on the twelve steps of Alcoholics Anonymous. Everyone is given books to read when they sign in, and they also have homework to do from each book. They do a personality assessment of themselves. There is no vocational training primarily because most of their clients have jobs (they are referred through their insurance companies).

Although some women are placed through their husband's insurance and may need job training, this need appears to be overlooked.

Arms Acres does not have a program that addresses racial or ethnic needs of their clients; however, they appear sensitive to developmentally disabled people.

Clients who have lost their housing because of substance abuse problems are placed in housing through Arms Acres.

²⁰ "Sweats" refer to the purification process of entering the sweatlodge. The sweatlodge is a small hut made of canvas tarp stretched over a circular wooden frame. Inside the sweatlodge, water is poured over hot rocks to produce steam. Medicinal herbs are added to purify the mind and the body. Prayers are said by each participant.

Clients are referred to appropriate programs in their communities when the program is completed, but there appears to be no follow-up through Arms Acres. Once in a while, the director said she gets a post card from a former client reporting her progress.

CRITERIA

Arms Acres does not accept women with children or pregnant women. Women who have children must make arrangements for them.

Arms Acres does not appear to take many parole or probation referrals, probably due to their short treatment period. Most clients at Arms Acres appear to be economically advantaged and have resources not available to women caught up in the criminal justice system.

ADMINISTRATIVE VIEW

The administrative people we met with were very nice but they did not overly extend themselves to us. We met with the clinical director, who expressed surprise over the fact that many women volunteered to be interviewed. He did not invite us to his office to talk. With him was the Director of the Women's Project. She was obviously pressed for time, and after answering a few brief questions and promising to leave curriculum data and client rules for us, she left to get the women who volunteered for interviews.²¹

When we asked whether there was any difficulty from insurance companies, she said, "sometimes with client case management." The insurance companies keep a very close watch on each client's progress and usually do not allow any time over the twenty-eight-day program. Occasionally, Arms Acres is able to convince the insurance company that a client may need more therapy. Conversely, if the insurance company does not think that a client is making progress, it may refuse to pay for her further treatment. The insurance companies also constantly inspect the facilities.

The staff appeared to be remote from the clients, and there seemed to be a definite hierarchy of supervision.

CLIENTS' VIEWS

V.B. is a 35-year-old white woman who has a history of alcohol abuse. She has a teenage daughter and a husband. She had been in several programs and had successfully stayed off alcohol for about six years through A.A. Her husband began to go on extended trips, and she fell off the wagon when he was gone. She had been in the program for one week.

A.M. is an African-American woman who had worked for the phone company for 18 years. During the telephone strike, while she

was home, she began to "mess around with crack" and then became addicted. She lived in a co-op and stopped paying her rent. She lost her co-op. When her drug problems came to light, the telephone company dismissed her. The union fought for her and arranged for her to come to Arms Acres. The union is also fighting for her job. However, she does not have a place to live and she knows she has to find a place when she leaves the facility. A.M. is also learning disabled. She had been

in the program for three weeks.

Both women liked the program very much. V. B. said that when she arrived, everyone knew who she was. Her picture and files had been circulated among the staff, who greeted everyone by their name on the first day of arrival. The women said the program is very structured. A.M. showed us her daily schedule. She has activities from morning to night. The women are given two books (both Alcoholics Anonymous literature) when they come in. They attend group

²¹ When we left the facility we asked at the desk for the materials and were told quite nastily by the receptionist that nothing had been left for us. We were told to "call back tomorrow" and ask to speak to the head of the Women's Program should we need anything further.

CRITERIA

The population that the program services is Latina and African-American. The program is for persons eighteen years or older. Parolees are referred to the program. Most court referrals seem to come as result of the involvement with child welfare agencies: women are required to attend because their newborns tested positive for a controlled substance.

ADMINISTRATIVE VIEW

We spoke with the director of the program. She had started with the clinic as a nurse when it was still a methadone treatment program. It is largely through her efforts that the women's program was developed.

The program has five full-time counselors, a child-care worker, and a drug-testing technician. Client files, which include results of daily urine tests, are maintained on the computer. All the clients' health services are provided through Lincoln Hospital. The clinic is funded through the city's Comptroller's office. Most clients are Medicaid-eligible.

It was the director's view that their funding structure helps them circumvent many of the problems other programs that try to service women and children may encounter. She anticipates that this will not permanently insulate them from such problems.

She said that the needs of crack-addicted children must be tracked in a more comprehensive manner: the economic needs of her clients pose as many health risks as drug addiction.

The director appeared to be a very dynamic, caring person who was truly involved with her community and her clients. She appeared to be readily accessible to both staff and clients. She has also been able to gauge clients' needs through observation and personal contact.

CLIENTS' VIEWS

We interviewed two women who had been through the program and continued in it on a voluntary basis. In subsequent interviews at Taconic Correctional Facility, women who had attended this program prior to the tenure of the current director also commented.

The clients felt that the main strengths of the program, in the order of priority, were: the client's attitude, the immediate intake, group counseling, the staff attitude, and acupuncture. Acupuncture is available for anyone who wants it, and many clients continue to come to the clinic on a daily basis long after their programs end.

We interviewed two women, G.T. and S.M. Both women are in relationships and commented that their men are substance-

abusers. Both said that while they prefer their men not use drugs, it would not affect their decision to stay clean.

G.T. is a crack user. G.T. commented that she noticed her son who is under the age of three reacted negatively when she used drugs. She had ten children; her youngest, age two, will be the first to know her to be drug-free.

G.T. had a set of twins eight years ago who were born drug-free, but she lost custody of them anyway. She had admitted to a drug history because she wanted to ensure that if her children were born with a drug-related problem, they could receive the proper treatment. When she was released from the hospital, they were kept for observation. One day she came in to feed them and they were gone. She doesn't

know where they went (probably into a foster home) and hasn't heard about them since.

G.T. says that as she works to maintain a drug-free life, the loss of her twins has been a major factor in convincing her to deal with her feelings. She says that she believes she might have regained custody of them if she had faced the pain of the loss and then struggled to get them back. G.T.'s husband is addicted to heroin, but she feels this will not impede her progress. She says she has to move in her own direction. Because of the women's rap group, she feels that now she is able to ask him for what she needs—money to pay the bills and to buy things for the children—without recriminations.

S.M., a crack user, had also lost a child to the child-welfare

Neither woman had comments about how the program could be improved—they felt it was perfect. This an example of something we found in other community programs: the clients had no problems with their program. Everyone thought her program was the best. A woman we spoke to at Riker's Island who had been to the Lincoln

There is an implication in the comments we heard that the women are struggling to build social lives in their neighborhoods without drugs. Due to the high demand for other types of services, it does not seem that

When asked what they thought was needed for the perfect program, they said, "group sessions, receiving treatment immediately, women's sessions, caring staff."

Individual intensive counseling is done with each woman to provide both for her immediate needs and to develop referrals that will aid her once she is released. Substance-abuse program people also come into the facility to do presentations for the women on various topics, including the services they offer. The Director is attempting to develop a two-year life-skills program and a three-year follow-up program to track the progress of their clients. There is no consistent follow-up at this time because the staff is too small and too over-burdened to provide these services. Family support services

are provided by referrals. The program has about twenty-five people in the women's program and approximately thirteen adolescents. Medical services are provided through Montefiore Medical Center at Riker's Island.

This program is not an alternative to incarceration; however, they work closely with the Osborne Association²², courts, women's attorneys and assistant district attorneys to get their women placed in programs as alternatives to incarceration. Clients who are to be transferred to New York State Correctional Facilities are referred, when possible, to appropriate programs at the facility to which they will be sent.

ADMINISTRATIVE VIEW

CRITERIA

Riker's Island was chosen for this study because it is located in a city correctional facility and has a woman's program that attempts to serve all types of women: pregnant women, women with children, and adolescents. The program allows mothers to keep their newborns with them. The clients are Latina and African-American.

We spoke with the director of the program, a social worker and an adolescent worker. We also met the head of the nursery program. It is largely through the director's efforts that the women's program was developed.

Client files are maintained by the facility and the individual caseworker. All health services are provided through Montefiore Hospital.

The Director's role is primarily administrative. She oversees the maintenance and development of the program services. In addition to the life-skills and the follow-up programs, she views the development of an educational program a top priority.

The counselors provide advocacy for the women. The social worker runs the group sessions and meets with women to develop individual treatment plans that include short-term goals, such as

meeting the vocational counselor, and long-term goals, such as choosing a drug treatment program on the street. The adolescent worker does not run a group, but her role with adolescents is similar. Both women advocate on behalf of the clients involved in the criminal justice system. The social worker and the adolescent worker both enjoy a high credibility with the clients we spoke to. They appeared very dedicated to the women in the program.

We talked to the social worker about AIDS education and pre-test and post-test counseling. She said that when some of the women are told that they are HIV-positive and that they only have a 50% survival rate, they say that this is the best odds they have ever been given. Others when told they are HIV-positive seem to give up. It's a double blow: they have just begun to straighten out their lives only to be told they have a fatal disease.

The nursery program allows mothers to live in the same area as their children and allows daily contact with them in a setting that looks much like a hospital nursery. Mothers take their meals with their children and can spend their free time with them. We did not have an opportunity to speak to the Director of the nursery at any length.

CLIENTS' VIEWS

We interviewed four women who were in the program, in addition to one who had just begun the program. All the clients but one felt that group counseling was a strength of the program. They also

²² The Osborne Association, 135 E. 15th Street, New York, New York, 10003 is dedicated to providing needed rehabilitative services to those involved in the criminal justice system, such as El Rio, a crack treatment program. They also work to develop other alternatives to prison.

stressed the importance of the high level of staff commitment and the importance of staff attitude. Clients also stated that they did not think they would have gained as much from a program that was co-ed. They did not think they could talk about problems they have had with men in a mixed group. The women felt that the nursery was a positive program and provided stability for many women.

K.H. is 19 years old and a client in the adolescent program. She had recently given birth to a son who was in the nursery program. She had also recently been diagnosed with cancer. Overall, she was the least satisfied with what the program had to offer. She had the fewest resources to deal with her secondary problems and did not see her use of alcohol and marijuana as drug abuse.

Her family had been broken up as a result of her mother's drug use. Her mother is H.I.V. positive. Her brother and sister are in foster care. Her elderly grandfather is housebound and lives alone in the house where K.H.'s family lived. The neighborhood by K.H.'s description is drug-infested.

When we spoke to K.H., she had been working with the caseworker for about two weeks. The worker attempted to place K.H. in a residential treatment program, but she refused although it meant K.H. would have to be incarcerated for a few months longer and be placed on probation following her bid. She refused because: (1) The treatment center was out of state; (2) she could not have kept her baby;

(3) she felt that she could not stand to be "locked-up" for the period of time that the residential program required; (4) she feared she would lose contact with her grandfather and siblings. For many clients, the only reason they keep going is their babies; the counselor felt this was the case for K.H.

The counselor has not given up searching for suitable housing and treatment arrangements for K.H. and her baby.

Some of the older experienced inmates had advised K.H. that the correctional facilities were "better" upstate and so K.H. thought she had options as far as incarceration was concerned rather than to work to get released to the outside.

Y.D. has been a client of a variety of treatment programs. She is twenty-seven years old. When we spoke to Y.D., she was waiting to begin the program. She had been arrested on two prior occasions. When she was first arrested, no one spoke to her about treatment programs or alternatives to incarceration. After her second arrest, she was placed on probation and attended Narcotics Anonymous meetings; however, she had no understanding of her addiction to heroin. She also had no support system for staying clean. The counselors are working to find appropriate placement for her. The counselors have suspected that Y.D. might be developmentally disabled and would like to have her tested.

D.R. is 24 years old and has been using cocaine for six years. She had smoked pot since she was nine but didn't think of it as

a hard drug. She has two children who are being cared for by an aunt. She stated that she first started smoking pot with her boyfriend and then progressed to crack.

T.M. is twenty-one years old and has been using drugs since she was sixteen. She was pregnant at the time we interviewed her. She had a daughter that died and has a son in foster care. She started smoking crack with her husband.

V.S. is twenty-eight years old. She has a child living with relatives and had a son that died.

These women were interviewed as a group. They informed us that they had never been offered any alternative to incarceration. T.M. had been arrested twice before and each time her arrests were drug-related. At neither arrest was drug treatment even mentioned. Two of the women had no information about drug abuse until their incarceration at Riker's.

All these women said that group counseling was critical to their abstinence. They also felt that the group sessions enabled them to speak up for themselves and gave them a better self-image. D.R. said that she thought she was the only one with the kind of problems she had but began to relate to others when she heard their problems were not unlike hers. She felt that she wasn't alone anymore. Y.D. said, "You can't bullshit in group." They also felt that there was a much greater demand for drug counseling than the facility can meet. Women have heard of the group by word of mouth, and the meeting room is packed to

capacity. The counselors said that there just wasn't enough time or staff to meet the demands for adequate group sessions.

The women commented

that the fact that the program is only for women gives them confidence to speak out about problems they would have difficulty discussing. They also mentioned

that prior to the program, they had never had women friends on the outside. Group counseling taught them how to trust each other.

Bayview, Stay'n-Out Program

FACILITIES

The Stay'n-Out program for women is housed in the Bayview Correctional Facility, a New York State prison in Manhattan. The program offers forty beds in a segregated section of the facility. The cells are furnished with beds and each woman is allowed her personal belongings and pictures.

SERVICES

The Stay'n-Out program is based on the therapeutic community model, which encourages group identification in the form of group counseling sessions, group responsibility and peer counseling. Clients are drug- and alcohol-abusers. Most prisoners are "detoxed" at Riker's Island before coming to any drug program. Women are usually paroled to community-based drug treatment programs, but there appears to be no active follow-up of clients other than through recidivism rates and sporadic studies.

There are no family services. They do not have any special services for pregnant women or women with children. Because lesbian relationships in prison are overwhelming and a natural solution to an unnatural situation (prison), they are overlooked and not considered a problem.

Although most of the women at Bayview work for the Department of Motor Vehicles answering phones, they do not consider this vocational training as, realistically, none of them will ever be hired by the DMV when they are released from prison. Women attend group counseling and receive individual counseling on an as-needed basis. They receive no educational services. AIDS education and counseling is sporadic.

CRITERIA

The Stay'n-Out program has been in existence for ten years. Women are accepted into the program when they are not less than six months nor more than 12 months away from parole. They must possess a positive record before they are accepted into the program, which means no violence and no prison rule infractions.

ADMINISTRATIVE VIEWS

We met with the Executive Director, the public relations person and the on-site director of the Stay'n-Out Program. These people are committed to their program. They seem to be the key to this successful program. We got the feeling that every person in this program is cared for on an individual level, and this caring is a powerful thing. The executive director is an ex-addict; perhaps this is where the dedication of this program stems from.

This program is run by New York Therapeutic Communities, Inc. but has been funded through the Department of Corrections for the last few years. Bayview has three counselors in addition to the on-site director. Almost all the counselors for Stay'n-Out are ex-offenders and ex-substance abusers. They function as the role models for the clients.

The clients have to work for the DMV from 9-11 am and then from 1-3 pm answering phones. The Stay'n-Out program must operate its curriculum around these hours.

CLIENTS' VIEWS

We met with the group of women in the Stay'n-Out program as a whole. They asked why we were here and we explained that we were researching programs for addicted women. They responded favorably to that. They liked the idea that someone was looking into alternatives to incarceration, as most felt that the women who were in prison for drug-related problems shouldn't be there.

The group as a whole felt that there should be more AIDS education. More and more women are testing HIV-positive, and they feel that there is not enough pre-test nor post-test counseling. Some of the women complained that they are trying their best to stay off drugs and straighten their lives out; but with lack of vocational training, they will have no economic opportunities once they leave prison. Most of these women lose contact with their male and domestic counterparts while incarcerated and they have children to support. Without vocational training they will have to depend on the welfare system or go back to selling drugs to earn a living. They voiced their frustrations very eloquently over this situation.

We interviewed a group of

three women, but we were not alone, as a counselor stayed in the room with us. She did not seem to interfere with any of the answers given and apparently had the trust of the women in the program.

J.J. is a 30-year-old black woman who has a learning disability. She grasped some concepts, but other questions had to be explained to her. She had been in the Stay'n-Out program for about four months.

M.L. is a 34-year-old Latina woman. She has three children who are living with her mother. She was addicted to crack. She has a history of drug-related criminal activity but was never offered a drug treatment alternative or program. When she transferred to Bayview, she noticed the women in the Stay'n-Out program and asked about the program herself.

M.L. stated that she would have never succeeded in a drug treatment program out in the street. She said it took the shock of incarceration to make her realize that she had a drug problem and that she could do something about it.

J.F. is a 50-year-old white woman. She was addicted to drugs given to her for a back problem. She was transferred to

Bayview to general population, had never heard of drug treatment programs and had never been offered one. She saw how the women of the Stay'n-Out program seemed to care more about each other as a group than the other prisoners so she asked about the program.

All the women like the group-therapy sessions. They felt that the group-therapy sessions gave them a chance to air their feelings. The topics of some group-therapy sessions are at the request of the women.

The women felt very strongly that there should be more vocational training. They also felt some frustration at having to work for the DMV while in the Stay'n-Out program. They wanted more time to concentrate on their program. They felt that working for the DMV was not going to help them get a job on release, that it was not very useful for them when they got out.

The women also felt that there should be more AIDS education and sensitivity within the prison as a whole. With the exception of the time limitation and the lack of AIDS sensitivity by the prison officials, they felt that the Stay'n-Out program was the best program it could possibly be.

□ Taconic Correctional Facility ASAT Program

FACILITIES

The ASAT program is housed in Taconic Correctional Facility. The women in the program are not housed separately from general population, although there is a nursery program where women live with their children. The nursery has a separate wing and the women are able to spend a good deal of time with their babies.

It is not clear how much space the ASAT program has but the director has an office and there is space provided for group sessions. We assume there is space provided for individual counseling sessions.

Taconic was running an ASAT program; however, as of July 1, it became a program based on the therapeutic community model using the ASAT program as its first phase of operation. This transition was being funded by a federal research grant. Most of the time we spent talking to the director was about the new program not the ASAT program that had existed. The clients, however, could only talk about the prior ASAT program. This may be a little confusing.

SERVICES

The program at Taconic Correctional Facility is an "enhanced" Alcohol and Substance Abuse Treatment Program or A.S.A.T. program. This program was chosen because it is in a New York correctional facility and is a program designed and operated by the Department of Correctional Services. We call it an "enhanced" program because the director has attempted to service pregnant women and women with children as well as single women. The program at Taconic apparently provides a range of services far beyond those ordinarily available in ASAT programs. The director has made this possible by networking with programs that already exist within the facility and obtaining grants for additional services. The director's ultimate goal is to develop a residential treatment program based on the therapeutic community model that will offer a full range of services to incarcerated women.

When the program is fully operational, two-thirds of the women in the facility will be in treatment (260 women). This program was funded in response to a huge waiting list of over three hundred women. This program is currently in the first stage of a three-stage process to increase services. At this point the program allows mothers to keep their newborns with them through networking with the nursery program.

Women in the corrections system are scheduled to participate in daily activities. The day is broken up into three modules or blocks of time. The women in the ASAT program have three treatment modules per day. Every woman attends group counseling sessions dealing with substance abuse. These groups are based on the traditional twelve-step model used by both Alcoholics Anonymous and Narcotics Anonymous. Individual counseling is provided by the director, corrections counselors, the facility psychologist, and peer counselors. Stage two of the program will be two modules of treatment per day, and one module of educational or vocational training. In the third stage of the program, the women will spend three modules in educational programs or vocational programs and will work on their pre-release programs. Substance-abuse and life-skills program people will come to the facility to do presentations for the women on topics such as parenting and budgeting.

The clients are supposed to be assigned to the program on a voluntary basis; however, there is an incentive for women to participate because it may speed up their release date. Clients who are transferred

to Taconic from county correctional facilities are referred by the staff of the county facility. There is no plan for follow-up at this time other than parole. Family support services were not really discussed: it was the director's view that while many women make extraordinary efforts to keep in touch with male loved ones who are incarcerated, very few men make any effort to maintain contact with women who are incarcerated. There is some appreciation that these family support services would

be valuable for grandparents and older children.

Medical services are provided through the facility medical department.

This program is obviously not an alternative to incarceration. It was the director's view that many of clients would be better placed in alternatives to incarceration programs; he recognizes that too few real alternatives exist.

ADMINISTRATIVE VIEW

We spoke to the director of the program. He is a therapist and maintains a practice outside of the prison. His doctoral thesis deals with substance abuse and treatment programs. He sees a social trend which does not recognize addiction as an illness and which seeks to punish addictive behaviors. He feels that in designing his grant proposal, he had to be sensitive to this pattern and work to build a program inside the prison walls which uses the most effective methods from programs on the streets. It is very clearly his view that many of his clients would be better placed in treatment than incarcerated.

To work within the constraints imposed by the corrections system and state hiring policies, many of the existing employees and new staff that will be hired under the grant are employees who have passed the civil service test and /or are employees who are currently laid off by the state. Because of this, the director does not have the final say on who his employees will be; he feels he can overcome this obstacle by designing his own training process.

The director is also trying to insure that women have meaningful participation in the running of the program given the fact that peer counseling will be eliminated. Ideally, there would be a smaller client-to-staff ratio and more groups. With the increase in staffing starting July 1, these things may occur; however, there are

CRITERIA

The clients are primarily Latina and African-American. They are eighteen years old and above. They do not have to be in range of parole to enter the program. They cannot have a history of violence while incarcerated.

new problems on the horizon. Taconic is being converted to a forensic facility: all but the most severely mentally ill prisoners will be housed there. This means that although the proposed staff-to-client ratio was appropriate for women whose main problem was addiction, it may not be appropriate for a unit which is mandated by D.O.C.S. to house and treat mentally ill substance-abusers.

The director would like to see testing for developmental disabilities; as a practical matter, without additional staff, it cannot occur. Presently the program can accommodate prisoners with special needs: women who are H.I.V.-positive or who have been sexually abused, for example. It is not clear if the upcoming changes will affect the provision of these services.

Client files are maintained by the facility; this includes the Department of Corrections, the Division of Parole, and the corrections counselors. Future files will be maintained by the individual caseworker and will provide greater privacy for the individual client, thus promoting greater trust. All client health services are provided through the prison infirmary and Westchester County Hospital.

The director has a good rapport with the clients. It differs in tone and attitude from that of the Corrections employees.

CLIENTS' VIEWS

We interviewed three women who were in the program as it existed prior to July 1.

The clients like the group counseling. They also stressed the importance of the high level of staff commitment and the importance of staff attitude. Clients also stated that they didn't think they would have gained as much from a program that was co-ed. They cited the distractions caused by competing

for male attention, low self-esteem, and differences in the ways men and women view the problems associated with addiction. They also did not think they could talk about problems they have with men in a mixed group. The women thought the nursery was a positive program and helped to provide stability for many women.

The women we interviewed had very different backgrounds. They were between twenty-five and thirty-five years old. Two of them had children; one of the mothers had a child in the nursery program.

M.F. is from the Albany area and lived in a middle- to upper-class neighborhood. She described herself as a recreational user of cocaine. She is serving an indeterminate sentence of 4-15 years for possession of thirty dollars worth of cocaine. She was arrested with her ex-boyfriend. This was her first offense; she was not offered any alternatives to incarceration. She is currently a peer counselor in the ASAT program.

In M.F.'s opinion, her most serious problem is the length of her sentence and the type of structure that keeps her behind bars for this type of infraction rather than her drug use.

Both R.L. and S.K. were living in neighborhoods that were overrun by drugs. Both are from the New York City area.

S.K. was convicted of a drug-related robbery. This is her first offense. She was a heroin user

on the streets with her husband. He masterminded the robbery and is also serving time. Her mother-in-law is taking care of her two children. She had been using heroin over ten years; however, she had no understanding of her addiction to heroin prior to coming to the program. She had tried to quit on her own in a fourteen-day methadone program, but the program didn't provide the kind of support she needed.

She receives letters from her husband but does not respond. She says he is recovering in prison, but she feels he is a part of the old life that would only lead to her relapse. The woman's program helped her see how she can take responsibility for her life; she has never done this before. Her main priority is her children. She would like them to know her as drug-free, even though she feels she maintained a home life for them while she was using. She felt that an important factor in this program was that they had a peer counselor who spoke Spanish. She spoke almost no English at the time of her arrest. She would like to give something back to the program by becoming a peer counselor. This may not be possible because under the new grant, peer counseling is to be phased out.

This is R.L.'s third felony. She was convicted of possession and sale of a controlled substance. She has consecutive sentences of 1-3 years and 2-5 years. She had been abused much of her life and had begun using mari-

juana as a teenager. R.L. is now in her twenties. She had tried other treatment programs, but the programs she was referred to had no support services. She has a daughter in the nursery program and likes Taconic for this reason.

She likes the peer-counseling component but would like more professional help. She was the only person who said she wished there were psychiatric help available on a regular basis. This is interesting because while many women had been severely abused—sexually, mentally, emotionally and physically—few seemed aware prior to entering treatment that there was any type of help available. R.L. wished there were more counselors. R.L.'s first priority was her daughter and succeeding in the program. The program is the first place she has encountered where people were committed to rebuilding her self-esteem.

The women at Taconic would like to see the family component expanded to include older children. They want more life-skills classes. They would like to see more professional staff. Currently the program's focus on women gives them the confidence to speak out about problems they would have difficulty discussing in front of men. It is not clear what impact the hiring of more male staff will have on the women. The most important fact in the success of the program is the amount of individual interest the women feel they are given.

☐ Catholic Family Center's Liberty Manor

FACILITIES

Catholic Family Center's Liberty Manor is located in Rochester, New York. Liberty Manor is a residential program and is housed in its own building. The women have kitchen, laundry and other facilities. The rooms are nicely furnished and there is ample space with a backyard.

SERVICES

Unlike Partridge House or Arms Acres, Liberty Manor maintains separate living and treatment locations. Some group activities take place at the residential quarters, but for the most part, the treatment activities take place at RESTART. The women are expected to attend all activities at RESTART and are responsible for their own schedules. They may be expelled from the program for missing their appointments at RESTART.

Both group and individual therapy is provided. The clients receive parenting classes, addiction education, attend G.E.D. classes and leisure classes. Leisure classes teach recovering addicts positive, non-abusing activities to participate in. Many of the women had no idea how to spend time they once spent "drugging."

Clients have to be referred into Liberty Manor. They receive a large variety of referrals including through the courts, parole and probation. Some women are sent to Liberty Manor to complete sentences on parole. If they do not complete the RESTART program, they must go back to jail.

Each resident is responsible for daily chores. They also contribute food stamps to a common food fund. With whatever is left over, they can buy personal food preferences. Decisions dealing with life at the Liberty Manor are decided through group consensus.

Aftercare and follow-up begins six weeks after discharge from the program. The clients attend RESTART activities. No woman can leave the program without a sponsor from either N.A. or A.A. Aftercare may last for as long as a year.

ADMINISTRATIVE VIEW

We met with the director of the program. She was very informative and pleasant.

The staff for Liberty Manor and RESTART programs consists of a program manager, two primary therapists, one part-time therapeutic recreation specialist, one part-time coordinator of volunteers, one van driver, one house coordinator, four therapy assistants and relief staff.

Liberty Manor operates under state as well federal guidelines. The program did not originally include children, but pregnant women needed to be served as well. The addition of children occurred gradually as pregnant mothers delivered babies while in the program. There are now five beds available for children. The administration has not yet run into any problems with children in the facility due to governmental regulations, perhaps due to the original purpose of the program which did not include children. The children are just there.

Client files are maintained by the director as well as the counselors. The director appears to maintain a relationship with the

CRITERIA

Liberty Manor is a RESTART program under the Catholic Family Center of Rochester. It is a six-month residential program with beds for 15 women and 5 pre-school children. This program was started with the idea of providing services to homeless women. Through the multiple difficulties that the homeless women presented, Liberty Manor evolved into the program it is today. It serves primarily Latina and African-American women.

clients. Because the residential program is separated from the RESTART treatment program, we did not get to speak with any of the drug counselors or visit their facilities.

CLIENTS' VIEWS

P.L. is a 27-year-old woman with an infant who was born while she was in Liberty Manor. She has three other children ages 4, 6, and 8. Her sister, who is a nurse and also abused drugs, called the child protection agency on P.L. and gained custody of the children. Although the sister abused drugs, she managed to keep her life together while P.L.'s fell apart. Threatened with the permanent loss of her children, including the one on the way, P.L. decided that it was time to do something about her problem.

P.L. felt that it is necessary to be in a residential program. She felt that she could not get the help that she needed on the streets. She said that it is necessary to "get in touch with yourself" and it is important not to have any relationships while going through recovery. Liberty Manor allowed her to do this because she didn't have to depend on anyone for support.

She felt a co-ed program wouldn't work because women would be competing for male attention. She felt the group therapy sessions were a vital part of the program. P.L. also thought that the rigid schedule and the emphasis on personal responsibility was vital to the success of the program. She felt comfortable that the RESTART program

would be available when she was discharged from Liberty Manor.

P.L. said that being able to keep her baby with her while she was in the program helped maintain her program. The desire to regain custody of her children was a strong motivation to succeed in her program; however, she stated that she was doing this for herself, not for her kids. She said the program would not work any other way. P.L. wants more emphasis on job readiness and job placement. "When people go back on the streets they need job skills."

A.J. states that she began using alcohol and marijuana at thirteen. She moved on to cocaine. She stopped using at fifteen when she became pregnant with her daughter but then started again at nineteen when she started selling drugs for money. She stated that she started using drugs to medicate herself because her man started running around.

She went to prison for the first time in 1983 for forging checks for money. A.J. was still on drugs in prison and sold drugs while she was in prison. She said no drug programs were offered to her at that time, partly because she said she would have had to admit that she had a drug problem and she didn't believe she did.

She said she came out of pri-

son selling drugs. While on parole she was busted again for selling drugs. This time she "admitted" to her parole officer that she had a drug problem because she didn't want to go back to jail but she really didn't believe it: "A drug addict is someone who doesn't have a house, job or family."

A.J. said she "maintained." She was paroled to Liberty Manor. She had to do the whole six-month program or go back to jail and do the whole time over. She feels that this incentive is needed.

A.J. likes the RESTART program because it puts emphasis on getting in touch with feelings and how to deal with anger. She said she began to learn to relate to other people in group therapy. She said people will tell you if you have an attitude or not. "If a lot of people are saying it, it might be true."

A.J. said she comes from a middle-class background and was used to having money. She had a hard time getting used to being supported by welfare, but now feels that it is better than being on drugs. A. J. was a legal secretary and feels that she didn't need job skills but sees a need for vocational training for others. A.J. feels that she will not need the RESTART follow-up service. □

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We would particularly recommend reviewing programs from California, Minnesota, Pennsylvania and Massachusetts. The Minnesota model is interesting in that it provides community housing for its clients who are in a non-residential program. The California program is similar. We would like to analyze any “treatment matching” with particular attention to gender, race, and class.

We would survey community programs that have an organized tracking system. This would enable us to determine what type of follow-up support is effective.

Some attention has been given to the children of cocaine-addicted mothers. In the long term, it is important that studies continue to track the progress of children born addicted to any substance and their mothers. It is important as well to track the progress of children exposed prenatally to drugs and alcohol. And it is important not to assume that newborns who test drug-positive are actually addicted. It is not known whether social or economic deficiencies play a part in developmental disorders of children born addicted. Such a study would help identify other services that should be made available to addicted mothers and their children. It could also provide useful information on the long-term social damages of addiction.

In order properly to finish the current study, Taconic's therapeutic community deserves a second look once it becomes fully operational in 1992. It would then be possible to see how well a prison program with primary focus on drug treatment would work with a nursery program.

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