

**The 38<sup>th</sup> Annual Morris Fromkin Memorial Lecture  
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**THREE STRIKES: SUBSTANCE ABUSING, FEMALE, & IN JAIL**

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## Preface

We originally proposed two facets of research for the Fromkin fellowship. The first involved review of a dispersed, multi-disciplinary literature, some of it historical and some contemporary, concerning the disparities experienced by women with substance abuse problems while they are in jail and as they work through reentry to community living. The second involved conducting a series of interviews with reform leaders, promoting their visions of ways to address these disparities and improve our system's responses to the needs of women with substance abuse problems during incarceration and community reentry. We have also included some thoughts from the women themselves, collected during our focus groups and interviews related to a 2-year jail in-reach project entitled "Supporting Jails in Providing Substance Abuse Services to Women."

Today's lecture includes just some of the highlights from our many months of work—and represents only the tip of the iceberg from all that we have learned. We each learned a tremendous amount that simply will not fit into this afternoon's time and could easily fill four more hours of lecture. Today, Audrey will begin by describing the three strikes. Then, Susan will pick up with a discussion concerning incarcerated women's child welfare concerns and what we learned about a nascent social reform movement and recommendations for change from scholars and the women themselves.

## Lecture Outline

- I. Strike One: Substance Abusing
- II. Strike Two: Substance Abusing and Female
- III. Strike Three: Substance Abusing, Female, and In Jail
- IV. Social Reform
- V. Recommendations for Change

## Strike One: Substance Abusing

The ways in which we choose to define a social problem have a profound impact on the nature of the solutions and responses that we develop and implement. Throughout much of our nation's history, alcohol and substance abuse have been identified, at least by some, as significant social problems. But, the ways in which these problems have been defined have varied quite markedly.

Some of the various theories and models used to explain how and why individuals abuse alcohol and other substances include:

- a. they are demonstrating significant moral failure,
- b. they are evidencing character flaws or personality disorders,
- c. they are victims of family dysfunction,
- d. they suffer from spiritual weakness,
- e. they suffer from a brain disease or disorder,
- f. they are victims of an oppressors' efforts to exert social control over them or of efforts to stigmatize disenfranchised groups where there exists a high incidence of substance abuse,
- g. they are merely exerting their individual rights to self-direction, individual choice, and self-determination, and
- h. they are a threat to society (Anderson, 1995).

<p style="text-align: center;"><b>Strike One:</b> <b>Substance Abusing</b></p> <p>Understanding Substance Abuse &amp; Dependence</p> <ul style="list-style-type: none"><li>• Array of Explanations</li><li>• Many invoke stigma, blame</li></ul>
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As a result of these varied definitions and theories concerning problems with alcohol and other substances, a wide array of responses have been offered; many with mixed degrees of ethical comfort. Coincident with these philosophical differences, there have also been dramatic shifts in the criminal justice system emphasis on retribution, restitution, or rehabilitation (Chandler, 1973).

Our conceptions and definitions of substance misuse, abuse, and dependence are, most definitely, shaped by our times and cultures. For example, historic definitions may have included overt references to morality and sin.

### Current Perspectives

Our modern definitions are also shaped by cultural constructs. In some cultural contexts, any use of alcohol or other substances is defined as problematic. Or, the use of certain substances to modify mood may be culturally accepted under certain circumstances. For example,

- alcohol is accepted at many celebrations,
- alcohol and peyote may be accepted for specific religious rites, and
- "medication" is an accepted response to diagnosed affective disorders.

The etiology of substance abuse and dependence (which means the causes and natural course of the disorders) has been the subject of considerable study. The

preponderance of recent research suggests that alcohol **dependence** has strong biological and hereditary components. This conclusion is drawn from evidence that:

- (1) individuals with alcoholism have higher rates of alcoholism among their parents and siblings than do other individuals;
- (2) alcoholism patterns reflect significantly greater similarity among monozygotic (or identical) twins than within dizygotic (fraternal) twin pairs;
- (3) adoption studies indicate that children born to an alcoholic parent have higher rates of the problem than children born to non-alcoholic parents, despite being raised in non-alcoholic families;
- (4) researchers have begun to identify brain activity and neurotransmitter differences between individuals who are or become alcohol dependent compared to other individuals.

**Strike One:  
Substance Abusing (cont.)**

- Current Perspectives
  - Bio-psychosocial perspective
  - Chronic relapsing disease
  - Progressive without intervention/effort to change

The nature of the actual drugs being used also contributes to the likelihood of dependence emerging. For example, the route of administration (i.e., intravenously, snorting, inhaling, smoking, or ingesting) tremendously affects the rate of absorption and speed of delivery to the brain. Specific formulations of the drug affect the short *versus* long acting nature of the drug. All of which influences the probability that use, misuse, or abuse of the substance will result, eventually, in dependence on the substance.

This is not to say, however, that environment is irrelevant. It is clear that heredity is not destiny with regard to substance dependence. Genetic and biological factors contribute to an individual's vulnerability, but environmental, experiential, and co-occurring risk factors interact in formulating individual outcomes.

The National Institute of Alcohol Abuse and Alcoholism (see NIAAA.gov) and the National Institute on Drug Abuse (NIDA.gov) advocate a **chronic, progressive, relapsing** disease model of alcohol and substance dependence. In essence, this perspective suggests that:

- (1) individuals vary in terms of their **susceptibility** to developing dependence on alcohol or other substances,
- (2) individual susceptibility has significant genetic, biological, and physiological components, and,
- (3) these factors interact with development, environment, experience, social learning, and risky social contexts to determine individual outcomes.

The chronic relapsing disease perspective also implies that efforts to control dependence, once incurred, are long-term; often necessitate repetition and reinforcement; are likely to progress to more serious levels without intervention or conscientious self-directed effort; and, may require multiple strategies for achieving adequate control, preventing relapse, and promoting health.

We currently rely on specific clinical definitions that distinguish between substance abuse and substance dependence. Research results concerning the epidemiology of substance use, misuse, abuse, and dependence suggest that these behaviors **do not** fall along a single continuum. Alcohol and drug dependence (or alcoholism and addiction) appear to be **qualitatively** distinct phenomena, not only **quantitatively**

“Everyone keeps telling me that my substance abuse is a problem. It’s not my problem it’s my solution.”

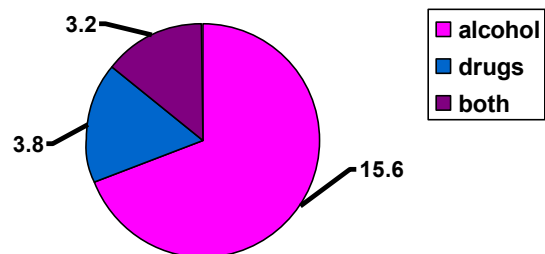
-D. Kerr, 1998 quotes incarcerated woman, p.114

different, in comparison to substance use, misuse, and abuse. Substance dependence appears to inflict long-term changes in the brain, some of which are permanent and irreversible. Substance dependence, however, is not the only one of these forms that can be considered problematic.

Dependence diagnoses involve elements of **tolerance** to a particular substance, meaning that the person needs markedly increased amounts of the drug or alcohol to achieve an effect (like feeling “high”) or there is a markedly diminished effect from a continued use of the same dosage. **Withdrawal** is another characteristic of dependence. This is where physical symptoms (e.g., tremors, feeling sick, seizures, anxiety/panic, restlessness, agitation) are experienced when none of the substance is used, or the person needs to take the substance in order to avoid withdrawal symptoms. Substance dependent individuals continue to use substances— despite the health, social, legal, and other problems it may cause in their lives. [Note: in response to a question from the audience, information about the need for medically supervised detoxification was conveyed. People can die from abrupt cessation of a drug or alcohol on which they have become dependent.]

In 2006, as in previous years, the National Survey on Drug Use and Health (NSDUH) was conducted across the general population (see SAMHSA.gov). The study results lead to the estimate that in the United States, 22.6 million persons aged 12 or older met the clinical criteria for substance abuse or dependence during the past year. This represents 9.2 percent of the U.S. population of individuals aged 12 or older.

**Substance Abuse or Dependence in Millions: 2006**



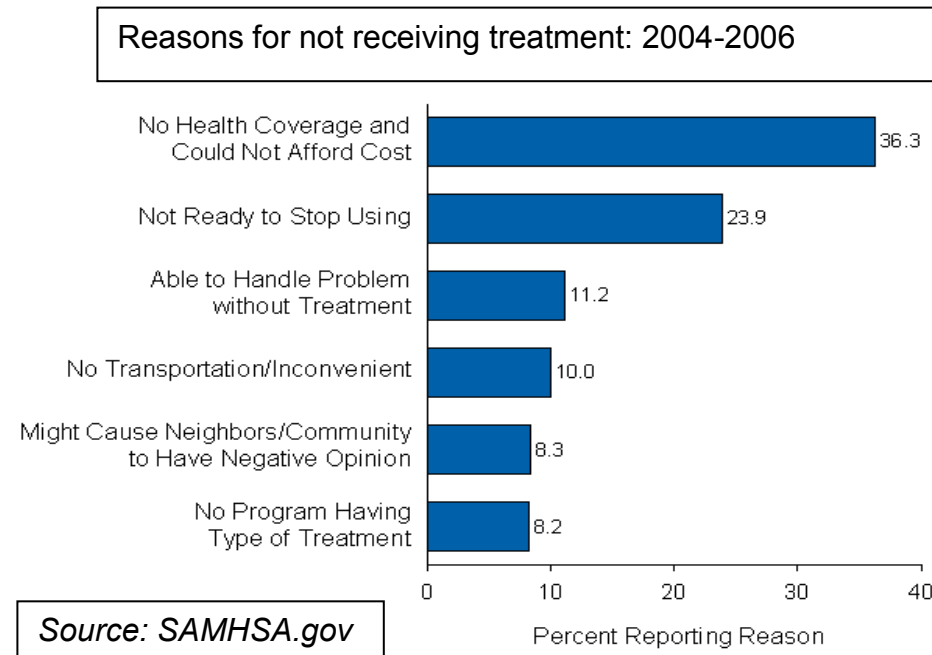
Of these 22.6 million individuals, 15.6 million abused or were dependent on alcohol alone; 3.8 million were dependent on or abused illicit drugs, but not alcohol, and 3.2 million were classified with abuse or dependence on both alcohol and illicit drugs.

Source: SAMHSA.gov

While alcohol remains the most common substance of abuse in the United States, the illicit drugs which had the highest levels of “past year” dependence or abuse were marijuana, cocaine, and pain relievers used outside of medically prescribed parameters.

These figures are *not* the same for men and women, as we will see in a few moments.

During 2006, according to the same survey, 4 million persons (or 1.6 percent of the population) received some kind of treatment for a problem related to their use of alcohol or illicit drugs. Remember that 9.2% have a problem warranting treatment intervention. An estimated 420,000 of these 4 million individuals had received their substance abuse treatment at a prison or jail. Tighter budgets and new constraints have resulted in many proven programs being cut or eliminated.



Clearly, there exists considerable discrepancy between the numbers of individuals who could benefit from intervention and those who receive it. The simple (but inaccurate) explanation is that the 18.6 million who **did not receive** treatment probably **did not want** treatment. This logic only

applies to the 24% who stated that they were not ready to stop, and the 11% who report that they are able to handle the problem on their own, without treatment. (And, evidence suggests that many of them actually can.)

Unfortunately, the reality is not so simple: 940,000 individuals report needing treatment but not receiving treatment. Looking more closely at these folks, 1/3 of them reported that they **had** made an active effort to get treatment. The single most often reported reason why they didn't get treatment (36%) was not having any way to pay for it. In combination, the reasons of "not being able to get **to** treatment," "possible stigmatization related to being in treatment," and, "no programs being available" explained why another 26.5% of people did not get the help that they wanted.

**THUS, THE FIRST STRIKE WE IDENTIFIED: HAVING A PROBLEM WITH SUBSTANCE ABUSE OR DEPENDENCE.**



## STRIKE TWO: SUBSTANCE ABUSING AND FEMALE

Epidemiological studies over time, and pretty much across substances, have indicated that more men than women use substances. For example, 57% of U.S. men *versus* 45% of women drink alcohol, a difference of 12 percent. However, this does not mean that substance misuse, abuse, and dependence are “*male*” problems alone. Data trends suggest that many of the past differences may be disappearing in the not-too-distant future. Currently, according to the 2006 National Survey of Drug Use and Health (NSDUH), among 18-25 year olds, only eight percentage points separate the 66% of men and 58% of women in this age group who drink alcohol. Furthermore, the 58% drinking rate among the young adult women is higher than the 55% rate seen in the 2005 survey. Among youths aged 12 to 17, the percentage of males who currently drink was similar to the rate for females (16 and 17 percent respectively).

Also from the 2006 NSDUH report, men were more likely than women to be current illicit drug users (10.5 vs. 6.2 percent, respectively). While the rate of men’s marijuana use during the past month was about twice the rate for women (8% of men *versus* 4% of women used), men and women had similar rates of past month use of most other classes of drugs.

With regard to alcohol dependence, on the other hand, relatively recent data from the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) indicate that approximately 6.9% of US men meet criteria for alcohol dependence, compared to 2.55% of women. This represents a somewhat smaller ratio than the 3:1 ratio which has been historically observed for alcohol abuse and dependence figures (*see Baletka & Shearer, 2005*). This greater frequency among men does not negate the significance of the problem for those 2,762,000 women who are alcohol dependent (NIAAA.gov).

### Epidemiology

- Alcohol and illicit drug use, abuse and dependence are more common among men
- BUT:
- Degree of differences are narrowing
  - Significant consequences for women who *are* affected
  - Significant impact on children and families

Increasing rates of women’s heavy episodic use of alcohol and other drugs is of concern for a number of reasons:

- the long-ranging effects on their health and mental health status,
- increased risk of exposure to violence and victimization,
- the potential negative impact of fetal exposure, and
- the deleterious impact on parenting, work, and other significant social roles that women occupy.

Concerns about the effects of alcohol on women and their offspring have been expressed since at least the 1750s—mostly related to the childbearing concerns. Clearly, women’s abuse of substances is not a new phenomenon. In 1900, most of the nation’s estimated 200,000 opiate addicts were women. Opiate substances, along with alcohol and cannabis were used medicinally, frequently prescribed by physicians for a

wide array of “female complaints.” Ironically, alcohol was prescribed as a **treatment** for opiate addiction, and cocaine was used to treat both opiate and alcohol addiction (Kandall, 1998; Straussner & Attia, 2002). Alcohol was used alone and in combination with other drugs to treat certain psychiatric disorders, as well (Plant, 1997). Women may have been “cured” of one addiction or psychiatric problem through substitution of another.

Interesting Note:

We asked women recently released from jail in Milwaukee their thoughts concerning the use of new medications for treating alcohol and other drug dependence. Many of them said that they would not choose to go that route because of their concerns that it would end up being “just like methadone—where you got hooked on the treatment as bad as being hooked on the drug.”

By 10 years into the 20th century, attitudes toward alcohol and drugs had shifted. The 1914 Harrison Act formalized a popular, stigmatizing stance toward drugs. By 1919, a series of Supreme Court decisions not only supported the Harrison Act, they also prevented physicians from prescribing drugs for the purpose of drug maintenance for addicted individuals (Kandall, 1998). Racism toward Chinese immigrants was a strong force driving these policy changes (Plant, 1997).

During these years, many self-prescribed drug-store solutions were being heavily marketed to women. These “tonics” and cures often had very high alcohol content—as much as 80 proof, which means they were 40% alcohol.

Unfortunately, at this contracting point in our nation’s history, treatment options for addicted women were few, far flung, and female-unfriendly. Their treatment often involved involuntary commitment to hospitals or criminal justice facilities. These institutionalizations came with the problems of how and where to segregate the women from the men for whom the institutions were designed. As a result, women were often placed in harsher, poorer quality environments, and left with access to fewer services. This picture has not changed considerably over the past century: “Unfortunately, only a very small percentage of all women [are] offered appropriate treatment. [M]any women continue to struggle alone in their search for an effective solution to their painful addictions to alcohol and other drugs” (Straussner & Attia, 2002, p. 22).



Beginning in the 1960s and 1970s, some prevention, treatment, and research programs were earmarked for women. But these programs generally emphasized pregnancy outcomes, **not** the health of mothers or other affected women. During this new era, women who used, abused, and were dependent on substances were blamed for the social problems of fetal substance exposure, HIV positive newborns, and later drug abuse by their children. Media coverage from the 1980s and 1990s concerning “a crack baby crisis” has been criticized as being based on insufficient medical research and anecdotal stories, as well as for further fueling the gendered side of the “War on Drugs.” A period of “toxic shame” emerged for women who admitted to substance misuse, abuse, or dependence which persists today. Even in recent years, women who abuse substances are often excluded from many types of welfare and human services intended for them and their families. With respect to these women, Barbara Owen notes that, “Often marginalized outside of conventional institutions, many women conduct this struggle outside legitimate enterprises” (2001, p. 245).

Currently, women are incarcerated at fairly high rates for drug and alcohol related offenses. According the ACLU, the cost of incarcerating a woman in 1997 was approximately \$27,000 per year. Adding the cost of foster care for placing her children during her incarceration, the overall cost more than doubles. By comparison, the cost of long-term residential drug treatment was under \$7,000/year and for outpatient treatment under \$2,000. But, in many communities, “Prisons are big business” (Burkhart, 1973, p. 283)—a statement with considerable applicability to many local jails, as well.

“Unfortunately, only a very small percentage of all women [are] offered appropriate treatment. [M]any women continue to struggle alone in their search for an effective solution to their painful addictions to alcohol and other drugs.”

-Straussner & Attia, 2002, p. 22

Woman-specific substance abuse research did not begin in earnest until the mid-late 1980s and 1990s when the United States’ federal research industry recognized that many treatment methods developed, utilized, and tested with men needed to be re-examined for their applicability (and lack thereof) in treating women. Until this point, women were often excluded from biomedical research because they tended to introduce too much inexplicable variance to the data. These exclusion practices were true even more for women of color and from various ethnic groups.

During the 1980s, National Institutes of Health (NIH) scientists began to lobby for inclusion of women in medical, mental health, and clinical trials research largely because it was becoming increasingly apparent that many diseases and treatments worked differently for women than for men.

- Many of the differences are related to women’s physiology.
- Many of the differences are related to women’s life experiences and contexts.

Federal research policy today dictates inclusion of women and under-represented populations in these types of studies. As a result, we are learning that addiction is not the same process in men and women, and in many cases, treatment effects differ, as well.

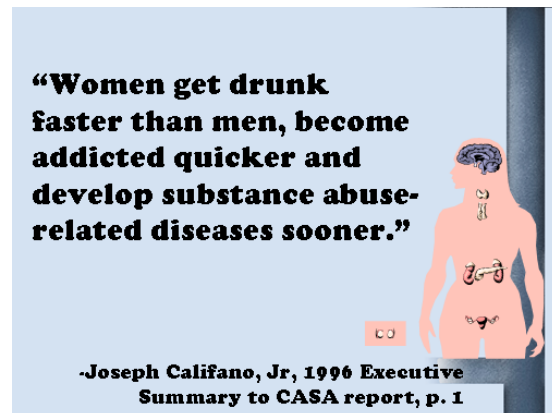
Substance abuse and dependence involve several physiological aspects that are distinct to women. There exists a phenomenon that has been dubbed “telescoping,” which means that alcohol and other drug use are associated with more risks and more rapid progression to serious physical and mental health consequences for women compared to men—including faster progression to addiction or dependence, even at similar doses. At similar doses, a woman’s blood alcohol level (BAL) and the concentration of alcohol or other drugs in her body tissues may be as much as 36% higher than for a man of the same size (Plant, 1997). It takes longer for her body break down and clear alcohol and many other drugs due to physiological differences in body mass, body fat-to-water ratios, and concentrations of first order breakdown enzymes (e.g., alcohol dehydrogenase). As a result, her overall exposure is **higher** for **longer**, doing more damage. Telescoping reflects the relatively shorter time and dramatically increased risks for:

- liver problems,
- dampening of the immune system,
- heart rhythm and muscle damage,
- hemorrhagic stroke,
- loss of brain mass,
- hypertension,
- bone breakage, and
- certain types of cancer.

This, of course, is in addition to reproductive risks.

Unfortunately, when we compare women and men at the point of entering substance abuse treatment, we find that women, on average, are significantly more seriously impaired or addicted. Not only does the path to treatment differ for men and women, but the original path to using and abusing substances differs a bit, as well. While men and women have many of the same reasons for using substances, women are more likely to **begin** using along side their partners who use, and to use for social reasons. Women, more often than men, begin abusing substances following a traumatic event—incest, rape, and other physical abuse are common precipitating events for women’s drug use (Nelson-Zlupko, Kaufman, & Dore, 1995).

**HENCE, OUR IDENTIFICATION OF THE SECOND STRIKE: BEING A WOMAN WHO ABUSES OR IS DEPENDENT ON ALCOHOL OR OTHER DRUGS.**



to

### STRIKE THREE: SUBSTANCE ABUSING, FEMALE, AND IN JAIL

Considerably less attention has been paid to the role of women in the criminal justice system than to men (Taxman & Cropsey, 2006), and historically in the field of criminology, “Women were correctional afterthoughts, at best” (Chesney-Lind, 2003, p.3). Immarigeon (2006, p. v) summarized even the 1960s and 1970s in the following way: “...the conditions of confinement for women and girls were more convenient than constitutional, and treatment intervention programs...were largely an afterthought.” In many instances, theories or models of male offending have been applied indiscriminately to women. Others have attempted to explain “women who commit crimes” in terms of their deviance from traditional gender roles and norms or, as being biologically “defective women” (Belknap, 2001). Explanations of women’s increased rates of arrest have been offered by still others as being a by-product of feminist movement efforts to secure legal and social equality for women (Chesney-Lind, 2003). More recently, increased rates of woman arrests has been attributed to increases in the feminization of poverty, systematic losses in supports for women living with poverty, and increased rates of women’s involvement in substance abuse and dependence.

To some extent, this “criminal neglect” of women’s issues can be attributed to their comparatively smaller numbers in the system. As part of our Fromkin lecture research, I reviewed the Milwaukee County Historical Society jail admission records from 1847-1914.

Here is just a sample for the single month of July, 1909, when a total of 24 “females” were admitted to the jail. But, this number is quite misleading:

- Mary Czydukeowick was arrested, along with her husband, and had her two young daughters with her, thereby accounting for 3 of the female admissions that month.
- Josephine Olberka was arrested on July 10<sup>th</sup> as a common drunk, taken to emergency hospital, and re-arrested on July 12<sup>th</sup>. This time she was taken to House of Correction.
- Annie Buckhaus was arrested along with her baby Anita on July 15<sup>th</sup>.
- 17-year-old Victoria Bronczykoski was arrested on July 24<sup>th</sup> as disorderly and released on bail.
- She was arrested again on July 26<sup>th</sup>.
- Her friend, Blanch Guzyunski, also 17, was arrested on the 24<sup>th</sup> and released on probation.

All 24 of these women were white, but for each, her country of origin was noted in the “race” column of the ledger.



By contrast, on a **single day** in 2007, July 24<sup>th</sup> for example: 27 adult women were arrested: 21 of them were black, 6 were white. Nationally, during 2000, women represented 11% of the average daily jail population. During 2006, they were 13%.

Unlike men, women are more likely to be incarcerated for drug or drug-related offenses than for **violent** offenses (Harrison & Beck, 2003). Women's incarceration rates are significantly related to the commission of nonviolent substance use-related property crimes like:

- shoplifting,
- forged checks,
- welfare fraud,
- driving while intoxicated,
- relatively low-level drug violations, and
- prostitution (Girshick, 1999; Beck, 2000).

"Beneath the statistics lie a human tragedy of a magnitude most people cannot fully comprehend: A disproportionate number of women are wasting away in nonrehabilitative institutions that perpetuate rather than correct criminal behavior."

-George Henderson, 1993, p. xi

Providing a little perspective, our Lt. Walker oriented our student interns at the Milwaukee County Criminal Justice Facility with the comment: "Remember, these ladies aren't here because they were singing too loudly in Sunday choir."

A number of contemporary feminist authors have argued that the nation's "War on Drugs" has actually translated into a "War on Women," particularly women of color and women living with poverty (Bush-Baskette, 1999; Chesney-Lind, 1997). The evidence offered for "War on Women" conclusion is the disproportionate rise in women's arrest and incarceration rates during this period. Comparing FBI data on arrest trends for the ten years between 1992-2001, the percentage increase in female arrests for drug violations was 51% compared to 38% for men (McC Campbell, 2005). Comparing 2005 and 2006 midyear incarceration data from the Bureau of Justice Statistics, the number of female prisoners increased by 4.8% while the number of men in prison increased by 2.7% (Sabol, Minton, & Harrison, 2007). Similarly, the **rate of increase** for women in the nation's local jails increased by more than twice the rate of increase for men (4.9% compared to 2.2%). Between 2000 and 2006, the actual number of women in jail increased by 40%, compared to a 22% increase for men in jail. Women are also under criminal justice supervision at rates disproportionate to their arrests (McC Campbell, 2005).

The American Civil Liberties Union (ACLU) reports that: "Women tend to be 'very small cogs in a very large system, not the organizers or backers of illegal drug empires' " (Caught in the Net: The Impact of Drug Policies on Women and Families, 2005). They also state that **mandatory minimum laws** subject women to harsher sentences than those principals in the drug trade who, ostensibly, were the target of these stricter policies. Women most commonly occupy the lowest of drug trade echelons, running the

greatest risk of arrest and prosecution for drug-related crimes (Taxman & Cropsey, 2006).

This criminal justice system trend coincides historically with an increased feminization of poverty, increased levels of social insecurity, and significant retrenchments of income supporting and insuring programs (Frances Fox Piven lecture, 2007). Bloom, Owen, and Covington (2003) conclude, from multiple data sources: “Enactment of harsh drug laws, mandatory minimums, and repeat offender statutes has resulted in **more** women being incarcerated for **longer** sentences.”

Substance abuse is driving, at least in part, rapid increases in rates of women incarcerated (CSAT, 1999). In general, incarcerated women are more likely than men to have substance abuse and dependence in their histories: 52% of women in jail and 44% of jailed men meet the criteria for alcohol or drug dependence (Karberg & James, 2005). The alcohol and other drug problems that incarcerated women experience tend to be more severe and chronic than those experienced by their male counterparts (CSAT, 1999), and these problems appear at prevalence rates many times higher than observed in the general population (Fazel et al., 2006).

Much of the evidence-based literature surrounding addiction services to incarcerated populations describes services specific to **prison** contexts (Dowden & Andrews, 1999; Krebs et al., 2003). Important differences between prisons and jails have significance for translating prison work to jails. Two important differences in particular are:

“Historically, assignments to program and treatment resources in correctional facilities have been based more on what *is* available than on what *should* be available.”

-Susan Sharp, 2003, p. xiv

- (1) The typical length of time to discharge in jails, measured in days, weeks or months, leaves less duration **available** for treatment, compared to prison sentences measured in years; and,
- (2) The sheer numbers of individuals admitted annually to jails can overwhelm human service delivery systems. For example, it was estimated that approximately 733,000 individuals were admitted into state and federal U.S. prisons during 2005, whereas Stojkovic (2005) states that jails admitted over 12 million persons in a similar year, 2003.

In criminal justice systems, it is sometimes perceived that solutions to inmate problems such as drug dependency lie outside the walls. But waiting until women return to the community is a losing bet:

- The women lose the motivating impetus derived from being in jail;
- They lose sight of their substance problems in the midst of reentry crises related to housing and homelessness, child welfare worries, seeking safety for themselves and their children, health problems, employment problems, and the demands of post-release criminal justice system requirements;
- And, they often lose out in the competition for treatment slots in an under-funded treatment system.



The availability of drug treatment for women in criminal justice facilities is “limited at best” (Bloom, Chesney-Lind, & Owen, 1994). A little more than half (55%) of jails provide substance abuse **education** programs to incarcerated women and less than half (47%) provide substance abuse **treatment** to female inmates (Koons, Burrow, Morash, & Bynum, 1997).

### **HENCE: OUR IDENTIFICATION OF THE THIRD STRIKE—BEING IN JAIL WHEN YOU ARE A WOMAN WITH SUBSTANCE PROBLEMS.**

Compounding all of these issues are issues of the women who are mothers and issues for their children and extended families. This part of the story Susan will tell.

### **THE INTERSECTION OF SUBSTANCE ABUSE, INCARCERATION, AND PARENTING**

The issues for parents who are incarcerated are quite painful for them and their families as women in the House of Corrections told us in focus group interviews. The disparities in the parental experiences of mothers and fathers who are incarcerated become more obvious as we look more closely.

For women, incarceration is a frequent consequence of substance abuse, and the communities and families of these women pay the price of their use and subsequent incarceration. As Audrey has discussed in the beginning portion of this lecture, more women are being incarcerated for drug offenses than men. Prison sentences are more common for female substance use offenders than male offenders for similar offenses, and women with children (more than men with children) are a larger percentage of those who are incarcerated; in 1991, 35% of all persons incarcerated for drug offenses were mothers and 23% were fathers (Mumola, 2000).

The number of children affected by parental incarceration is significant. The Bureau of Justice estimates that up to 2 million children have a parent or relative in prison or jail (Butterfield, 1999). In 1999, 1.5 million children under 18 had a parent in state or federal prison; most of these children were less than 10 years old, and 22% were under the age of 5 (Mumola, 2000). This represents over 2.1% of all children in the country. In that same year, 250,000 children had at least one parent in county jails (Greenfield & Snell, 2000).



Children are more likely to be affected by the incarceration of their mothers for several reasons.

- ❖ First, incarcerated women are more likely to have children than incarcerated men (Bloom & Steinhart, 1993). Atwood (2000) estimated that 75-80% of incarcerated women had minor children as opposed to 64% of incarcerated men.



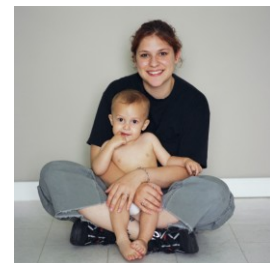
- ❖ Second, these children are more likely to have been living with their mothers than their fathers in the years prior to their incarceration. Sixty-four percent (64%) of children were living with their mothers in the year before their incarceration while 40% were living with their fathers (Belknap, 2003).
- ❖ Finally, women are three times more likely than men to have been the only parent living with the children when incarcerated. This suggests that children suffer more residential displacement when their mothers are incarcerated.

### **WHAT HAPPENS TO CHILDREN WHEN PARENTS ARE INCARCERATED?**

When fathers are incarcerated, 90% of their children are already living with their biological mothers, either with or without their biological fathers (Snell, 1994). Mothers reported that 28% of their children were living with their fathers at the time of their incarceration (Mumola, 2000). Only 22% of mothers in prison said they could depend on a child's father to provide care during their incarceration (Raeder, 1993). These children may suffer the loss of the companionship of their fathers, their financial support, their guidance and caring, but it is unlikely they will be displaced from their homes by their fathers' prison or jail sentence.

When mothers are incarcerated however, children's lives are more disrupted. These children lose not only the presence and caring of their mothers, but they lose their homes as well. When mothers are incarcerated, about 20% of their minor children living with them move into their father's homes and stay there during their mother's sentence. Most, about 51%, move in with their maternal grandparents, and another 20% live with other relatives – an aunt, a sibling, a godparent, etc (Enos, 2001).

While older siblings can sometimes be relied on to care for younger brothers or sisters during a parent's incarceration, it is a more common picture that siblings are separated (Sharp & Marcus-Mendoza, 2001; Belknap, 1996). This is especially true for sibling groups of three or more children (Mumola, 2000). So the normal routines of a child's life are disrupted and the comfort they might get from their siblings is often denied them as well.



Surprisingly, only about 9-10% enter the formal foster care system. Mothers resist their children entering foster care for fear that they will lose custody and that their children will never be returned upon their release. Children of incarcerated mothers enter the formal foster care system either because of no available caretakers or because their caretakers cannot care for the children over the length of an entire imprisonment ((C. S. DeChamps, personal communication, August 1, 2007).

In addition to residential displacement the effects of incarceration on children are profound and far-reaching. Often because of the lack of contact with their mother, temporary placements, whether with relatives or in formal foster care, are disrupted and do not last throughout the period of incarceration. Children of incarcerated mothers have also been reported to experience poor school performance, poor social skills, depression, and sleep disturbance (Gaudin, 1984; Johnston, 1995; Kampfner, 1995). In

addition, these children face an increased likelihood that they will enter the criminal justice system themselves in the future (Barnhill, 1996; Gabel, 1992; Johnston, 1995).

Mothers cannot fulfill their role as caretakers while they are incarcerated and this is a significant stress during their confinement. Many incarcerated women report that concern about the whereabouts and well-being of their minor children is the “most stressful” aspect of their imprisonment (Belknap, 2003). These mothers are either misinformed or not informed at all about details of their children’s lives or the difficulties they face in school and community (Enos, 2001).

“I went to jail and it really made me feel like I had lost. I felt a lot of guilt. I felt like I had lost my dignity, my self-esteem and by me being locked down and my children was out there. If anything happened to them I couldn’t do anything about it.”

- Woman inmate, HOC

The picture of women in Milwaukee County jail mirrors that of women nationally. Among women screened for substance use in 2007 in Milwaukee County Criminal Justice Facility and the House of Correction, 80% had at least one child living with her in the year before incarceration. Additionally 60-70% had more than one child living with her, with the mean age of the oldest child reported to be 14. Only 46% of these mothers were living with a partner in the year before their incarceration in the county jail.

### **STAYING CONNECTED FOR PERMANENCY**

When parents lose custody of their children, either through voluntary or involuntary placement in foster care, the permanency clock starts ticking. The Adoption and Safe Family Act of 1997 (*Public Law 105-89*) mandated that services to parents and permanency planning efforts for children must begin when a child enters foster care and cannot extend beyond 15 months. A petition to terminate parental rights must be filed for children who have been in foster care for 15 of the previous 22 months. If a mother is incarcerated in jail longer than the period of time required for unification, the permanency plan can be changed from reunification to adoption or other more permanent alternatives.

For women in jail who generally have shorter sentences than those remanded to state or federal prison, staying connected with their children during their incarceration is critical to their ability to regain custody of their children upon release. Incarcerated women have impaired ability to regain custody or reunify with their children before termination of parental rights often because of this lack of connection.

Visits, phone calls, and mail are the primary way parents keep contact with their children while in jail or prison. Women depend on caretakers to bring children to them for visits, to facilitate phone calls and to receive or make phone contact. Women, and poor women in particular, are at a distinct disadvantage in their ability to maintain contact with their children while they are incarcerated. Poor women with children in foster care rely on child welfare workers or other social service personnel. In discussions with child welfare workers from the Bureau of Milwaukee Child Welfare, we were advised that it takes about anywhere from three to five hours to accomplish one

child visit to jail (DeChamps, 2007). These visits must occur after school for most children, which may not coincide with a child welfare caseworkers work, day making it difficult to arrange special visiting times (Women's Prison Association, 1996). Child welfare workers commonly rely either on agencies or foster parents to accomplish visits.

Mothers need to maintain connection but prisons are often located far from community supports (Corston, 2007), and jails do not have the resources to coordinate services needed to keep family bonds intact. In addition, any contact between inmates and family poses security issues for jails and are not encouraged (Perez, 1996). As a result, jails, unlike prisons, do not allow child-friendly contact visits. Children must talk with their parents through glass on a phone, and some child welfare workers and mothers themselves are concerned about the impact of such visiting conditions on children (Henriques, 1982; Johnston, 1995). In some jails, children are subjected to invasive searches, cannot have physical contact with their parent, and cannot talk with their parent with any degree of privacy (R. Sarri, personal communication, September 10, 2007).

As a result, while a number of prisoners have contact with their children, most prisoners do not have regular visits with them. Women in general have fewer visits with their children than men. This is related to women's role as facilitator of visits. Mothers are more likely to bring children to visit a father than fathers are to bring children to visit a mother (Hairston & Rollin, 2006). In 1997, 40% of fathers and 60% of mothers in state prisons reported weekly contact with their children, primarily by phone, however 57% of mothers and 54% of fathers reported that they had not had a visit with their children since their incarceration (Mumola, 2000).

In a study of the family connections of 12,633 state prisoners, 52% of women prisoners reported no visits in the past month and 54% of all parents with young children had not seen any of their children since their admission to prison (Hairston & Rollin, 2006). Black men and Hispanic men and women have few visits than other ethnic groups, most of this difference being accounted for by the distant location of prison and jail facilities from the communities in which prisoners live. (Hairston & Rollin, 2006). For example, the House of Correction in Milwaukee County is located over 20 miles south of here. There are only three buses a week that travel to the House, and these only on a Saturday.

## **SOCIAL REFORM MOVEMENTS**

Over the past 150 years, social reformers have exerted significant influences over policy and practice relating to the incarceration of women. Social reform movements consist of organized efforts to work for social change on issues of women's right, racial justice, human rights, peace, prison reform, child labor, humanitarian aid, mental health, gun control, pornography, and prostitution to name but a few. These reformers aim to change aspects of society rather than make individual change. As such they have been instrumental in how we have viewed substance abusing women in the criminal justice

system. For the purposes of this lecture, we will consider only those social reform movements that focused primarily on alcohol (or temperance), women, and prison reform.

The temperance movement is also known as the “clean living” movement, incorporated concerns about tobacco, diet, pure water, exercise, and social conditions into their concerns about drinking. While Audrey addressed some of the issues and concerns of these early reformers, the latest “temperance” movement began in the late 1970s. The effects of this current movement to limit alcohol consumption has been to raise the legal age of alcohol purchase, institute warning labels on alcohol, the adoption of government policy suggestion abstinence, and severe penalties for drinking and driving offenses (Engs, 2000).

Social reformers were very interested in women in the criminal justice system as early as 1820. Before this time, punishment was the result of crime, which was considered a function of sin. Rafter (2000) describes four distinct “turning points” in public policy on women in the criminal justice system that were impacted by various social reform movements.

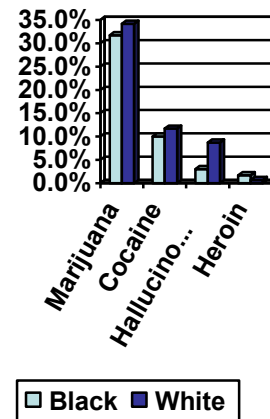
- ❖ **1820** – The notion that criminals could be reformed was introduced by Quakers who advocated for the purpose prisons isolating inmates from the corrupting influences of society. Work, rigid routines, harsh discipline, and heavy labor were all emphasized as a way to foster reform. While only about 1-2% of prisoners in these facilities were women, they were isolated by gender, fearing sexual assault by male staff as well as by other male prisoners.
- ❖ **1870** – At the first conference in Cincinnati of what was to become the American Correctional Association, investigators of eastern US prisons reported that prisons were significant schools for crime. Two principles emerged: (1) **indeterminate sentencing** should be used to allow those who reformed to have early release, and (2) **women are inherently different**, being more delicate and domestic than men, and should be incarcerated in separate facilities with female-specific training to teach them to be more obedient servants and good wives (Daly, 2005). As a result, prisoners were taught to read and write, given real job training, and the first women’s prison was opened in Indianapolis in 1873.
- ❖ **1970** – Reaction from both the political left and right, in concert with the women’s movement raised objections to incarceration practices. While conservatives were opposed to “coddling” prisoners, liberals viewed indeterminate sentencing as racist and sexist. The results of these reform efforts were that rehabilitation was abandoned for punishment, mandatory sentencing was enacted and gender-differential treatment was ended.
- ❖ **Current** – Beginning in the mid-1990’s the effects of earlier reforms and the “War on Drugs” were evident. Mandatory sentencing for drug-related crimes was seen as the primary cause of large increases in prison populations, most especially women and women of color who are usually accomplices. The causes of crime for women were understood to include complicated histories of sexual abuse and prior victimization (Richie, 1996). The goal of equality of treatment and separation into gender-specific

facilities resulted in women's programs having fewer programs than men's because their numbers are fewer (Baletka & Shearer, 2005) and women subjected to high security incarceration for primarily property and public-order offenses.

## DISPARITIES

### GENDER AND RACE DISPARITIES

The disparities noted by reformers continue today in gender and race (Girshik, 1999). First, black men and women are disproportionately arrested for drug law violations, despite their generally lower use in relation to white men and women. (Mauer & Huling, 1995). Second, and even more disturbing, the number of black women incarcerated for drug offenses increased by 828% between 1986 and 1991; twice that of black men (429%) and three times that of white women (241%) (Mauer & Huling, 1995). Bush-Baskette (1999) argues in a compelling statement that "The War on Drugs has been a war on women, and on Black women in particular."



### FEMINIST PERSPECTIVES ON DISPARITIES

Based on feminist research, social reformers argued that women in the criminal justice

"Equality does not mean treating everyone the same. The new gender equality duty means that men and women should be treated with equivalent respect, according to need."

- Corston, 2007

system should treat men and women equally, arguing that gender blind-crime control affects women primarily (Sarri, 1987;1995). They pushed for an end to differential sentencing and gender-specific treatment. Studies suggested that women were sentenced to longer terms than men for the same offenses (Atwood, 2000; Beck, 2000) and that women prisoners were trained only in secondary professions (cosmetology, office work, laundry, or kitchen help) where they could not make a living wage to support themselves upon release.

### CURRENT PERSPECTIVES ON DISPARITIES

Current criminal justice reform relating to women with substance use problems focus on three areas

- ❖ Mandatory sentencing
- ❖ Causes of crime among women
- ❖ Male normative policies and practices (Covington, 1997)

**Mandatory sentencing:** Mandatory sentencing is the primary cause of recent large increases in incarceration rates and costs to the criminal justice system (Chesney-Lind & Pollock, 1995). While severe sentences for drug offenses are politically popular, they snare large numbers of women who are primarily accomplices to the significant others

in their lives (Chesney-Lind, 1997). Finally, women have no one to “name” except their partners, so they have little leverage to gain leniency (Taxman & Cropsey, 2006).

**Causes of crime among women:** The causes of crime and pathways to offending are different for women than for men. First, women are more likely to have histories of sexual abuse, trauma, and victimization related to their offending (R. Sarri, personal communication, September 10, 2007). Second, women are more likely to engage in property crime to support their use as opposed to violent crimes seen in male prisoner populations. For example, in the Milwaukee County Criminal Justice Facility, the most frequent charge for women in 2006 was operating a vehicle with a revoked license. Third, women’s relationships feature strongly in their pathways to crime. They are more commonly introduced to substance use by their partners and continue to use as a component of their relationships.

**Male normative policies and practices:** Despite the lack of violent crime for most women inmates, women are exposed to practices that are more appropriate for violent offenders, i.e. strip searches, lack of contact visits with children, and lock-downs. Second, while the proportion of women to men in the criminal justice system is increasing exponentially, the goal of equal treatment is practically impossible due to the relatively small size of the female population. In local jails, cash-strapped administrators are less likely to devote scarce programming dollars for gender-specific programming that may be equivalent to that for men. Thus women usually receive volunteer services or poorly funded social services from outside the jail. Smaller numbers of females have made programs too expensive, but courts have ruled that cost cannot be an acceptable defense to the lack of programming for women (Sharp, 2003).

## **SCHOLARS, POLICY MAKERS, AND INCARCERATED WOMEN SHARE THEIR THOUGHTS**

In the course of this research, we interviewed a number of scholars around the country who have conducted both qualitative and quantitative studies in the areas of women in the criminal justice system. Most have included some work on women with substance abuse, but this is a more recent development, and social work scholars are more recent entrants in this work. These scholars represent the combined wisdom of over 100 years of work, and many of their comments echo key points in the literature previously described.

In a related project, we conducted focus groups with women at the House of Corrections in Milwaukee County and at the Benedict Center. The women were eager to talk and had much to say about why they were in jail, what the role of their families were in their addition and in their recovery, what they thought they needed to remain sober once they were released, and how they would change the treatment system if they had a chance.

The following is a distillation of interviews with scholars and policy makers who addressed five main disparities in current corrections practice and policy:

- ❖ rehabilitation and training available to incarcerated women
- ❖ etiology of substance use disorders among incarcerated women
- ❖ life Challenges faced by incarcerated women
- ❖ parental roles
- ❖ treatment barriers facing women seeking care upon re-entry to the community

### **REHABILITATION & TRAINING**

With the introduction of welfare reform in 1996, the need for poor women with children to become self-supporting is imperative. Scholars have noted that women receive almost no vocational training in jail because the time is so short. While they do receive some training in prison, they do not receive training for jobs that might help them become self-sufficient upon release or earn a living wage. Many women in jail and in prison have difficulty with basic skills, such as reading, writing, math, personal hygiene, and house maintenance that would allow them to become economically self-sufficient. Women continue to receive training in menial jobs and experience a lack of training in life skills that can translate into meaningful work.

### **ETIOLOGY OF SUBSTANCE PROBLEMS**

Recent research by some of these scholars has focused on the incidence of PTSD among incarcerated women, as Audrey noted in her discussion of the different progression of substance dependence among women (e.g. telescoping effect). Women's pathways to addiction and subsequent incarceration include more environmental and social factors, including sexual assault, physical trauma, and victimization by family members or intimate partners (Blume & Zilberman, 2004).

Physiologically, women may be more vulnerable as well. The Stress-Diathesis model of trauma has highlighted neurochemical changes in brain functioning as a result of trauma, which may make women even more vulnerable to substance abuse. Early life trauma results in long-term (maybe permanent) hyperactivity of neurological systems, sensitizing circuits to even mild stress in adulthood, leading to exaggerated stress response (Austrian, 2005). Upon exposure to persistent or repetitive stress in adulthood, these already-sensitive stress pathways become markedly hyperactive, causing alteration in receptors and forming basis for development of mood, anxiety, and substance use disorders.

### **LIFE CHALLENGES**

Scholars noted that women are more vulnerable to chronic health and mental health issues. In addition they are more likely to be victims than perpetrators of violence. Because relationships are so pivotal for women in their substance use, they become victims of through conspiracy laws that encourage men to turn in women to mitigate their own sentences. Finally, a woman's role as a family caretaker has a dual impact. First, it increases the chances that their children will enter substitute care upon their incarceration. Second, it acts as a barrier to obtaining treatment, as women do not always have placement resources for their children while they see treatment for

themselves, and cannot meet the competing conditions imposed by all the systems involved in their lives.

### **PARENTAL ROLES**

Some scholars noted that daughters of incarcerated women are more vulnerable to further incarceration. Women appear to have more ruptured relationships with their mothers, while family members are more willing to care for released men than women.

### **TREATMENT BARRIERS**

Scholars noted that many residential programs do not allow children at all or allow only those over/under a certain age. Some programs do not allow male children over a certain age, making it doubly difficult for some families. Women in the House of Correction talked specifically about the limitations of having their children in seeking treatment. In particular they believed that there were more alternatives for halfway houses, residential care for men because they did not have children.

Women also have less knowledge of and resources to secure treatment. In our Milwaukee Jails study, women cited a lack of knowledge and resources as well as the location of treatment settings as major barriers to seeking substance abuse treatment. Finally scholars noted that women are less likely to be mandated to treatment upon release than men.

### **RECOMMENDATIONS FROM SCHOLARS**

From their research, they suggested key policy and practice recommendations for women in the criminal justice system.

“We must find better ways to keep out of prison those women who pose no threat to society and to improve the incarceration experience for those who do.”

- Corston, 2007

1. Incarcerate only women convicted of violent crimes.
2. Incarcerate women in smaller units closer to the community and to their children.
3. Create greater access for women to alternatives to incarceration.
4. Rehabilitation should be reinstated as a primary goal.
5. Incarcerated women with substance use problems should have access to substance abuse and mental health treatment in jails.
6. Imprisoned women should have access to real vocational training that can lead to economic self-sufficiency upon re-entry to the community.
7. Indeterminate sentencing should be re-instated.

### **RECOMMENDATIONS FROM INCARCERATED WOMEN**

Women who at the House of Correction and at the Benedict Center, an agency focused on women in the criminal justice system, talked about how they think the system should be changed. In many respects, their voices echo that of the scholars and policy makers we interviewed.



**Need for vocational training in jails:** “I think there should be programs in the jail to help these women get jobs.”

**Location of treatment settings:** “I have one question. Why do they put halfway houses always in the center of drug neighborhoods? Every one of them. Is that a test or what?”

**Availability of services:** “...there should be more places where women can go and have people to talk to, and have help, and have people to work with them.”

**Include support networks in treatment settings:** “I feel that if they’re going to have programs to help people get off drugs...if they got positive people in their life, let them be able to bring them positive people around them to be able to support them in the groups and activities.”

**Reduce cost of treatment programs:** “I would have [the programs] be free. You know, by donations and have a big home like a Ronald McDonald home where that you could bring your kids in and you all work together.”

**Provide care in a safe, homelike environment:** “I would have a place for women that use alcohol and drugs to go to. Like a house. It would be like a safe house where they could work on their problems. Because a lot of people don’t have places to go, and they just go right back into their old surroundings.”

**Start substance abuse treatment in jail:** “I say, have it start while you’re in here so you’re motivated when you get out. So you want to continue. I think they should help women before they get out of here because women are using the day they walk out this door.”

Thank you for your attention and interest in the women we discussed today. As one author (Enos, 2001) said: “We may not be winning the war on drugs, but we are taking a lot of prisoners.”

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