Susan Sered, PhD (ssered@suffolk.edu) & Maureen Norton-Hawk, PhD (mhawks@suffolk.edu)
Department of Sociology, Suffolk University, July 2011

Women and the Criminal Justice Landscape in Massachusetts: Where Are They Now?

Introduction

Women are the fastest growing prison population, yet little is known regarding the post-incarceration trajectories of women. The majority of criminalized women in Massachusetts is mentally ill, has been victims of physical or sexual abuse, use drugs, and were incarcerated for relatively minor offenses. Upon leaving prison, women often find themselves unemployable, without custody of their children, poor, sick and marginally housed -- conditions that position them for further victimization as well as ongoing involvement with the correctional system.

The Commonwealth of Massachusetts spends a great deal of money and expends a great deal of effort and good will on housing, work training, health care, family support, and rehabilitation for criminalized women. Studies have looked at the short term success rates of specific programs (generally defined in terms of *retention rates in the program*), yet little is known about the long term impact of the landscape of programs and services that criminalized women utilize.

In order better to understand post-incarceration outcomes for Massachusetts women, we have undertaken a series of studies designed to track women's experiences over substantial periods of time.

Our research is designed to replicate Sheldon and Eleanor Glueck's ground breaking *Five Hundred Delinquent* that followed the post-parole lives of former Massachusetts Correctional Institution (MCI) Framingham inmates in the first decades of the twentieth century.

The picture of criminalized women portrayed in Glueck and Glueck's study is eerily similar to that of criminalized women today in terms of high rates of cognitive and physical disabilities, dysfunctional natal families, histories of sexual abuse, and limited abilities for financial self-sufficiency.

Fifteen Years Later: An Overview of Life and Death Post-Incarceration[1]

This archival/historical study of the 839 women released from MCI Framingham in 1995 notes the whereabouts and status of the women at five year intervals beginning in 1999 and ending in 2010. Records available through the Registry of Vital Statistics, the Department of Corrections, the Department of Transitional Assistance, the Department of Revenue and the Registry of Motor Vehicles serve as the core data bases for this project.

Preliminary Findings

1) Women entered MCI Framingham from many communities: Worcester – 16%, Lynn – 9%, Boston – 7%, Lowell – 7%.

[1] The project has been approved by the Suffolk University IRB and by the Massachusetts Department of Corrections. Names and identities of all interviewees are kept confidential.

2) 74% of women were released to the street.

3) The median age at time of release was 32 years of age.

4) At least 97 of the 839 women (11.6%) were dead within fifteen years of release from prison.
   a) The median age at death for these 90 women was 44 years of age.
   b) Primary causes of death: alcohol, drugs, HIV/AIDS, pneumonia.
   c) In the United States overall, the life expectancy of women born 1960-1970 is 74 years.

Surviving Day-to-Day: An Ethnographic Study[2]

Launched in March 2008, this five year prospective study is designed to develop deeper understandings of the experiences of a smaller cohort of women released from MCI Framingham or the South Bay House of Corrections. Forty-eight women released during the year preceding the study launch were enrolled at the Kingston House (Boston Rescue Mission) and St. Francis House. At this time – three plus years into the project -- 27 women remain actively involved.

Women involved in the study meet with Norton-Hawk or Sered at three-month intervals to discuss a structured set of questions regarding their housing, legal, family and health issues during the past months. In between these meetings, we speak informally on a monthly basis. As the women have come to know us, we have accompanied them to numerous court hearings, medical appointments, parties, shopping trips, christenings, and program graduations.

The demographic make-up of the study participants is nearly identical to that of the overall population of incarcerated women in Massachusetts (72% White, 19% Black, 11% Asian / Other). The majority of the women did not complete high school, have never married, have experienced periods of homelessness, and suffer from multiple physical and mental health problems and substance abuse issues. These challenges result, at least in part, from histories of repeated physical and sexual abuse.

While the ages of study participants range from their early 20s to mid 50s, we have chosen to over-represent women in their late 30s and early 40s. Women in this age group seem to begin to "age out" of the correctional system; however, little is known about their experiences at this life stage: Do the numbers of incarcerated women drop-off in middle-age because they are no longer alive? Have they become invisible to the police? Have they reached a certain psychological maturity that makes it possible for them to move their lives into more stable directions? Are there specific programs that have greater success with women in this age group?

Preliminary Findings

1) Many of the same women cycle through being homeless, sex workers or petty drug dealers, prison inmates, residents of mental hospitals, and victims of violence. Consequently, they sequentially and repeatedly utilize services, programs and facilities geared towards each of

[2] The project has been approved by the Suffolk University IRB, by the Massachusetts Board of Parole, and by the directors of the both the Kingston House and the St. Francis House. Names and identities of all interviewees are kept confidential.

these categories: battered women's shelters, homeless shelters, prisons, jails, rehabilitation facilities, detoxification facilities, respite care (e.g. Barbara McGinnis House), hospitals, and public housing.

2) The women utilize a bewildering number of public services: clinics, hospitals, shelters, job training and job readiness programs, detoxification, rehabilitation programs, transitional assistance, food pantries, soup kitchens, etc. Typically, each woman uses several different programs / facilities of each type.
   a) The length of each program tends to be relatively short. Typically, detoxification programs last for 7 days, at the end of which many of the women are not placed into longer term facilities.
   b) All of the women who are substance users have gone through multiple (sometimes as many as fifty) detoxifications and rehabilitation programs.
   c) All of the women have attended numerous (sometimes hundreds) of AA / NA meetings. Typically, they are mandated by the Court, DYS, or their parole or probation officer to attend. Most of the women do not find AA / NA helpful.

3) Almost all of the women suffer from complex multiple physical and mental illness challenges, yet do not receive consistent, coordinated health care attention.
   a) Medical and dental treatment tends to be disrupted when the women enter or leave prison or change housing arrangements. Post incarceration treatment is often erratic as they move from one facility/agency/shelter to the next.
   b) Women are assigned new therapists and psychiatrists frequently. This undermines the therapeutic relationship and disrupts medication regimens.
   c) Women tend to struggle with following-up on medical referrals.

4) Housing is a significant challenge for most of the study women. Without stable housing they are (1) vulnerable to predatory men (2) unable to maintain strong relationships with their children (3) unable to hold onto paperwork, personal identification and other items that they need in order to move forward with their lives.
   a) Many of the homeless shelters limit the number of consecutive nights that a woman can stay at the facility.
   b) Women often are barred from a shelter because of breaking a rule.
   c) Some of the women succeed at getting a room in an SRO. While this is better than living on the streets, typically SROs are filled with men with histories of drug abuse, violence, and criminal behavior. Moreover, without a real kitchen, women are unlikely to prepare appropriate meals or care for their children.
   d) "Sober houses" do not meet the needs of the study women; in fact, "sober houses" often are the scene of drug relapse.

5) Motherhood poses a variety of challenges.
   a) For many of the women, new motherhood was an extremely difficult period in which long-term mental health problems became more acute.
   b) Many of the women work with multiple DYS caseworkers – each child has a different caseworker. This leads to a great deal of confusion, double booking of appointments, and disjointed parenting and custody decisions.

c) Many of the women who had lost custody of their children regain close contact once the children turn 18. There do not seem to be services in place to help with this transition.
d) Most of the women view DYS workers as enemies rather than allies.
e) Programs that help women mother more effectively (such as Early Intervention) tend to be seen in a positive light.

6) Only two women have been employed steadily throughout the study period.
   a) While all of the women have participated in numerous job readiness and training programs, the combination of CORIs, homelessness, behavioral health problems and the responsibilities of caring for children make them virtually unemployable.
   b) Programs that promise to prepare them for employment may offer skills that are not marketable.
   c) The approximately 50% of the women who do not receive SSI or SSDI are dependent upon men, prostitution or petty theft for economic survival.
   d) Those women who do receive SSI or SSDI typically encounter episodes in which their SSI or SSDI is cut off, typically because their address had changed and they did not receive and return the renewal forms sent to an old address or because they were incarcerated. Thus, even women deemed disabled are not able to rely upon a steady, monthly income, however small.

7) Almost all of the women experience themselves as being controlled by others -- by violent men and by government agencies. Often, this sense of powerlessness is expressed in terms of "it not being worth trying to do the right thing" because the powers-that-be will find a reason to hurt them, take their children from them, or send them back to prison. While many of their therapeutic programs talk to them about the importance of "standing up for yourself," "making good choices" and "developing self-esteem," structural and institutional conditions preclude their doing so.

Recommendations

1) It is crucial to continue to educate local police officers and public officials regarding the population of homeless women, addicts and sex workers. Understanding that they are as likely to be victims as perpetrators – can help the women stay out of dangerous situations as well as out of prison.

2) Given the strong evidence showing the therapeutic and functional importance of empowerment for trauma victims, it would be useful to urge correctional and social services institutions to re-examine rules and policies that may unnecessarily limit the women's sense of autonomy and empowerment.

3) Stable housing is a critical.
   a) Most of the women would benefit from a long-term supportive housing facility where they would have high measures of stability, autonomy, and support.
   b) Several study women have apartments in senior citizens housing. This seems to work extremely well for the women.
   c) Programs such as Home Start that help women hold onto housing are important.

4) Programming that helps women keep or maintain relationships with their children are critical.
   a) The early intervention program in Chelsea seems to be a good model in terms of helping women acquire parenting skills as well as coordinating services for new mothers.
   b) Assistance with children who have "come back into" their lives at age 18.

5) Improve the network of detox and rehabilitation programs.
   a) Develop and support long term residential rehabilitation programs. Most current programs are too short.
   b) Streamline the detox system. Currently, in order to get a detox bed, the individual has to call a central number where they are given the phone numbers of three facilities to call to see if there is availability. They are told if those three places are full to call back and get three more numbers. Since many of the women do not have telephones or notepads on which to write down phone numbers, this system does not work. It would be more sensible for the central office to keep track of bed availability than to tell each addict to make numerous phone calls.
   c) Ensure that space is available in an appropriate rehabilitation facility before releasing women from a seven day detox.
   d) Develop mechanisms to direct women back to detox and rehabilitation facilities that they have used in the past. While this will not solve all of the problems of fragmented care, it will help the women achieve some level of continuity of care.

6) Given the women's complex physical and mental health challenges, we recommend arranging a medical caseworker / advocate for each woman. This caseworker / advocate would be associated with the Commonwealth (rather than with a particular hospital or clinic.) The caseworker / advocate would help coordinate services for a woman regardless of where she is living (including prison). This solution likely would save a great deal of money in terms of avoiding repeated medical testing and interrupted treatment protocols.

7) Given the fragmentation of services and programs utilized by this population, it would be useful to offer a "hotline" style central phone number with information regarding where and how to obtain shelter, food, detoxification, medical assistance and other urgent services.

8) While paid employment in the mainstream economy is a noble goal, it is not realistic for the majority of the study women. Development of opportunities for these women to volunteer in return for a stipend would encourage the development of self-esteem through helping others as well as provide activities to address their feelings of boredom, anomie and disconnectedness.

Biographical Background

Susan Sered, PhD is Associate Professor in Suffolk University's Department of Sociology. The author of six books and dozens of scholarly articles, her most recent work *Uninsured in America: Life and Death in the Land of Opportunity* (University of California Press, 2005) was a catalyst for this project. Sered has extensive experience in qualitative research among women.

Maureen Norton-Hawk, PhD is Co-Director of the Center for Crime and Justice Policy Research at Suffolk University and has served as research associate, consultant and trainer for the National Institute of Justice ADAM project, Boston Police Department, the Massachusetts Trial Court, and the Governor's Commission on Domestic Violence and Sexual Assault. She developed and implemented a Needs Assessment of women who were arraigned for a prostitution-related charge in Boston Municipal Court.

Sered and Norton-Hawk have published several articles and research reports based on this project. Copies of these publications are available electronically or upon request from the authors.

- "Mothering in the Shadow of the United States Correctional System" in Michelle Walks and Naomi McPherson (eds.) *Mothering: Anthropological Perspectives*. Demeter Press (in press).
- "Whose Higher Power? Criminalized Women Confront the "Twelve Steps." *Feminist Criminology* (in press.)

- "Disrupted Lives, Fragmented Care: Illness Experiences of Criminalized Women," *Women and Health* (2008).

- "Why Health Care Services for Postincarceration Women are Ineffective," *Women, Girls and Criminal Justice* 9/6 (2008).

- "Barriers to Health Care for Women who have been Incarcerated," Center for Women's Health and Human Rights, Suffolk University (2007).