

## Washington State's Residential Parenting Program: An Integrated Public Health, Education, and Social Service Resource for Pregnant Inmates and Prison Mothers

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### Abstract

Increases in the number of women incarcerated have created a corresponding need for health services for pregnant inmates. There have been relatively few comprehensive prison-based programs that address the prenatal health care needs of these expectant prisoners, as well as providing a safe and nurturing long-term environment for their infants. This paper outlines the key health care issues for female prison inmates and focuses on pregnant women and their unique health, educational, social, and vocational needs. An in-depth process analysis of a promising integrated program, Washington State's Residential Parenting Program follows. Since most inmates return to their communities, prison programs for mothers that aim to reduce recidivism, enhance long-term public safety by providing a bridge between the institution and community, enhance the relationship between mother and child, and improve the prospects for the family should be a priority.

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In 2000, 1,305,253 individuals were incarcerated in United States prisons — of these, 86,028 were women (Stephan & Karberg, 2003). This figure marks a dramatic change in the number of women incarcerated, up 37.9% from 1995, and stands in contrast to the 26.8% increase in the number of men incarcerated during the same period. Belknap (2001) notes that this change has occurred despite the fact that there has not been a corresponding increase in women's criminality and that most female offenders have committed non-violent crimes. Many of the women incarcerated in state prisons — 32.8% — were sentenced on drug-related offenses, such as drug possession or trafficking (Snell & Morton, 1994). Another one-third were violent offenders (32.2%) convicted of crimes ranging from assault to murder, while the remainder of crimes committed by these women consisted of property offenses (28.7%), and public order offenses (5.7%) such as "morals and decency."

Patterns of criminal activity among women are more complex than are often presented (Widom, 2003). Some scholars (see for example Richie, 2003) speculate that female criminal activity may be attempts to address "a history of unmet social, educational, health, and economic needs in addition to a history of victimization." Specifically, many crimes committed by females are characterized as "survival crimes" that enable women to earn money to support drug habits or escape abusive relationships (Richie, 2003). This observation is borne out by statistical and qualitative evidence regarding women's experiences with victimization and substance abuse (Greenfeld & Snell, 1999; Chesney-Lind, 2003).

A history of physical and/or sexual abuse appears to play a key role in violent offenses committed by women (Chesney-Lind, 2003). A 1999 study of women incarcerated in state prisons found that nearly six in 10 of these

offenders had experienced physical or sexual abuse in the past (Greenfeld & Snell, 1999). An examination of homicides committed by women, for example, revealed that an overwhelming number of victims had been close to the offender; furthermore, 42% of women convicted of violent crimes had been victims of abuse (as compared to only 25% of women who did not report abuse) and half of abused females convicted for violent offenses were sentenced for homicide (Snell & Morton, 1994).

The link between women's criminal behavior and substance abuse is equally compelling. One in three mothers in state prisons reported that they were incarcerated for crimes committed to support drug habits (Mumola, 2000). In 1998, women accounted for 18% of all persons convicted of drug-related offenses (Greenfeld & Snell, 1999) and a 1991 study showed that women were more likely to have been regular drug users than male offenders (Snell & Morton, 1994).

Changes in arrest policies and the popularity of "get tough on crime" measures appear to be responsible for sending increasing numbers of women to prison (Belknap, 2001; Richie, 2000; Acoca & Raeder, 1999). "Gender-neutral" sentencing policies tend to work more harshly against women because the crimes women commit often do not allow them to bargain with prosecutors for downward departures of their sentences (Chesney-Lind, 2003). For example, women involved in the drug trade are often so low in the hierarchy that they lack access to information that prosecutors reward in plea negotiations. Mandatory minimum sentences for drug offenses ensure that women convicted of these "non-serious" offenses — comprising the largest component of their criminal activity— still face longer prison terms (Weatherland, 2003).

The fact that women are often the primary care providers for dependent children is rarely a mitigating factor when women are sentenced (Krisberg & Temin, 2001). This has serious implications for women once imprisoned and their families. Among state prisoners, 65% of women had minor children (Mumola, 2000).

Between 1991 and 1999, the number of children with a mother in prison doubled, leaving some 35,400 families without their birth mothers. Mothers in both state and federal prisons were also more likely than fathers to have been living with their children at the time of arrest, and 31% of mothers in prison had been living alone with their children, compared to only 4% of men (Mumola, 2000).

In 1998, 16% of the total corrections population — including those on probation, on parole, in prison, and in local jails — were female, although fewer than 6% were in prison (Greenfeld & Snell, 1999). Because the total population of female prisoners is small, they are at comparative disadvantage to their male counterparts — in many states, for instance, there is a single prison for women, usually located far away from the urban areas that are the source of most prison inmates. According to Belknap (2001: 163), "institutionalized sexism," has occurred, because women are often incarcerated at a great distance from loved ones, and this makes it difficult for them to visit. The relatively small size of the female prison population is also used to justify providing fewer rehabilitative programs, a reduced level of treatment, and mixing serious offenders and minor offenders in a single institution.

Chesney-Lind (2003) argues that many female inmates face the threat of "vengeful equity" in state prisons because they are treated similarly to men "in the name of equal justice" despite having a greater need for substance abuse and health care treatment. Poverty among these women is widespread, especially for those with children who are more likely than their male counterparts to be homeless, unemployed, and receiving welfare prior to incarceration (Mumola, 2000; Greenfeld & Snell, 1999). In addition, these prison inmates face gender-specific health issues, including pregnancy — that may be exacerbated by poor community health care. In 1998, for instance, 5% of state prison inmates were pregnant at the time of admission (Greenfeld & Snell, 1999). Extrapolating this estimate to the national prison population, some 4,300 women are likely to give birth in prison this year, and this number is far

higher when one considers the numbers of pregnant women in local jails or juvenile facilities.

### **Female Prison Inmates**

Given the health and psychological challenges female offenders confront, programming provided during their incarceration may determine their ultimate success in escaping the criminal justice system once their sentences end. Comprehensive vocational, educational, physical, and psychological health-related programming can help these women become independent and contribute to more successful community reintegration upon release (Morash, Bynum & Koons, 1998). Successful programs for women should be created with their gender-specific needs in mind to facilitate the long-term goal of succeeding after release (Richie, 2000). This includes not only programming tailored to the experiences of women inmates, but also the staff who deliver the programming. Morash et al. (1998) suggest that successful rehabilitative programs in women's prisons include "strong female role models" as well as the opportunity to develop "supportive peer networks."

The quality and variety of programs actually available to female inmates is questionable, especially in states with small numbers of female inmates (Morash et al., 1998). Parke and Clarke-Stewart (2002) praised efforts made to develop appropriate parenting skills programs for women. However, assessments of the substance abuse treatment and job training women receive have been less enthusiastic. Shearer (2003) criticized substance abuse programs provided to female inmates as being reliant on techniques that are effective for men, but are unproven for women. In fact, androcentric substance abuse programs may actually inhibit women's abilities to confront the abuse issues and feelings of worthlessness that underscore their problems with addictions. Shearer (2003) also notes the failure of many of these substance abuse programs to provide a parenting component, which is "essential" for these offenders. Educational and vocational programs for women have traditionally been focused on outdated stereotypes of women's capabilities and roles in society (Belknap, 2001).

Incarcerated women, for example, are often offered training for jobs that pay low wages and present few career advancement opportunities, such as hairdressing or clerical careers (Belknap, 2001; Shearer, 2003). This discrepancy has traditionally been justified by explaining that women are not "breadwinners" or by claiming that their small numbers in the overall prison population coupled with their relatively short sentences do not warrant more educational and vocational opportunities (Belknap, 2001). However, given the number of women who are likely to return to their roles as single parents upon re-entry — 30% of female inmate in state prisons and 34% of female inmates in federal prisons lived with their children in single-parent households prior to their arrest (Mumola, 2000) — such rationalizations are inappropriate.

Despite the increasing numbers of women being incarcerated, there has not been an equivalent increase in the programming tailored to meet their needs (Shearer, 2003). Part of the problem may stem from the facilities where the women are incarcerated. Given the fact that most states have only one prison for women, typically all offenders are housed in a single facility regardless of levels of dangerousness or individual treatment needs (Shearer, 2003; Belknap, 2001). Thus, it is no surprise that the programming women receive is often recycled from male facilities and fails to address women's needs. One example of unmet needs is the health care often provided to women in state prisons.

### **Health Care Challenges for Female Prison Inmates**

Many of the health problems of female inmates are brought into prison from the community (Ross & Lawrence, 1998). Women tend to have more serious health problems owing to poverty and lack of access to community medical care (Anderson, 2003; Belknap, 2001). These issues are compounded by high rates of alcohol or drug dependency, the prior physical and/or sexual abuse of these women, as well as mental health problems such as depression and anxiety (Anderson, 2003; Ross & Lawrence, 1998). Thus, as Maeve (1999) notes, women often enter prison with "long-standing illnesses" such as

high blood pressure and diabetes as well as exposure to tuberculosis and HIV infections. Most significant, however, is the fact that women's reproductive systems are far more complicated than those of men, a challenge that many prisons have disregarded (Anderson, 2003).

There are no national standards mandating the proper medical and health care treatment for prisoners in state correctional facilities. Both the American Correctional Association and the National Commission on Correctional Health Care (NCCHC), however, have outlined voluntary standards in their accreditation programs. The NCCHC also has guidelines for treating pregnant women as well as providing prenatal care and family planning services (NCCHC, 1994). In a 1994 position statement, the NCCHC recommended specific actions for female inmates, such as intake procedures that include a woman's reproductive history, pregnancy tests, comprehensive health care services tailored to women's unique physiology, and counseling about parenting.

The Federal Bureau of Prisons (BOP) also provides a model for correctional health care that state institutions might emulate. Women in federal prisons — which incarcerated 110,974 men and women in 2000 (Stephan & Karberg, 2003) — may be somewhat more fortunate than those incarcerated in some state facilities, because BOP has clear standards for accommodating the special health care needs of female prisoners. Of the 86,028 women incarcerated in 2000, however, only 8,237 of them were federal prisoners (Stephan & Karberg, 2003). All inmates entering federal prisons are to be medically screened within 24 hours of their arrival (**US Department of Justice, Federal Bureau of Prisons, 1999**). The Initial Health Care Status Screening for women is tailored to women's health concerns and potential for having been victims of sexual assault. In addition, this screening includes a Pap test, breast examination, pregnancy test, and a mumps, measles, and rubella (MMR) inoculation for women of child-bearing age (**US Department of Justice, Federal Bureau of Prisons, 1996**). Further, the BOP provides

regular gynecological and breast exams, biannual physicals, and special health care for women over 50 years of age, including annual mammograms (**US Department of Justice, Federal Bureau of Prisons, 1996**). Although health care standards exist in the BOP, Murphy (2003: 251) observed, however, that there is some disconnect between the Bureau's health care policy and the treatment that inmates actually receive.

Anderson (2003) notes that medical testing and treatment for inmates being admitted to state prisons has increased, but still no minimum national standards exist. The health care services that are typically available to male inmates often are not available to female inmates, posing a "widespread and invidious impediment to adequate health care for women offenders" (Ross & Lawrence, 1998). "Gender-neutral" standards applied to women prisoners may be partially to blame for the unwillingness to address the insufficient medical treatment they receive in prison and rectify the need to treat women's health care needs differently (Weatherland, 2003). Additionally, a "penal harm" movement—the view that incarceration is intended to inflict pain on offenders—may have infected prison health care systems, a further barrier to the provision of adequate health care to all prisoners (Maeve, 1999).

### **Pregnant Prison Inmates**

Women who are pregnant when entering prison bring with them many of the hallmarks of "high risk" pregnancies, including prior homelessness, poverty, problems with substance abuse, and a greater likelihood of having been physically or sexually abused (Daane, 2003). With no national-level standards for state prisons to follow with regard to the treatment of pregnant inmates, the resources and programs available to these women vary according to jurisdiction (Wooldredge & Masters, 1993). According to Wooldredge & Masters (1993) "little is known about the extent and types of policies which are being used across the United States to deal with the problems faced by pregnant inmates" in state prisons. This study responds to the gap in the knowledge by highlighting a Washington State Program that attempts to enhance the physical

health and social functioning of pregnant inmates, while creating a bridge to the community for the inmate, her child, and family. The type of health care that a pregnant inmate receives is somewhat contingent upon where they are serving their sentence. As previously noted, although the BOP has established clear standards for women's health care, most women are in state prisons, and some jurisdictions have less stringent standards. While most correctional systems have made prenatal and postpartum treatment available to women, these institutions are not required to do so and the treatment is usually offered only if requested (Anderson, 2003). Prisons tend to provide the medical services minimally required for legal compliance (Siefert & Pimlott, 2001; Wooldredge & Masters, 1993) and to avoid civil litigation (see Schlanger, 2003). Many state women's prisons, for example, failed to provide prenatal care, nutritionally appropriate diets, or appropriate work assignments to pregnant inmates (Belknap, 2001; Wooldredge & Masters, 1993). Moreover, many facilities lack written policies for management of pregnant inmates (Siefert & Pimlott, 2001). These practices seem shortsighted when one considers that good prenatal care is important for a child's long-term wellbeing.

In addition, incarcerated women face restrictions on their reproductive freedom, and there have been cases when abortions were forced on unwilling inmates, or denied to women who could not afford them (Belknap, 2001). Decision making about the placement of infants born in prisons has also been denied to some of these inmates, and women have been forced to surrender their infants for adoption, release the child to foster care, or placed in the care of relatives (Wooldredge & Masters, 1993).

Prison is a stressful environment, and pregnancy places further stress on the inmate, as these women must also contemplate questions of carrying their pregnancy to term, placement of the infant, and coping with the inevitable separation (Daane, 2003). Additionally, while there has been an increase in incarcerating pregnant women addicted to drugs to protect the fetus, drugs are still "available" to these women

in prison (Siefert & Pimlott, 2001). Most facilities lack the specialized staff and services to ease the detoxification process (Siefert & Pimlott, 2001). Consequently, the stress and uncertainty of an impending childbirth may be exacerbated by withdrawal from substance abuse and the temptation to use contraband drugs or alcohol.

In a review of studies about the pregnancy outcomes of incarcerated women, Siefert and Pimlott (2001) found "high perinatal mortality and morbidity." In addition to high rates of infant mortality, babies born in prison were more likely to display growth retardation, be born prematurely, and require neonatal intensive care. Yet, as awareness of the special health needs of female inmates grows, improvements in the type of care and the kinds of services offered have improved. Research has revealed that the longer a pregnant woman is in prison before giving birth, the "better the birth outcome and the greater the infant's birth weight" (Daane, 2003).

In order to provide appropriate care for the inmate and her unborn child, prisons must provide a broad range of health and social services. Prisons should provide comprehensive prenatal care, including access to appropriate medical care, access to pain-killing drugs, wholesome diets, appropriate work assignments, and living quarters apart from the general inmate population (Wooldredge & Masters, 1993). Moreover, women should receive supportive individual or group counseling, including information about pregnancy and different options for placing infants after their birth (Daane, 2003).

The health needs of pregnant inmates extend to the delivery of the infant. In some cases, security requirements of the prison have resulted in inmates giving birth while handcuffed or shackled (Weatherland, 2003; Krisberg & Temin, 2001). Amnesty International (1999) has been critical about the use of mechanical restraints on pregnant women being transported to hospitals, during labor, and following birth. In addition to the possible psychological damage, handcuffs and shackles can interfere with

emergency care. As a result, prison policies should allow for less restrictive and more humane practices (Krisberg & Temin, 2001; Amnesty International, 1999).

Following a birth, counseling to ease the pain of separation from the infant should be provided as well as classes in parenting and child development offered for those women who will be reunited with their infants upon release (Daane, 2003). Counseling and parenting programs are, in addition to general vocational/educational programs, services that will help these women to become independent following their release. Parke and Clarke-Stewart (2002) emphasize the need for “connecting” the different agencies that will ultimately provide services to these women upon their release, such as housing and health care agencies. Without a conscious effort to coordinate the services provided to these families, their needs sometimes go unfulfilled and therefore undermine their prospects for success.

### **Infants in Prison**

Pregnant women and mothers have always been a challenge for correctional systems. Fry and Cresswell (1847/1974) outline how English gaolers held women and their children in squalid and crowded conditions at the turn of the 19th century. While much has changed in the past two hundred years, the care of women — and their children—in some prisons, has not lived up to the expectations of many public health scholars (e.g., Murphy, 2003). Should, for example, these children be allowed to bond with the mother, or be removed as soon as practical and placed in adoption, foster care, or with the mother’s extended family living in the community? A number of programs have attempted to offer comprehensive pre- and post-natal care. The goals of these programs are to allow the mother and child to bond, and in some cases, provide long-term supportive care for the mother and child within a prison setting.

The first year of life, according to many child development scholars, is critical to a child’s intellectual, emotional, and social development (American Medical Association, 1997).

Attachment between a child and their primary caregiver is thought to develop in the first months of life. When this bond is disturbed, the effect on the child’s development can be “devastating” (AMA, 1997). As these children mature, they may develop problems such as psychopathology or difficulty with intimacy due to a “‘disorganized’ attachment pattern” with their primary caregivers (AMA, 1997; Wooldredge & Masters, 1993). According to Bowlby’s attachment theory (Parke & Clarke-Stewart, 2002), “the lack of opportunity for regular and sustained contact between an infant and a parent will prevent the development of the infant’s attachment to the parent.”

Researchers have found a connection between disorganized attachment and negative behavior in children. Lyons-Ruth, Alpern, and Repacholi (1993) found that disorganized attachment earlier in life was the “strongest single predictor of deviant levels of hostile behavior toward peers in the classroom.” Johnston (1995) examined the possible effects of parental crime, arrest, and incarceration on children at progressive stages of development. For infants under two years of age who develop a sense of attachment and trust during this period, impaired parent-to-child bonding was the critical effect of the parent-child separation. For children between the ages of 2 to 6 years — the “early childhood” phase — the parent-child separation negatively affected the child’s ability to develop a sense of autonomy, independence, and initiative: ultimately resulting in separation anxiety and developmental regression.

Correctional facilities have used a number of strategies to address concerns regarding the connection between an incarcerated woman and her infant or small children, although provision for contact is limited (Belknap, 2001). Most children born to incarcerated women are directed to placement with other family members or foster care, but some women are permitted to keep their infants in prison nurseries (AMA, 1997). The concept of prison nurseries is not new: the Bedford Hills Reformatory for Women, for example, established a nursery in 1901. Such programs were commonplace by the 1920s and 1930s, but

fell out of favor by the 1970s (Morton & Williams, 1998).

Currently, a limited number of jails and prisons in the United States provide on-site nursery facilities as well as residential units that allow incarcerated mothers to live with their new infants (Services for families of prison inmates, 2002). The issue of whether to permit imprisoned women to keep their infants with them in prison is a controversial matter (Belknap, 2001). While separation of the infant from its mother can be traumatic and may damage the child's development, allowing infants to live in prisons may cause other problems (Catan, 1992). However, there are a variety of prison nursery programs in the United States. A South Dakota nursery, for example, allows infants to stay with their mothers up to one month following birth. A program offered by the California Department of Corrections, on the other hand, accommodates not only the incarcerated woman and her newborn infant, but also the woman's other children up to the age of 6 years. Advantages of these types of programs include providing a place for a mother and her child to create a strong attachment (AMA, 1997). This is often the primary goal of prison nursery programs insofar as it encourages family connections, and some experts believe that a stronger relationship with family members during incarceration can encourage overall rehabilitation and prevent recidivism.

Prison nurseries also offer women a chance for maternal support during the stressful months that follow an infant's arrival, support that may facilitate development of the attachment between a mother and her infant (Jacobson & Frye, 1991). Such programs allow women and their infants to form a strong bond and enable the inmate mother to develop parenting skills. Moreover, these programs often offer vocational or educational classes to improve the family's likelihood of a successful community reintegration. After release, the mother and child can maintain the relationship formed during incarceration (Parke & Clarke-Stewart, 2002).

Prison nurseries have disadvantages as well. While younger infants in prison nurseries

developed similarly to those infants in a control group in one study, as the babies aged they experienced a developmental decline in locomotor and cognitive skills (Catan, 1992). This finding suggests that the environment of these nurseries restricts an infant's ability to practice and enhance their skills. Given the social and psychological problems that many incarcerated mothers face, the AMA (1997) suggests that their infants may experience behavioral problems despite participation in a nursery program. It has also been suggested that a child who stays with its mother in prison is itself being unfairly punished, given the restrictions and deprivations of prison environments (Parke & Clarke-Stewart, 2002).

Few empirical studies have substantiated the value and impact of prison nursery programs thus far, but anecdotal evidence gathered by the American Medical Association (1997) indicates that they have been successful because of the stability prison life provides to women, the prenatal health care they receive, and the social stimulation infants receive during the important first year of life. Nevertheless, the AMA's endorsement of prison nurseries as a means of providing these infants a positive foundation was lukewarm given the lack of empirical evidence and the inability to guarantee that the mothers would use the parenting skills once released.

The AMA suggests that for children to benefit from these programs, separation of a child from its primary caregiver should be avoided after six months of age, which has distinct implications for women with longer prison terms. Given this criterion, a consistent caregiver—mother or otherwise—should be a priority during a child's first four years. As a result, the women who are eligible for nursery programs must be carefully screened. To evaluate a woman's fitness for inclusion in the program, administrators might conduct a detailed investigation into the woman's family history, her conduct while incarcerated, and the circumstances described in her pre-sentence investigation (AMA, 1997).

### **Washington State's Residential Parenting Program**

One program that has attempted to provide appropriate prenatal care, as well as offering the mother and infant a long-term opportunity to bond is the Residential Parenting Program (RPP), developed by the state of Washington's Department of Corrections (DOC). The Washington Corrections Center for Women (WCCW), which houses the Residential Parenting Program, is the only state correctional facility for women and held 888 female inmates on September 30, 2004 (Washington State Department of Corrections, 2004). The RPP is a collaborative, inter-agency initiative that partners with a number of local and state agencies, including the Puget Sound Educational Service District (PSESD), the Mary Bridge Children's Hospital, the Woman, Infant, and Children (WIC) program, Tacoma Community College (TCC), the Department of Social and Health Services, Child Protective Services (CPS), Catholic Community Services, Chapel Hill Presbyterian Church, and the Rebuilding Families Board. All of the RPP partners are community stakeholders that provide support and deliver services to program participants.

The primary focus of the RPP is to provide inmates and their infants access to an enriched environment suitable for skill-building and education. The mission statement of the comprehensive program emphasizes its collaborative nature and the services it provides incarcerated women:

In a safe and secure environment, the Residential Parenting Program will provide eligible incarcerated mothers with the opportunity to bond with their infants and gain the necessary parenting and childhood development skills through education and external support systems for a successful transition into the community (Washington State Department of Corrections, 2001).

The RPP enables pregnant, minimum security inmates with relatively short sentences the opportunity to keep their infants after giving birth. Consistent with other long-term prison nursery programs, there are stringent eligibility criteria as well as application, screening, and operations processes. In the following sections

we describe in detail the program's features and operations as well as some of its particular components.

The RPP program has become, since its inception in 1999, the DOC's primary response to meeting the challenges posed by the 10 percent of female prison inmates who are pregnant and expect delivery during their period of incarceration (Washington State Department of Corrections, 2001). The goals of the RPP program are to provide a residential setting for incarcerated new mothers and their infants, maximize the healthy growth and development of these babies, provide inmate mothers and their children access to the Early Head Start (EHS) program, and, upon the inmate's release, assist mothers and their children to successfully reintegrate back into their families and communities. The RPP was developed and implemented as a comprehensive program that utilizes the strengths of community stakeholders to address and help alleviate a broad spectrum of health, educational, parenting, and life-skills issues that pregnant inmates face.

### **RPP Eligibility and Screening**

Admission into the RPP is contingent upon a number of criteria and careful screening by the program staff. First, all inmates must have a minimum security designation. These inmates must also be pregnant, scheduled to give birth during their term of incarceration, and have a sentence of less than three years to serve. Additionally, these women must be both physically and mentally able to care for their child. Women must also meet the Early Head Start eligibility requirements and be willing to participate in all parenting education, training, and services offered by EHS. Inmates must also be willing to participate in various activities provided by RPP and its partners, including pre-release programs, work release, prenatal parenting activities, education, and training programs. Finally, all inmates eligible for RPP must be given clearance by Child Protective Services (CPS) (Washington State Department of Corrections, 2001).

Inmates who meet the strict eligibility requirements but also fall into one or more of the

following categories are rigorously screened by both RPP and CPS to evaluate whether the inmate should be allowed to participate: documented behavior of abuse/neglect of children; mental health issues (evaluated by a service professional in addition to RPP and CPS), and; documented medical concerns. There are also circumstances that will prohibit an inmate from RPP participation regardless of her ability to meet the eligibility criteria. These circumstances include the existence of a court order that prohibits contact with minor children and/or the existence of a documented history of sexual offenses against children (Washington State Department of Corrections, 1999).

Inmates must apply for placement in the RPP, and this process involves a comprehensive screening, including a file review and interviews conducted by a classification counselor. The screening process includes a review of the inmate's criminal history, health status, psychological or psychiatric reports, and presentence investigation. After reviewing the inmate's file, the RPP counselor conducts an interview with the applicant to determine her ability and willingness to participate in the program. Applicants are further scrutinized by a placement committee that makes the final decision regarding RPP placement, although the DOC Superintendent has the ultimate responsibility for approving an inmate's participation.

### **RPP Programming**

Once accepted into the RPP program, inmate participants (referred throughout the rest of the paper as "inmate mothers," "RPP participants," or "RPP mothers") receive an orientation into the program and are expected to know and adhere to the rules and regulations. RPP mothers are expected to be the primary caregivers of their children and are fully responsible for the child's safety and wellbeing. Expectant mothers receive a variety of health-, education-, or parenting-related programs provided by RPP partners. WCCW contracts with a multicare health provider in Tacoma, Washington, to provide health services to the expectant mother — prior to and up to the birth — and pediatric health care for the child (Washington State

Department of Corrections, 2001). Nutrition services are also provided for both the mother and the child in the RPP program. Once the child has been delivered, however, WCCW staff again provide the mothers' healthcare whereas responsibility for children's health services remains with the Tacoma multicare system.

The Child Development Center (CDC) is one of the services provided to the mothers and children. This center provides daycare and family support services, enabling the inmates to engage in vocational or educational programming. Much like a community nursery or daycare center the CDC is open from 8:30 a.m. until 3:30 p.m. Monday through Friday, and inmates are responsible for bringing their children to the center and picking them up after their programming ends. Mothers are provided daily activity charts and summaries of their child's progress, and are encouraged to visit the CDC during its normal hours of operation.

The Center's staff follows precisely the schedule that the inmate mother has established for childcare, including feeding, sleeping/naps, administering medicine, and diapering. Due to Washington State licensing requirements, only a limited number of children can attend the CDC at a given time (two per each childcare provider). Two other childcare options are available for inmate mothers if the Center is unavailable: leaving the child with another RPP mother or with an Inmate Caregiver. Placing children with another mother or caregiver are contingent upon a number of rules, and under strict conditions that are intended to protect the safety of the children.

Inmates are expected to participate fully in the various activities and services provided by the RPP. Typical programming includes: DOC case management (e.g., release planning), parenting and education programs offered through EHS, work programming (once a new mother has been medically released), family support networking, and the Tacoma Community College (TCC) parenting program. Mandatory inmate participation is required for both the EHS and education programs. Other services available to the RPP participants

include literacy training, GED or high school completion courses, and chemical dependency courses. Additionally, the RPP staff encourages inmate mothers and mothers-to-be to take advantage of other community resources. These include parenting programs such as Motherread, Fatherread, Childbirth Education, Labor Support, lactation education, exercise classes, and pre/postnatal health courses. It is important to note that none of the RPP participants are required to participate in any of the programming offered by RPP until she has been medically approved to do so (typically about six weeks after childbirth).

RPP participants work hand-in-hand with community partners to develop and implement three types of plans aimed at the successful programming of the inmate mothers and, subsequently, the successful formation of the mother/child relationship and community re-entry: the Individual Learning Plan (ILP), the Individualized Family Service Plans (IFSP), and the Family Partnership Plan (FPP). These plans identify for the inmate mother as well as the service providers several key areas: child and family strengths, areas of need, level/type of services provided, and evaluation criteria. In addition, these plans provide goals, objectives, and activities aimed at helping both the mother and the child to move toward specific goals (e.g., educational attainment, specific parenting/skills training). These individual and family plans also identify sources of support outside of the institution (e.g., family, community services) to aid the mother/child in meeting their goals both during the term of incarceration and upon re-entry into the community. Finally, the individual and family plans are reviewed by the inmate and appropriate staff monthly to ensure that the mother/child programming is moving along in the expected direction.

The correctional staff and the community partners are also responsible for coordinating, planning, providing, monitoring, and evaluating the kinds of educational services inmates receive. In addition to the development and implementation of individual and family plans for inmate mothers and their infants and as well

as the other services discussed above, EHS also provides a broad spectrum of programming options for inmate mothers in the RPP program. EHS is responsible for providing a positive, enriched environment for the children of RPP participants. This responsibility has resulted in the establishment of the Child Development Center discussed above. Additionally, EHS provides training and support for inmate mothers in child development, parent education, community resources, childbirth, health and nutrition, and other needs specifically identified in the individual and family case plans.

The EHS component of the RPP program consists of six full- and part-time staff members who work in combination with RPP and its partners to provide family, parent, and infant education. There is an EHS director and program manager as well as two family educators and two infant/toddler educators. The family educators meet regularly with individual inmate mothers to discuss family-related issues such as prenatal and child development, parenting planning, safety issues, nutrition, and transitions. These family-focused educators also engage the inmate mothers in parenting meetings and workshops, mother-baby playgroups, and prenatal groups for pregnant inmates preparing to give birth. The infant/toddler educators work with RPP mothers to develop strategies and activities to stimulate the child's growth and development. These educators are based in the Child Development Center with the children and coordinate the care between the mother and the CDC. The infant/toddler educators emphasize stability and strive to make sure that the children are exposed to similar routines and environments even when the mothers themselves are in programming.

Inmate mothers regularly meet with the EHS educators to discuss individual and family plans, make appropriate changes to those plans, review the mother/child records, and receive referrals to other community-oriented service programs upon transition back to the community. Inmate mothers receive regular correspondence regarding their child's development and growth. These evaluations are made by EHS staff at the CDC and provide feedback about the child's

medical and developmental progress. The EHS program staff keeps detailed confidential records for both the inmate mother and her child. Inmate mothers have access to these records for purposes of programming and educational needs (for the mother) and health- and developmentally-related needs of the child.

Currently, there are nine inmate mother/infant pairs and six pregnant inmates participating in the RPP program (personal communication, 2004). According to a RPP spokesperson there are also 12 pregnant inmates, newly admitted to the correctional facility, who have applied for placement in the RPP program. Although precise numbers were unavailable, the RPP has served more than 90 women inmates at the facility between 1999 and 2004. As discussed below, more specific information regarding RPP's participants and other innovative programs and their participants will allow for rigorous empirical examinations of these programs and their impact in the future.

Although EHS provides inmate mothers and their children (as well as extended family members) with much-needed programs during inmates' participation in the RPP program, they also provide substantial support to these fledgling families during their transition out of the institution and back into the community. Many of the services that EHS provides to the inmate mothers/children in the RPP program are also available in the community (e.g., WIC, parenting support, EHS, family/parenting programs) and EHS staff work with the RPP staff to ensure that soon-to-be-released inmate mothers are provided with links to these community programs and services. Altogether, the in-custody and community services offered by the RPP and their partners are intended to increase the likelihood of successful community reintegration, lower recidivism rates, and increase the long-term psychological and physical health of the inmate and her child.

### **Discussion and Conclusions**

Women entering the criminal justice system need to be evaluated according to the circumstances they present, rather than being evaluated as if their challenges mirrored those of

men. Policy makers should educate themselves about the women most likely to fall into the grasp of the criminal justice system. Early interventions with these high-risk populations will prevent them from costly criminal justice system interventions. Moreover, women's programming within the system should target the goals of lower rates of recidivism and improved life circumstances following incarceration (Chesney-Lind & Immarrigeon, 1995). This is especially necessary because women inmates are substantially more likely than male inmates to be the primary caretakers for their minor children and because some of these women are also pregnant at the time they are incarcerated.

Given that most crime committed by female offenders is nonviolent (see Greenfeld & Snell, 1999), the use of prison nursery programs for pregnant inmates, such as RPP, to prevent mother-child separation makes sense for a number of reasons. Most significant among these is the lack of sufficient placement alternatives for the children of these women. The alternative to care from their mothers—such as placement with grandparents (53%), other relatives (26%), or foster care (10%) (Mumola, 2000)—can come at a great expense to these children and their wellbeing. Separating women from their infants may be an excessive punishment for both persons once the non-violent nature of most women's crimes is considered. Placement with grandparents and other relatives often poses a significant financial burden for the caretaker, who may receive little or no assistance from welfare agencies (Krisberg & Temin, 2001). Additionally, this choice often is made by mothers who fear losing custody of children placed in foster care. Yet, these extended families may be the same source of physical or sexual abuse that harmed the infant's mother in the first place.

Nor is the possibility of foster care considered a viable solution by some female offenders. Women studied by Kampfner (1995) felt this option was "a huge failure" in large part because of the perceived inadequacies of these services. Foster care can be unstable either because children are moved about frequently or because

the conditions of these placements are undesirable. According to Kampfner (1995), foster care placement also increases women's fear that they will be permanently separated from their children.

Although the monetary cost of prison nurseries has been cited as a reason against developing additional programs (AMA, 1997), it can be argued that the costs of not creating these kinds of programs will eventually place a greater burden on the criminal justice system and society. Separating mothers from their children has potentially distressing consequences as these infants grow into adolescents and adults. As noted by Roulet et al. (1993), prison nurseries are "nowhere near as inconvenient and expensive as the possibly maltreated, maladjusted, permanently damaged street children who might have been saved with intelligent, loving care through infancy and weren't because no one was there to give it to them." Thus, money spent on a program to help mother/infant pairs may end cycles of intergenerational crime (Krisberg & Temin, 2001).

More attention should be devoted to "preserving and strengthening" the relationship between a mother and her child rather than leaping to assumptions in favor of separating them (Bloom, 1995). Prison nurseries may well serve those women for whom, for whatever reason, incarceration is an appropriate punishment. However, because most offenses committed by women sentenced to prison are nonviolent, community-based alternatives to incarceration should be considered and more programs designed to accommodate the needs of women with infants and small children (Krisberg & Temin, 2001). Chesney-Lind & Immarigeon (1995) make a variety of recommendations for

developing such alternatives, including imposing sanctions that are "based on the least restrictive alternative consistent with public safety" as well as those that address the existing challenges that women offenders struggle with as a result of poverty. Acoca and Raeder (1999) cite California's "Pregnant and Parenting Women's Alternative Sentencing Program Act" as a model for consideration. A variety of community-based programs for women and their children have also been developed. Most notable among these are the pioneering efforts of the Women's Prison Association in New York (Conly, 1998). If a decision is made to separate a mother from her child, legislative and judicial decision makers need to be more aware of the potential consequences this separation will have for the child's wellbeing and that making any decision regarding separation needs to consider the child's best interests (Krisberg & Temin, 2001).

Similar to other research, we lack the information necessary to conduct a comprehensive, empirical evaluation of the RPP program to determine whether it contributes to reduced recidivism, and increases the likelihood that mothers who have participated have successful family relationships afterwards. However, it is clear from the substantial body of research surfacing in the area of correctional programming for women inmates, in general, and for pregnant women inmates, in particular, that the RPP program is a step in the right direction. Future research on programs aimed at meeting the multifaceted challenges that these inmates face should attempt to more rigorously examine "how" these programs work and, possibly more importantly, whether these programs do indeed increase the likelihood that these offenders maintain healthy bonds with their children, and promote long-term public safety.

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