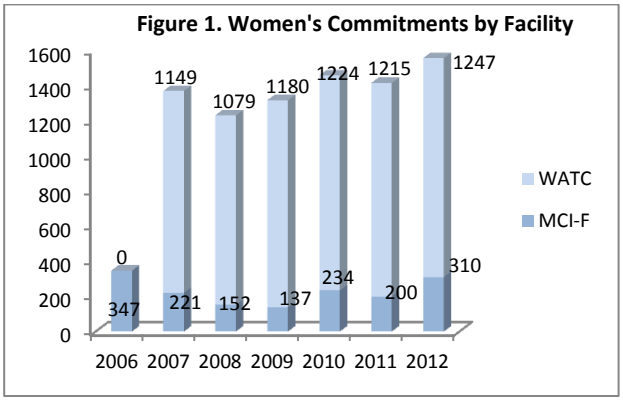
Moving Beyond Prisons: Creating Alternative Pathways for Women

Briefing Note #1 Civil Commitments for Women in Massachusetts

Massachusetts General Law, Chapter 123, Sec. 35 permits the courts to involuntarily commit someone whose alcohol or drug use puts themselves or others at risk, and allows for detoxification and substance abuse treatment for a period of up to 90 days. Prior to building the Women's Addiction and Treatment Center (WATC) in 2007, many women were housed in the state women's prison, MCI-Framingham (MCI-F). This Briefing Note examines the practice of continuing to house women with civil commitments in MCI-F; outlines the resulting inequities; and raises the larger question being addressed throughout the U.S. of reframing substance abuse as a public health problem that requires trauma-informed treatment for women.

Continuing Commitments to MCI-F

- In 2006, MCI-F had 347 women under Section 35 commitments. When WATC opened in 2007, the number of women's civil commitments increased dramatically. By 2012, there were 1,247 women in WATC and 310 women in MCI-F, a total of 1,557 and an increase of 450% (Figure 1).
- However, MCI-F continues to take Section 35 referrals and maintains 20 dedicated beds for these. In fact, the number of women referred to MCI-F continues to increase; it was greater in 2012 (310) than in 2007 (221).
- There is a mandate that women with a Section 35 who have bail issues or outstanding warrants *must be sent to MCI-F.*



Source: MA Dept. of Public Health, Bureau of Substance Abuse Services 2012

Permitting Extended Stays

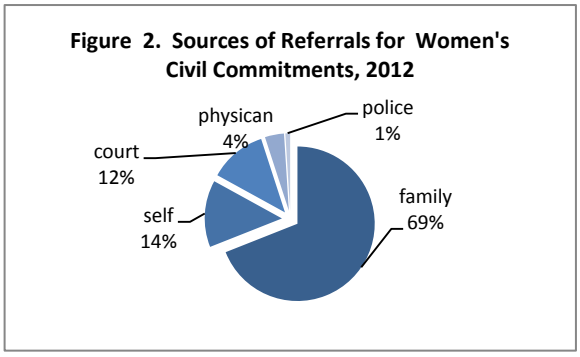
- In 2012, the length of time that Section 35s could be committed was extended from 30 to 90 days. Ostensibly designed to allow more time for treatment following detoxification, this policy has resulted in slower turnover and more pressure on detoxification beds.

Women Have Complex Medical & Psychological Needs

- In 2012, almost half of the women admitted to WATC were addicted to opiates and 38% to alcohol; and one-third had experienced a drug overdose.
- Most women suffered from co-occurring disorders. In 2011, 53% of women admitted to WATC were taking psychiatric medication on admission, and 14% had experienced a psychiatric hospitalization within the previous six months.
- 53% of women admitted have children.

Referral Sources

- Section 35s must be petitioned in court. The majority of petitioners are the family members of those committed (69%). Other referral sources include court personnel, 12%; physicians, 4%; police, 1%; and self-referrals, 14% (Figure 2).



Source: MA Dept. of Public Health, Bureau of Substance Abuse Services 2012

Variations in Courts Practices

- Court patterns of referrals vary widely. In 2012, 40% of Section 35 referrals came from courts in Boston and Southeast MA; 20% came from Metro-West; and 9% came from Central MA (see Table 1).

Table 1. Region	% Referrals
Southeast	32%
Metro-West	21%
West	17%
Northeast	10%
Central	9%
Boston	8%

Source: MA Dept. of Public Health, Bureau of Substance Abuse Services 2012

Note: Women with a Section 35 in rural parts of the state may be taken to a local Bureau of Substance Abuse Services treatment facility to avoid the risk involved in transporting women long distances while undergoing detoxification.

Disparate Treatment & Security: WATC & MCI-F

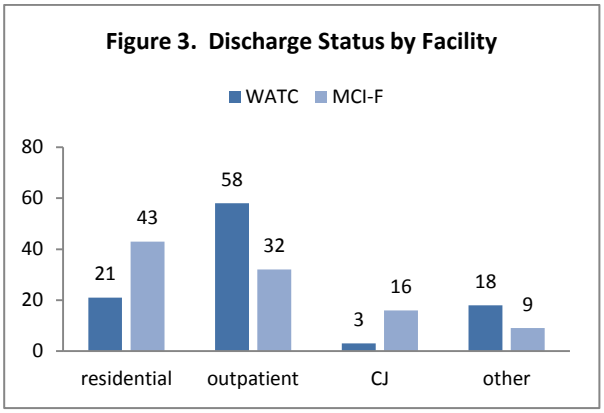
- WATC is not a locked facility; it is "staff secured." It provides a graduated series of services for women following

their detoxification, including transitional support services and family involvement.

- MCI-F is a locked, medium security facility and follows Department of Corrections' protocols. Women do not receive treatment following detoxification because a court order prohibits the prison from offering treatment to women with Section 35 commitments.
- Committed women are not allowed to mix with sentenced women and participate in their programs.
- Although detoxification typically takes 3-7 days, the average length of stay for women in MCI-F without treatment is longer than for women in WATC with treatment (30 compared to 20 days).

Disparities in After-Care

- WATC provides women with community referrals following their treatment; but women in MCI-F did not receive placement assistance for treatment from DPH until 2013.
- Figure 3 shows the follow-up placements for women leaving MCI-F compared with WATC. Clearly, more women are referred to residential treatment from MCI-F (43% compared with 21% from WATC); fewer women from MCI-F are released to an outpatient facility (32% compared with 58%); and more women from MCI-F return to court (11% compared with 3%) or to an awaiting trial unit (5% compared to 0%).



Sources: MA DPH, Bureau of Substance Abuse Services Report; MCI-F 6/2013

Disparities of Race and Criminal Justice Status

- During 2007-2012, the percentage of women sent to MCI-F with bail issues or outstanding warrants steadily declined from 83% to 29%, while a steady 40% of the women in WATC have a criminal justice status, e.g., pending charges. Thus, the differences in their treatment options cannot be explained by their criminal justice involvement.
- In 2012, 92% of women with Section 35s in WATC were white and relatively well-educated (22% with some college; and 40% with a high school diploma or GED).
- There is concern regarding racial disparities because more women of color with Section 35s are sent to MCI-F than WATC (31% compared to 9%).

Addressing Inequities: Women-Centered Treatment Instead of Prison

1. **Discontinue Civil Commitments in MCI-F**
   Massachusetts should follow the example of other states by not permitting women whose substance abuse problems pose a risk to themselves and others to be sent to a corrections facility for detoxification, particularly when no treatment is available.

2. **Rethink the Section 35 Policy and Process**
   With self-referrals making up 14% of referrals, the involuntary nature of Section 35s is a misnomer in many cases. What these women want, as do many of the families seeking commitments for them, is better access to treatment in a family crisis.

3. **Address Treatment in the Context of Parenthood**
   Massachusetts has residential programs for women, but for many women, treatment is often an option that must be weighed against their parental responsibilities, often as their children's primary caregivers. Women may choose treatment over living with their children for a while, but some are reluctant to enter treatment out of concern for their children.

4. **Draw on Agencies' Experience and Cooperation**
   Close cooperation is essential between agencies protecting children, e.g., the Department of Youth and Families, and those providing treatment to parents, e.g., Department of Public Health. Examples exist with Bureau of Substance Abuse Services with the Institute for Health and Recovery to create programming for pregnant and parenting substance abusers without removing women from their homes.

5. **Reframe the Problem: Lead With Informed Practice**
   Nationally, addiction is being redefined as a public health problem.[1] Within this broader trend it is essential that women's special concerns are addressed and that real access is available to cost-effective, women-responsive treatment.[2] Like many other states, Massachusetts needs to provide women with effective trauma-informed treatment for co-occurring disorders.

6. **Data Collection and Monitoring**
   Collect comprehensive data on the women who need services, their access to and utilization of those services, as well as the outcomes, costs and benefits.

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[1] "*Blueprint for a Public Health & Safety Approach to Drug Policy*." New York Academy of Medicine and Drug Policy Alliance. May 2013.

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Note: A list of citations may be obtained from Erika Kates, Ph.D. ekates@wellesley.edu. Wellesley Centers for Women