Women's Prisons

Their social and cultural environment

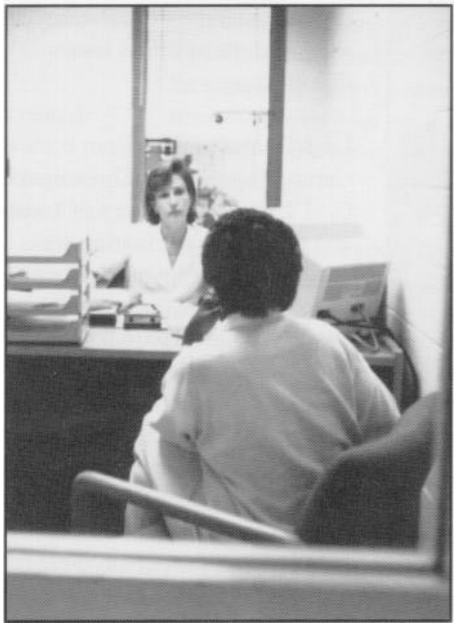
Anne Sims

This article describes the differences in the institutional cultures of women confined within the Federal Bureau of Prisons. The focus is on both the physical and social environments, according to the security level of the inmate and the facility she is in.*

I have worked for more than 3 years as a case manager in the female units at the Federal Correctional Institution, Marianna, Florida. I interact with inmates on a daily basis, and am responsible for advising them about their sentencing information, as well as for inmate classification, programming, and release planning. On a less formal basis, I listen to their problems and provide counseling and crisis intervention. In this article, I will discuss typical staff/inmate relations, psychological characteristics, frequency and types of visits from the community, educational/vocational participation, and release planning—all in relation to their physical surroundings and cultural and social situations.

Physical environment

First, let me describe the Federal Correctional Institution, Marianna, Florida. Marianna, opened in 1988, has three separate, self-contained areas. The main institution is rated medium-security and houses male inmates.



Above: The author counsels a high-security inmate. Right: An education class meets at Marianna's minimum-security prison camp.

The other two areas are for women. One is a Federal Prison Camp (FPC) with a capacity of 296 minimum- and low-security females. Inmate housing is provided by two modules, with two living units per module. The second level in each unit has 19 two-person cubicles; the bottom floor has 18 two-person cubicles. All cubicles contain two beds, two lockers, a desk, and a chair. A telephone is located on each level for inmate use, and each unit has a TV/ multipurpose room, laundry rooms, and toilet/shower facilities. The two modules also have offices in each unit for a case manager and counselor. Adjacent to the housing units are buildings for Administration, Receiving and Discharge (Records), Commissary, Food Service, Education and Recreation, Federal Prison Industries, Pastoral Care, and Psychology Services. Indoor/outdoor visiting areas are also provided. There is no fence around the facility.

The second female area is a Medium/ High-Security Women's Unit. In this unit, 54 rooms are located on three triangular tiers. Each room contains a bed, a toilet, two lockers, a television, dresser, and a chair. Common laundry, shower, and telephone areas are also located in the unit. The housing unit is totally enclosed by two parallel perimeter fences, and contains the same functional offices as the camp. There is a secure area for visitors, as well as for recreational activities. The staff complement in the unit includes a unit manager, case manager, two counselors, and 24-hour correctional officer coverage.

Staff/inmate relations and psychological characteristics

I worked at the camp from June 1988 until July 1990; my caseload consisted of about 130 inmates, with average ages ranging from 26 to 30. Most camp offenders (64 percent) were serving sentences from 1 to 5 years for drug-related offenses. Crimes involving extortion and bank fraud followed in frequency, with 19 percent. At least three-quarters of these women were first-time offenders, with the remainder only having minor prior histories, such as misdemeanor offenses or probation violations.

These women have little, if any, experience with prison and are initially uninformed about this new cultural environment. To most, it is a tremendous shock when the reality of "doing time" sets in. In my experience, this hits hardest when they actually see their

* 'The Bureau of Prisons manages and houses inmates based upon the degree of supervision required. Security needs are determined prior to an inmate's commitment and are rated by the seventy of the offense, length of sentence, prior criminal history, and other management variables. Security levels are categorized as "minimum," "low," "medium," or "high." Once an inmate is designated to an institution, the assigned security level may rise or fall, depending upon the inmate's conduct and time remainmg to serve on her sentence. Some institutions, such as medical centers, must be capable of accommodating inmates across the security level spectrum, and are thus referred to as "administrative" security level facilities.

Photos: Craig Crawford/DOJ

sentence computation sheet reflecting their release date. Tears and mild depression are common, but usually subside as the inmate interacts with staff and peers and becomes involved in the programs available at the institution. Once the inmate is more integrated with her surroundings, she is not unlike a person one would meet outside of prison. She is usually willing to talk freely with staff about her crime, and openly expresses remorse for using bad judgement and placing hardship on her family. She is generally eager to use institutional programs to improve her education and vocational skills, as well as her emotional stability.

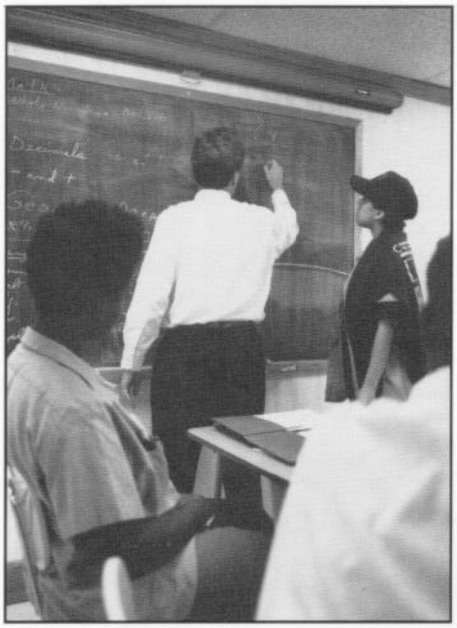
These women tend to suffer from anxiety and depressive disorders as a result of their situation. They are more likely than men to participate over the long term in group discussions led by a staff member, involving topics such as stress management, assertiveness, and family relationships. Most women display a genuine commitment to these groups and are motivated to take what they have learned back to the community. They display few inhibitions when discussing their experiences with their peers and are eager to gain as much information as they can from these self-help groups.

From July 1990 until earlier this year, I worked in the the Medium/High-Security Marianna Women's Unit. With a population of about 85 females, this unit consists of medium- and high-security convicted felons, with most ranging in age from 31 to 35. Almost three-fourths are serving sentences of 10 years or more; another 10 percent have a life term. Half of the unit's inmates were convicted of drug violations, with robbers the next largest group at 25 percent. The remaining 25 percent were

convicted of crimes involving violence, weapons/explosives offenses, property offenses, and more serious white-collar offenses.

Probably the most significant characteristic apparent to me when I started in this unit was the women's general lack of trust and unwillingness to talk with staff. Many of these women had been incarcerated before, either in State or in other Federal facilities, and had considerable experience with how staff and inmates interact. It took about 6 months for me to begin to feel trusted. Essentially, the inmates were getting to know me, and I them. My philosophy (and the Bureau's) in working with inmates is to treat them as I would want to be treated, but many inmates found that hard to understand and had to acclimate.

In comparison to the FPC, it is more difficult to work in this setting, because there are more personality disorders to deal with. A significant percentage of the inmates may be described as having defensive and paranoid characteristics, which could be the result of their longer histories of criminal behavior. Many have psychological problems because of their past histories; for example, they may have been abused—physically, emotionally, or both—in their homes. While about 10 percent of these women do participate in the self-help groups offered by staff, their commitment to using this information seems related to the population participation rate. Of 10 enrolled in a group, 7 may only be enrolled as "a way to do time." As one individual described her feelings to me, there is little variation in day-to-day activities.



Camp inmates are generally eager to use institutional programs to improve their education and vocational skills.

As is the commitment to self-help groups, the seeking out of staff for crisis intervention can be a short-term means by which the inmate learns to cope with her environment. Because these women face a long period of incarceration, any type of goal-setting can be problematic. Denial—a defense mechanism—is also a common characteristic of these women; they believe their crime is really not as bad as everyone thinks it is (if they admit to it at all). This way of thinking is also reflected during release planning, which will be discussed later.

Visits and family contact

During confinement, hardships surrounding an inmate's family, and especially her children, are unfortunate consequences of incarceration that add to the burdens on both the inmate and the community. I believe a good estimate of the proportion of unmarried female inmates who have children is 90 percent. Thus, the hardship is not only on the children, but on the grandparents, mothers, and sisters who are left with the burden of child-rearing. It is not unusual for the children's fathers to be confined as well.

FPC inmates can apply to participate in the furlough program. Inmates who have the lowest form of custody, are within 2 years of a firm release date, and have demonstrated responsible behavior while incarcerated can be allowed the privilege of a temporary stay in the community to reestablish family ties in preparation for eventual release. Furloughs may also be granted during emergency situations, such as a death in the family. I have never felt more helpless than when I tell an inmate a loved one has died, especially when the death was unexpected.

The women in the FPC may also receive pre-approved visits in a supervised visiting room on Saturdays, Sundays, and holidays. About one-third of the camp population receive visits, averaging one visit during a weekend per month. Visits are very important during an inmate's confinement—this keeps them in touch with the outside world, especially with their children. Some inmates fear that their children, especially the very young, may not know them when they return home. Even worse, the children's sense of time makes it difficult for them to think their mothers will ever be back.

In the Medium/High-Security Women's Unit, visits from family, friends, and attorneys may occur in a supervised visiting room on any weekday. Over a 3-month period, only 14 inmates out of the total population of 85 received visits—and about one-fourth of these were from lawyers. For many inmates' families, distance and the cost of travel prevent them from seeing these women. For most

inmates who are concerned about their relatives, and especially their children, the distance makes the realities of spending time in prison even more difficult. One feels especially helpless when there are difficulties with child placement, and court actions and social workers must make decisions that affect the whole family, instead of the mother (and perhaps the father) who is incarcerated.

Educational/vocational participation

Fewer than half of the camp inmates have earned a high school diploma at the time of commitment. Bureau policy mandates enrollment in a GED program if an inmate is without a high school education. College courses are only available through correspondence study; the participation rate is only 10 percent of the camp inmate population. Other courses in English as a Second Language, Adult Basic Education, and Horticulture, as well as a Cook Apprenticeship Program, have enrollment rates of about one of every four camp inmates. A data processing factory, part of Federal Prison Industries, is also available as a voluntary work assignment, and offers an opportunity to take a vocational skill back to the community.

In the Medium/High-Security Women's Unit, on the other hand, more than half of the inmates have a GED or high school diploma, as well as some college education. Education participation in this unit is about one-fourth of the inmate population and involves the same courses described for the camp. As with the camp, an automated data processing factory provides a job assignment that also contributes to vocational training. In both the women's units, it is not difficult to see the great feeling of accomplishment these women display when they not only earn their GED's, but go on to learn additional skills.

Marianna Warden Joseph P. Class (left) and Associate Warden Garland Jeffers make daily rounds. The high-security facility includes an automated data processing factory, which provides job assignments that also contribute to vocational training.

Release planning

Finally, as the offender nears a milestone—being within 12 months of her release from prison—it is time to take a serious look into residence and employment. To assist her in adjusting to the transition from confinement to living in society, placement in a Community Corrections Center (CCC)—or halfway house—is considered.

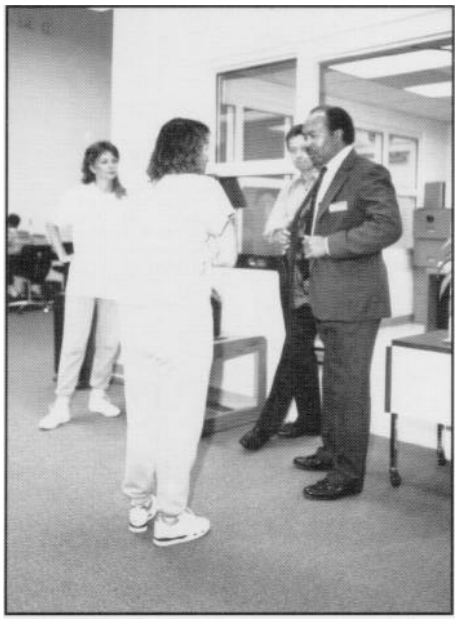
Depending upon the inmate's offense, past history, and institutional adjustment, the length of time spent in a CCC may vary from 1 to 6 months. Most camp inmates are placed in a CCC anywhere from 4 to 6 months prior to release. During this time, the inmate reestablishes family relationships and locates employment and a residence, if necessary. There is much anxiety during the planning period prior to CCC placement: during this time FPC inmates consult with staff to discuss their "prerelease jitters." If drug abuse was a problem prior to commitment, the inmate knows that it will be a problem for the rest of her life, making her struggle to return to society more difficult. Another concern is telling future employers about their conviction history. More often than not, however, the women are anxious to begin a new life. The success rate for female offenders returning to the community appears to be high, and most are determined never to see prison again. For those who do return to prison (I offer a "guesstimate" of less than one-fourth of the camp inmates), most do so because, for one reason or another, they were not motivated enough to succeed or still lacked the maturity to make the right choices.

In the Medium/High-Security Women's Unit, one exception to this pattern is the inmates' need to discuss with staff their feelings about returning to society. Many are self-assured and believe they will not have any problems finding a job, which may be related to their general attitude of denial or defensiveness regarding their criminal offense. The normal placement time in a CCC for these women is 60 days, in comparison to as long as 6 months for the camp inmates. The success rate in the community that I have observed for medium/high-security inmates is about the same as for the camp inmates. Of the 10 medium/high-security women I have processed for release, I know of 3 who have returned to prison.

Conclusion

As every experienced prison administrator knows, there are pronounced differences between minimum- and medium/high-security inmates. This certainly holds true for female inmates. Obviously, these differences directly correlate to the length of the inmate's sentence, and seem to affect the development of trust in staff-inmate relationships. The camp inmate who has been incarcerated before, is released, and returns again because of a violation is more likely to have the attitude of the higher-security inmate. Likewise, some newly committed medium/high-security inmates may display the same open and trusting characteristics as most minimum-security inmates.

It is interesting to note that medium/high-security females are older and apparently better educated, yet camp inmates are more oriented toward goal-setting and long-term commitments. The enhanced frequency and types of visits received by camp inmates are apparently the result of geographical location, rather than lack of family ties. When it comes time for release planning, the degree of participation is greater from the camp inmate than the high-security female, who one would think would require it more.



As in all Bureau institutions, staff members (here, Unit Manager Mike Pettiford) make themselves available for questions from inmates.

These differences are not construed as insurmountable, but are used by staff as management information. If we can understand why these differences occur, perhaps it can give us more insight into how to offer all women inmates more opportunities to learn to be responsible for their behavior, while assisting them in becoming functional members of society and maintaining or reestablishing their family relationships. **n**

Anne Sims is now Case Management Coordinator at the Federal Correctional Institution, Marianna, Florida.

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relationships, sacred space, and opportunities for service—are key elements in helping chaplains effectively minister to incarcerated women. Responding to these needs helps women grow in their relationships to God, and in their relationships to other inmates, staff, and to themselves.

Working with women is a challenge, but it is exciting. Incarcerated women are appreciative, loving, helpful, and nurturing, as exemplified by the often-heard statement, "Chaplain, take care of yourself. Get some rest; we need you." Our ministries will be rewarding and successful if we as chaplains are in constant touch with our Helper, who teaches, enables, and enlightens us in our own spiritual journeys. **n**

The Reverend Guylan Gail Paul is chaplain at the Federal Prison Camp, Danbury, Connecticut.

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Care of the Pregnant Offender

Anita G. Huft, Lena Sue Fawkes, and W. Travis Lawson. Jr.

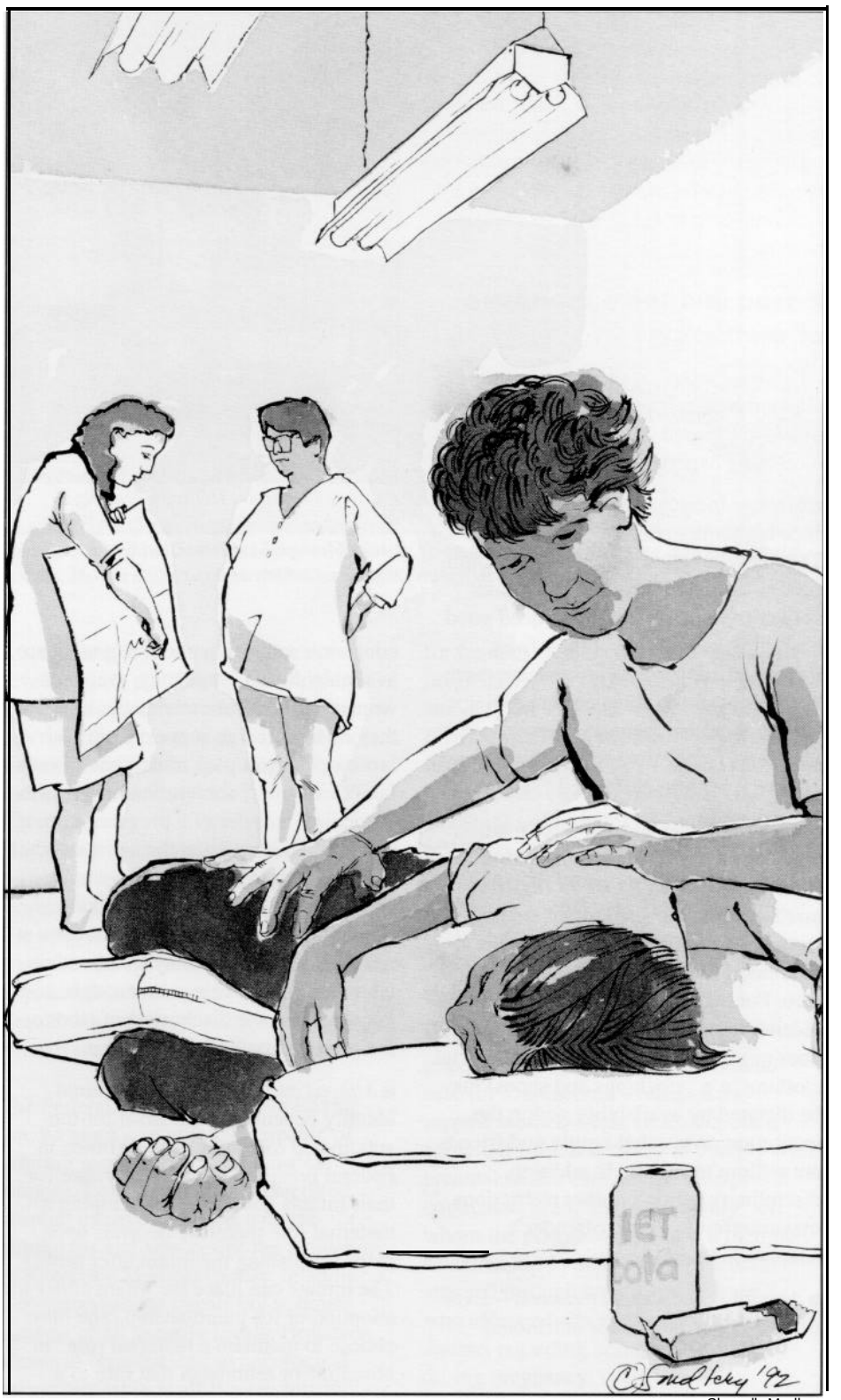
Women face many choices once they are pregnant. Even deciding to find out if she is pregnant can be an overwhelming experience for some women. Whether to continue the pregnancy, how to manage it, and how to select a particular childbirth method largely depend on the knowledge, attitudes, and disposition of people close to the pregnant woman.

While medical literature provides detailed guidelines on monitoring the fetus and performing appropriate medical interventions during labor and birth, there are few guidelines addressing the psychological issues associated with childbirth.

Pregnant women in prison face unique problems. Stress, environmental and legal restrictions, unhealthy behavior, and weakened or nonexistent social support systems—all common among female inmates—have an even greater effect on pregnant inmates.

Maternity care in the prison setting is based on the following values and assumptions:

- Pregnancy is a *healthy* state in which biological, psychological, emotional, and intellectual adaptations to one's surroundings increase the likelihood of a healthy birth.
- Every pregnant woman has the right of self-determination regarding her body and its functions.
- Every woman has the right to physical safety and access to certain health care services. Ensuring the safety of the



Sherrell Medbery

pregnant woman within the constraints of custody may warrant expanding her movement privileges and access to certain health care services. Staff access to previous health care records may be restricted. Violent or self-destructive women must be evaluated to ensure they are competent to select health care choices.

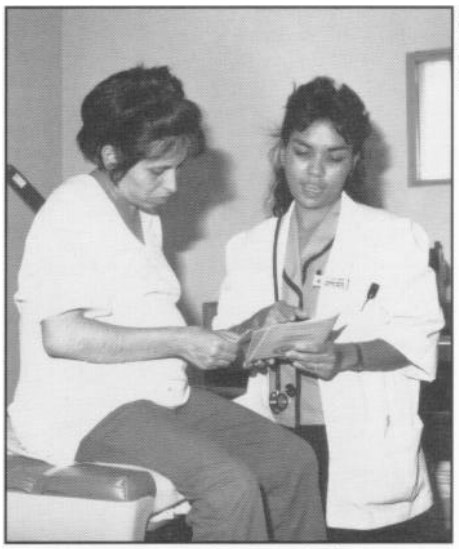
Prison and the experience of mothering

All of the "tasks" of pregnancy are affected by incarceration. Women in prison are placed outside the normal mothering experience in four ways:

- *Stress*—Incarcerated women experience higher than normal levels of stress. They have a higher incidence of complications during pregnancy, labor, and delivery. Many have not practiced good health habits throughout their lives. Infants of incarcerated women are more likely to have life-threatening problems at birth, contract serious illnesses, and be exposed to a negative social environment as they grow into childhood.

- *Restricted environment*—Adaptation to pregnancy is limited by the prison environment. Mandatory work, structured meal times, and lack of environmental stimulation may decrease the likelihood of individualized prenatal care. For instance, pregnant inmates receive standard clothing that often does not fit well. Alternatives for special clothing (e.g., stockings and shoes) may be dictated by availability within the institution or by what family and friends are willing to supply. In addition, disciplinary action or other restrictions may interfere with the offender's adaptation to pregnancy.

- *Altered social support systems—Even* if ideal opportunities for nutritional education and physical development are available during pregnancy, pregnant women will not take advantage of them if they do not receive support from their inmate peer groups. Limited health care facilities or staff sometimes warrant the immediate transfer of a pregnant inmate to a civilian hospital at the onset of labor. But that inmate will then miss the presence of a support person. These limitations may place certain mothers at risk for longer labor, may induce some in labor not to seek care soon enough, and may increase the discomfort of labor and the need for medical intervention.



Physician Assistant Herminia Galang provides prenatal counseling to an inmate at the Metropolitan Detention Center, Los Angeles, California.

- *Altered maternal roles*—Maternal identity depends on rehearsal for the anticipated role after birth. Women in Federal prisons do not directly care for their infants after birth. Developing a maternal role therefore depends upon plans for placing the infant after birth. The inmate can place the infant either for adoption or for guardianship. She may choose to maintain a maternal role "in absentia" or relinquish that role to a relative or friend, depending on factors such as support systems in prison, the inmate's self-esteem and problem-solving skills, the presence of an intact family on the outside, and the imminence of release.

Women who expect to give up their infants after birth do not experience bonding in the same way as mothers who know they will keep their babies. In addition to losing freedom, privacy, and self-esteem, inmates must also cope with losing a child and an identity as a mother. The ability to sacrifice one's own needs for another's is tested during the mothering experience. Whether the nurturing role is innate or learned, most women identify childbirth with infant care. Removing the mothering role from the woman in prison may trigger feelings of dependence, a loss of self-esteem, an inability to focus on the future, or self-destructive behavior.

For the medical staff, helping to resolve the issue of the placement of an infant after birth is based on accurately assessing the infant's potential family environment and the psychological state of the mother.

Preparation for care includes teaching the mother decision-making skills. Counseling should emphasize developing an identity during pregnancy and strategies for coping with the loss of the infant. After the birth, the mother will need counseling in making or accepting the decision to place the infant for adoption or temporary guardianship.

Plans for the female inmate's maternity and nursing care should therefore be guided by interventions to reduce stress, to decrease environmental restrictions. to

promote a healthy lifestyle, and to develop decision-making and coping skills for resolving infant placement problems and assuming a maternal role after the birth.

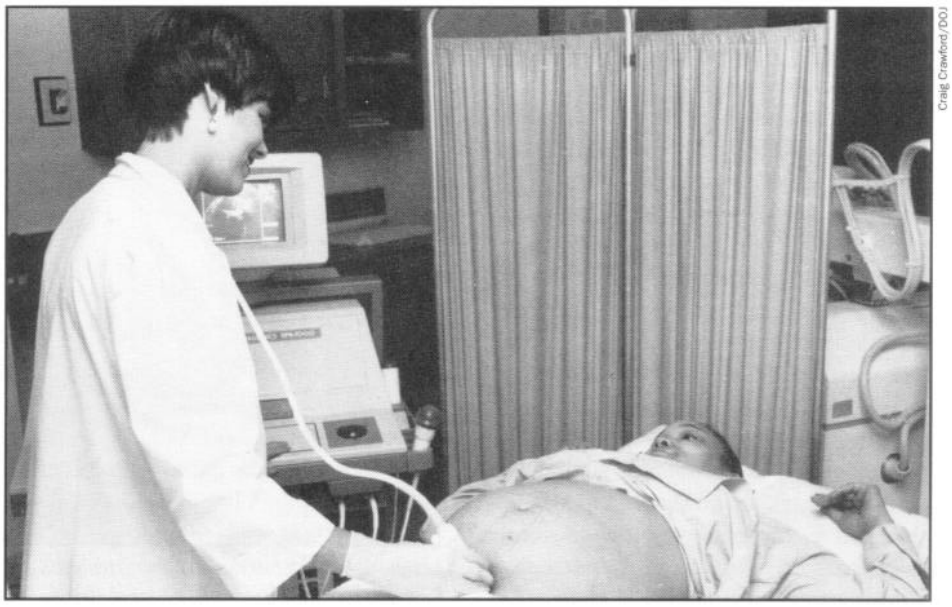
If the inmate is successful in coping with pregnancy and childbirth, she may have learned the skills necessary to successfully cope with her remaining period of imprisonment. Comprehensive maternity care for the pregnant inmate is one component of a supportive prison environment for the female offender.

The clinical dilemma

Recognizing that a small percentage of pregnancies have poor outcomes, doctors introduced the concept of "high-risk pregnancy" into clinical medicine. Early identification of high-risk pregnancies allows doctors to intensively monitor all stages. Moreover, the patient at "low risk" can receive more routine care, unless something changes her status to high risk. The central question, however, is "How do doctors recognize 'high-risk' pregnancies?"

Some high-risk factors can be recognized at the time of the first office visit; others develop or become evident in the latter months of pregnancy or during labor.

Within the unique setting of the Federal Bureau of Prisons and similar correctional systems, a majority of pregnant patients would meet at least some criteria for being high-risk. Within the correctional setting, medical staff recognize as "high-risk" the female with such demographic characteristics as: minority, older than 35 years, previous history of chemical dependency, previous history of multiple abortions or miscarriages, previous history of sexually transmitted diseases or pelvic inflammatory disease, and so on.


Craig Crawford/DOJ

The Federal Medical Center in Lexington, Kentucky, is uniquely capable of offering care for high-risk inmates. Here, a physician from the University of Kentucky Medical Center monitors a fetal heartbeat.

A single major medical condition, or several minor conditions, can indicate a less than favorable birth. Such pregnancies must be termed high-risk, and these patients cared for in specially designed and staffed centers.

That many individuals within the Federal system have "at risk" characteristics increases the importance of prioritizing—allowing individuals at lesser risk to be treated at the institution or in the community, and those at significant risk to be treated at a referral facility for more intensive care.

The Federal Medical Center in Lexington, Kentucky, is uniquely capable of offering medical care for high-risk inmates. Lexington has an accredited hospital closely affiliated with the physicians and services of the University of Kentucky Medical Center. In addition, Lexington has the capability to house inmates of all security levels. However, access to obstetric and gynecological care is available at all Bureau institutions for females. The concept of "high-risk pregnancy," for example, is well understood by the certified specialists the Bureau utilizes as local consultants.

All facilities can prudently meet the challenges of monitoring high-risk offenders. Appropriate budgetary resources can be allotted during the institution's strategic planning process.

The social network during pregnancy

Misguided advice about pregnancy impedes access to and use of prenatal care for low—income women. Low-income women—less educated, often exploited-are less likely to comply with prenatal health care advice. The prison population is an "invented family" of whom the pregnant woman is a member. Membership in this subgroup is often attained through an inmate "mentor," who offers advice and makes recommendations regarding acceptable practices during pregnancy.

Convenience is often cited as a reason pregnant women rely on peers or other sources for advice, rather than professional health care personnel. The prison subculture is a unique mix of racial, religious, and social customs and practices that, blended with institutional routines, organizes the activities of inmates, both within and outside the system. A prisoner's reference group includes family, friends, and acquaintances, who serve as a resource for acceptable information, including medical advice. This group plays a major role in the pregnant woman's interpretation of symptoms, self-diagnosis, acceptance of the need for clinical appointments, use of self-remedies, evaluation of treatment, and belief in professional explanations.

The health and lifestyle choices of pregnant inmates are determined by prison subcultures as well as inherited cultural practices. A thorough assessment of factors affecting pregnancies should include identification of groups and persons to whom the patient turns for information. While such networks can detract from the quality of health care, they can also reinforce medical advice. Knowing which is the case will help the health care practitioner use prison resources in the broadest sense possible. Areas of information concerning which patients turn to their networks for advice include:

- Diet and nutrition.
- Activity and hygiene.
- Harmful substances or practices to avoid.
- Remedies for the discomforts of pregnancy.
- When to seek advice about professional medical care.
- Information on labor and delivery.

Assistant Health Services Administrator Z.Z. Fort with an inmate at the Federal Prison Camp, Marianna, Florida.

This list suggests a pattern for dialog with the patient. Initial and followup visits should include this information, in this order, to spark the patient's attention and allow the practitioner to explore factors that may influence her compliance with medical advice. The physician should frankly and clearly explain the consequences of noncompliance—but in a nonthreatening manner, emphasizing physician-patient cooperation for a successful pregnancy.

Physicians should ask about important medical issues such as substance abuse and high-risk sexual practices in their initial assessments of the pregnant client.

Studies suggest that health education should be vigorously extended not only to the pregnant prisoner, but to her reference groups. Peers should be viewed as allies, not liabilities, in the reinforcement of good medical advice. Routine counseling and education by health care providers should dispel misinformation and the stress it causes for pregnant inmates.

Satisfaction with maternity care

A patient's satisfaction with her medical care is often cited as an ideal indicator of the quality of that care. By examining the components of satisfaction with maternity care, accurate quality assurance indicators can be developed.

Nonincarcerated patients are often afraid that voicing dissatisfaction with their maternity care will adversely affect that care. The female inmate is even more fearful: she is in a controlled environment in which every action may affect her well-being. Even though pregnant prisoners may complain about prenatal care, they are equally negative in their description of pregnancy and birth experiences. Part of this negative attitude may be due to a transference of feeling regarding their care to feelings regarding their birth experience. For quality control, it may be better to measure the frequency and total amount of satisfying conditions rather than to measure patient responses directly.

Conditions for positive pregnancies and childbirths include:

- Participation in decision-making.
- A high quality of explanations given to the mother (especially for delivery by Caesarean Section). The explanations of what could be expected are similar to the actual experience, and the woman receives emotional help from the physician and nurses.
- The nurses' responsiveness to the woman's pain.
- A short time spent waiting on appointments.

"Patient dissatisfaction" is a state of displeasure or disagreement with the

maternity care the patient actually experiences compared with the care she had expected. The stress the pregnant inmate experiences as a result of unmet expectations increases her risk of health problems during pregnancy, labor, and birth. Assuring the quality of maternity services in prisons should therefore include measures to increase patient satisfaction.

The halo effect—"satisfaction with care must make satisfaction with delivery"—does not hold up. Most studies collecting data within 2 months after delivery tend to rate the delivery experience and maternity care very highly. Satisfaction with care decreases, however, when women are interviewed more than 2 months after delivery.

Team delivery of services

Women experience pregnancy in a variety of settings and receive care from health professionals in a variety of ways. Health care delivery facilities become part of the social network of the pregnant woman; the outpatient clinic is a social system in itself. The professionals who staff the outpatient clinic represent various disciplines and clinical experiences.

The formulation of an obstetrical treatment plan for pregnant inmates is the responsibility of several different health care workers. The way such individuals work as a team affects the success of the treatment plan, and ultimately the health of the mother and infant.

The attending physician or chief obstetrical physician serves as team leader. He or she can make medical diagnoses that prioritize treatment. Other health care needs can be met (as deemed appropriate

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Pregnant in prison: An inmate's experience

My name is Dana Johnson. I am incarcerated at a Federal Prison Camp in Bryan, Texas. I have a story to share that I hope will touch people's lives.

I came to prison pregnant. I thought that it was the end of the world, but it wasn't. The psychologist and chaplain counseled me and gave me advice. They told me about a program where I could spend time with my child and form a mother/child bond. The name of the program is MINT, which stands for Mothers and Infants Together. I was excited to be leaving and spending time with my child, even if it was for a short time. They explained that I would spend 2 months with my child after it was born. I had previously spoken with other inmates who told me about their experiences being pregnant in other institutions and spending only a few hours with their children. But not me, because I was here at FPC Bryan. It was then that I realized how lucky I was to have the MINT program available to me.

To make a long story short, I left Bryan on July 2 and went to the Community Corrections Center (CCC) in Fort Worth, Texas, where the MINT program is located. I was 8 months pregnant when I left and my due date was August 8. One month away! Just like any other institution, I had to get to know everyone there. I was scared at first, but the staff knew my situation and helped me in more ways than I could imagine. I was introduced to a staff member who I didn't know would have such an impact in my life—I'll use her first name only.

Thava was one of the warmest, nicest, and sincerest persons who I had met since being incarcerated. We hit it off from the start. We talked and I told her how I felt at the time, which wasn't too great. She gave me some thoughtful words. It was then that 1 realized I had someone to talk to. As the days passed, Thava did so much for me. She set up my doctor's appointments and had films that I could watch—the subjects included mothers using drugs, the birthing process, breastfeeding, and so on. Thava was a hardworking and dependable woman. She was even in the delivery room when I gave birth to my precious son. (I'm not from Texas, but Illinois, and my family couldn't come.) She also bought my son clothes to wear back to the MINT program. She was the greatest! When my son was a week old, he had bad stomachaches. Thava would come at any hour, day or night, to take him to the doctor. She made sure that he had milk and Pampers. I don't know what I would have done without her.

I am grateful for having the opportunity to spend 2 months with my son and establish a mother/child bond. When my son turned 2 months old, it was time for us to say our farewells. Thava took us to the airport and waved at us until we were gone. I got a furlough, which I am also grateful for, and got to see my 2-year-old daughter, who I hadn't seen in 10 months. I finally had my family together, even if it was for only 5 days.

I am back in Bryan, Texas, finishing my time. My son is now 6 months old. Programs like the MINT program help mothers in prison and their children. **n**