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The Development of the Transition Readiness Scale for Female Inmates

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THE FLORIDA STATE UNIVERSITY

COLLEGE OF EDUCATION

THE DEVELOPMENT OF THE TRANSITION READINESS SCALE

FOR FEMALE INMATES

By

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This dissertation is dedicated to my mother, Patricia W. Bradley, who instilled in me the values that led me to the human services profession. She taught me to be kind, to listen, to respect the earth and its inhabitants, and to celebrate diversity. She taught me to be thankful for my virtues, to strive to reach my potential, and to help others reach theirs. Though she may not know it, my mother has changed the world for the better.

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TABLE OF CONTENTS

List of Tables	vii
List of Figures	viii
Abstract	ix
1: INTRODUCTION	1
Social Problem	1
Professional Problem	2
Theory Base	3
Purpose.....	4
Definitions of Terms.....	4
Delimitations	5
Assumptions.....	6
Significance of the Study.....	6
2: REVIEW OF THE LITERATURE.....	7
Prevalence of Female Criminality	7
Unique Characteristics and Needs of Women Inmates	9
Substance Abuse	10
Physical Health	11
Mental Health	12
Education.....	16
Employment.....	16
Support	17
Spirituality	18
Life Skills and Resources.....	19
Parenting.....	19
Interrelatedness of Issues.....	21
Readiness Assessment	24
Current Theories in Psychiatric Readiness Assessment.....	24
Current Theories in Criminal Recidivism Prediction and Prevention	26
Current Practices.....	27
Complexity vs. Capability Model.....	29
Instrument Development.....	32
Summary and Critique of the Literature.....	33
3: METHODOLOGY.....	35
Purpose.....	35
Population	35
Sample	35
Phase I: Instrument Construction	35
Instrument Specifications	35

Item Generation	36
Item Review	37
Phase II: Tryout Procedures (n=50)	38
Phase III: Field Trial (n=324)	40
Participants	40
Phase III Procedures.....	43
Statistical Procedures.....	44
4: RESULTS	46
Item Characteristics	46
Content Validity of Capability and Complexity	54
Internal Consistency	55
Factor Validity.....	56
Additional Analysis	69
5: DISCUSSION.....	70
Introduction.....	70
Limitations of the Study	70
Implications for Practice	71
Implications for Future Research	72
Summary and Discussion of Results	76
APPENDICES	78
Appendix A: Vita of principal researcher.....	78
Appendix B: Informed Consent	86
Appendix C: Background Questionnaire.....	89
Appendix D: Transition Readiness Scale (research version).....	91
Appendix E: Transition Readiness Scale (tryout administration version).....	96
Appendix F: Transition Readiness Scale (field trial administration version).....	102
Appendix G: Human Subjects Committee Approval Letters, FSU.....	108
Appendix H: Human Subjects Committee Approval Letter, BOP.....	111
Appendix I: Item to Domain Model: Capability	113
Appendix J: Item to Domain Model: Complexity.....	118
Appendix K: Response Frequencies for Capability (n=324).....	122
Appendix L: Response Frequencies for Complexity (n=324)	126
REFERENCES	130
BIOGRAPHICAL SKETCH.....	136

LIST OF TABLES

1. Number of Items Per Content Domain in Tryout Version of TRS	54
2. Items eliminated in Phase I: Tryout	58
3. Sentence Length of Sample.	60
4. Substances Used in the Two Years Prior to Arrest.....	62
5. Level of Education of Sample	63
6. Type of Community	63
7. Minimum Values for Goodness of Fit Indices.....	65
8. Descriptive Statistics of Items: Capability (n=324).....	68
9. Descriptive Statistics of Items: Complexity (n=324).....	71
10. Percent Agreement of Raters	74
11. Kappa Coefficients Between Raters.....	75
12. Internal Consistency of Content Domains and Capability Factor (n=324)	76
13. Internal Consistency of Content Domains and Complexity Factor (n=324).....	77
14. Inter-Correlation Matrix for Capability.....	81
15. Goodness of Fit Indices for Content Domain to Factor: Capability	81
16. Inter-Correlation Matrix for Complexity.....	83
17. Goodness of Fit Indices for Content Domain to Factor: Complexity	83
18. Goodness of Fit Indices for Item to Domain Model: Capability	85
19. Goodness of Fit Indices for Item to Domain Model: Complexity	91
20. Goodness of Fit Indices for Content Domain to Factor: Capability and Complexity.	96

LIST OF FIGURES

1. Complexity and Capability	45
2. Proposed Models.....	66
3. Path Model Content Domain to Factor: Capability	82
4. Path Model Content Domain to Factor: Complexity	84
5. Item to Domain Model: Capability	87
6. Item to Domain Model: Complexity	93

ABSTRACT

While there has been an increase in research concerning female offenders in recent years, there is no current standard for the comprehensive assessment of readiness for transition from a correctional environment into the community for this population. Most of the literature on female offenders focuses on factors contributing to criminal behavior and factors that predict recidivism risk with little focus on assessing readiness for transition from incarceration into society. Assessing and then addressing the special needs of women during incarceration may help them successfully re-enter society, live a quality life, and thus avoid recidivism. This study represents the first steps in the construction of a reliable and valid needs assessment, the Transition Readiness Scale, to pinpoint and target the needs of female inmates and enhance readiness for release.

The Transition Readiness Scale was based on a theory of readiness involving two dimensions: complexity and capability (Sampson, Peterson, Reardon, & Lenz, 2000). Complexity refers to readiness factors relating to an individual's environment or circumstances. Capability refers to factors relating to an individual's abilities or competencies. Upon review of the literature concerning female inmates, nine content areas were chosen to represent the most salient readiness areas in female inmates: substance abuse, physical health, mental health, education, employment, support, spirituality, life skills/resources, and parenting.

The instrument was developed in three phases. During the first phase, the items on the Transition Readiness Scale were written to assess the domains of complexity and capability across the nine content areas listed above. An average of five items per content area were written to represent each domain of complexity and capability, for a total of one hundred initial items. The items underwent professional critique and serial revisions. Data collection to refine the instrument was conducted utilizing female correctional inmates at a large southeastern federal women's prison. The second phase, Tryout, involved fifty subjects completing the 100-item Transition Readiness Scale. Items on the instrument were eliminated if they did not meet certain inclusion criteria or demonstrate significant statistical variability, resulting in an 85-item instrument. Also during this phase, a team of expert judges was asked to sort the items into the domains of "complexity" and "capability" for the purpose of assessing content validity.

During the third phase, Field Trial, three hundred and fifty inmates completed a reduced version of the instrument, producing 324 valid data sets. These subjects also completed a background questionnaire for the purpose of describing the development sample. The data for this phase were analyzed using a confirmatory factor analysis. Background information was compiled and used to describe the sample.

The results of this research indicate that the items on the Transition Readiness Scale represent the constructs of capability and complexity. Support was found for many of the content domains to be considered subscales of the measure, but such support was not found for some. The TRS can be considered a screening tool for the assessment of female inmates' capability and complexity needs to promote readiness for release into community living. Further development of the instrument is needed for all content domains to be considered subscales, and further reliability and validity studies need to be conducted.

CHAPTER 1

INTRODUCTION

This chapter begins with the social and professional problem that is the rationale for investigation into this topic. It presents an introduction into the theory basis as well as the purpose of this research. Definitions of relevant terms are included for reference. The delimitations and assumptions of this study are presented, as well as the study's significance.

Social Problem

According to the 1998 Bureau of Justice Statistics, 22% of all arrestees in 1998 in the United States were female. Women accounted for 16% of all convicted felons in the U.S. in 1996. Between 1985 and 1995, the number of incarcerated women tripled, and the proportion of women to men in prisons and jails increased, indicating that women inmates are a growing population (Morash, Bynum, & Koons, 1998). It follows that an increasing number of female offenders are facing reintegration into society. In 1978, there were 8,910 women released from federal and state institutions in the United States (U.S. Department of Justice, 2000). By 1988, that number had increased to 24,880, and by 1998 there were 57,345 women released from U.S. federal and state institutions. Studies have shown that recidivism among female offenders is also a problem (e.g. Bonta, Pang, & Wallace-Capretta, 1995).

Society expects the criminal justice system to rehabilitate criminals so that they will not commit further crimes (Lee, 1994; in Morris & Wilkinson, 1995). To move toward a goal of preventing recidivism, the focus during an offender's incarceration should be on addressing the dynamic predictors of recidivism (Zamble & Quinsey, 1997). This is problematic with the female inmate population, however, because the research on recidivism in women is scarce and sometimes conflicting (Harm & Phillips, 2001). It also defines "success" as simply avoiding imprisonment, a label that may not accurately describe an ex-offender struggling to make it in society. It would be wise to address factors that seem to have preceded a woman's criminal offense (Morris & Wilkinson, 1995) whether she is a first time offender or a recidivist, and also those factors that have been identified by inmates themselves as important for post-release success. This is a more comprehensive approach to the problem than addressing recidivism predictors alone, and it shifts the focus toward encouraging success rather than predicting failure.

Society would benefit from a more comprehensive approach to assessing readiness for transition into the community because predicting recidivism only examines similarities among those who are apprehended, not those who commit crimes without getting caught. What this implies is that recidivism prediction cannot be generalized to all former inmates who recidivate, because there may be factors common to people committing crimes without getting caught that are not captured in traditional recidivism prediction studies. Former inmates committing crimes affect society whether or not they are apprehended.

Professional Problem

Currently, psychologists' role with female inmates may take several forms, and these roles vary from state to state and institution to institution. Psychologists often provide intake services to screen incoming inmates for both acute and chronic mental health needs. They are responsible for suicide intervention and follow-up care. They may assist inmates with adjusting to incarceration, dealing with a crowded and often diverse inmate population, and coping with homesickness. They provide ongoing individual and group therapy to address a wide range of issues, including drug and alcohol addictions, childhood trauma, mental illness, and recovery from many sources of post-traumatic stress. Psychologists may be involved in release planning for inmates, including recommendations for continuity of mental health care in the community. They may recommend to the inmate's case manager that an appointment be made with a psychiatrist in an inmate's community. A psychologist may make specific recommendations to the inmate herself regarding follow-up care, the importance of medication management, individual therapy, substance abuse aftercare, or how to seek financial assistance for mental health related concerns.

Psychologists may provide a range of assessment, psychoeducation, and therapy in an inmate population. Often, separate departments within institutions address other needs such as physical health concerns, vocational and educational needs, spiritual needs, and parenting concerns with little coordination of services. Although the different departments may address inmate needs in a separate yet additive manner, there is currently no unified, holistic system to assess inmate needs both upon entry into incarceration and as an inmate plans for release. This system does not take into account the interrelatedness of need domains that is well documented

in the literature, and there is no current conceptual framework in the literature for addressing this issue.

Although women enter the correctional system with a variety of serious psychosocial and mental health concerns, it is apparent that psychological, social, and even educational-vocational services are not currently a top priority for the correctional system. For example, the mission of the Federal Bureau of Prisons (BOP) reads:

“The BOP protects society by confining offenders in the controlled environments of prisons and community-based facilities that are safe, humane, cost efficient, and appropriately secure, and which provide work and other self-improvement opportunities to assist offenders in becoming law-abiding citizens (Introduction to the Bureau of Prisons, 2000, tab 2, p.2).”

It is only upon close examination and interpretation of the mission statement that the mere inclusion of psychological services becomes apparent. Such services are captured under the “provide work and other self-improvement opportunities” portion of the mission. While it is reasonable that security is the main focus of correctional facilities, it is curious that the only specific prison program that is mentioned in the Bureau’s mission statement is “work”, which arguably has connotations of punishment rather than rehabilitation in a prison environment. Ironically, prison work details often consist of short periods of “busy work” that rarely mimic real-world employment and do not resemble substantive preparation for occupations or careers (Morris & Wilkinson, 1995; Pimlott & Sarri, 2002). The mission also illustrates the society-focused, recidivism-reducing flavor of the current correctional system that appears to stop short at the offender’s needs to prepare for responsible citizenship in communities after imprisonment. The mission statement clearly establishes society as the primary constituent group and prisoners as a very distant secondary constituency.

Theory Base

Enhancing readiness to re-enter society and live a successful, crime-free life is the focus of this study. It is an attempt to move away from the short term needs of society alone and toward the longer term needs of both the offenders and society. It is a statement that incarceration, while important, is only a small part of societal intervention with criminal offenders. It captures the holistic needs of an offender as not only a person who has committed a

crime, but as a person of high risk in many ways. These include coping with tendencies toward chemical dependency, having physical health limitations, struggling with the multiple effects of psychological trauma, suffering from poverty, having educational and vocational needs, and caring for dependent children.

As convoluted and overwhelming as these issues seem, there is a succinct approach to conceptualizing the many issues offenders face as they prepare for their return to society. The two-factor complexity vs. capability model first outlined by Sampson, Peterson, Reardon, and Lenz (2000) is well suited for this purpose. The factor of “complexity” refers to an individual’s environment, or circumstances. The “capability” factor refers to an individual’s abilities or resources. This theory is described in greater detail in the next chapter.

Purpose

The purpose of this dissertation was to develop a reliable and valid measure of female inmate readiness for transition from prison into society. The construct validity of the readiness measure was demonstrated through the following:

1. Content Validity
2. Internal Consistency
3. Factor Validity

Definitions of Terms

Complexity: Environmental or circumstantial factors that need to be overcome in order to be successful in a life domain of interest, e.g. physical health or spirituality.

Capability: Abilities or competencies needed for success in a life domain.

Criminogenic Needs: Offender need areas in which treatment gain will reduce the likelihood of recidivism; criminogenic needs have also been referred to as dynamic risk or contributing factors (Taylor, 1998).

Dynamic Variables: Offender characteristics that are able to be changed, such as substance abuse.

Inmate: A person currently incarcerated in a criminal justice facility.

Noncriminogenic Needs: Need areas that, while dynamic, are not associated with a potential reduction in recidivism; noncriminogenic factors have also been referred to as non-contributing factors (Taylor, 1998).

Offender: A person who is either currently incarcerated or has served a jail or prison sentence in the past.

Readiness Needs: The gap between an existing level of proficiency to successfully manage complexity factors and the level desired (Peterson, Lenz, & Sampson, Jr., 2003).

Static Variables: Offender characteristics that remain constant, such as prior criminal history and gender.

Recidivism: Returning to jail or prison with a new conviction after having been incarcerated at least one time.

Delimitations

This study was conducted with adult female inmates in a federal low-medium correctional setting in the southeastern United States. It is important to note, however, that the sampling institution is classified as a low-medium facility, meaning that it is equipped to securely manage inmates who require up to a moderate level of security. However, most of the inmates themselves are classified at security levels of “minimum” or “low”. Additionally, the current system of security classification for inmates was based on males, which may not accurately represent the dangerousness or security risk of female inmates (Pimlott & Sarri, 2002). Study findings are focused on adult female inmates in federal correctional facilities, and no effort is made to generalize results to male inmates or nonfederal correctional settings. Inmate populations differ in criminal demographics among jails, state prisons, and federal prisons.

This study is also delimited theoretically to a two-dimensional model of community transition readiness: complexity and capability. A comprehensive review of literature led to the identification of nine categories of complexity and capability with implications for successful transition from correctional settings to living independently in communities. It was decided during a research meeting that the number of categories of readiness in this population would be limited to nine to keep the instrument from becoming too cumbersome to be realistically used in a correctional setting. Only those areas of female inmate need that appeared more than once in the literature were considered for use in this study. The initial Transition Readiness Scale (TRS) assessment instrument was constructed with one hundred items, which represented the largest number of items that was reasonable to expect that inmates would complete voluntarily. Finally,

the Transition Readiness Scale is gender-specific and targeted for use only with female correctional inmates.

Assumptions

It is assumed that the female inmate subjects answered the items honestly on the Transition Readiness Scale and that they completed the background questionnaire truthfully. It is also assumed that the domains of complexity and capability have been represented adequately by the items that were written for the instrument.

Significance of the Study

The construction of this instrument is a way of providing a formal measure of readiness for transition from incarceration into the community for specifically female inmates. It is a step toward solidifying best practices in providing for the multifaceted needs of female offenders.

The results of this study are expected to contribute to the assessment of inmate readiness for release in multiple areas. A rating scale that identifies release readiness could have several implications for future use and research. It could point to the utility of the instrument as a quality measure to determine the effectiveness of a prison's release preparation program by rating inmates upon entry and upon release. If there were a significant difference in readiness between women beginning incarceration and women approaching release, it would indicate that the release preparation program is effective.

If it is found that the needs of women do not change over the course of their incarceration, it may suggest that the release preparation program needs to be reevaluated. This scale could be used as a screening instrument upon entry into prison to identify areas of need to streamline and target resources during program planning. It could be used to evaluate inmates who are approaching release to help with release planning and community referrals. Finally, identifying the unique needs of inmates and targeting them with efficient program planning may reduce recidivism. Psychological and educational efforts to prepare female inmates for transition, which represent prevention of criminal activity and rehabilitation, should be substantially increased if subsequent research shows significantly higher rates of criminal activity and re-incarceration for released inmates with lower scores on the TRS.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter begins with a statement on the prevalence of female criminality in the United States. The ways in which female inmates differ from their male counterparts is discussed, with emphasis placed on need areas. The nine most salient need areas are then discussed individually, followed by a statement on their interrelatedness. The concept of readiness assessment is discussed, particularly with respect to female inmates' readiness for transition into the community, as well as literature on instrument development. Finally, a summary and critique of the literature in the area of readiness assessment for female inmates is provided.

Prevalence of Female Criminality

According to the 1998 Bureau of Justice Statistics, 22% of all arrestees in 1998 in the United States were female. Women accounted for 16% of all convicted felons in the U.S. in 1996. Between 1985 and 1995, the number of incarcerated women tripled, and the proportion of women to men in prisons and jails increased, indicating that women inmates are a growing population (Morash, Bynum, & Koons, 1998).

Pimlott & Sarri (2002) outline several trends occurring in the 1990s that may explain the significant increase in female offenders during that decade. First, there has been an increase in the placement of juvenile offenders of both genders in adult facilities. Secondly, and perhaps most salient for federal prisons, the national policy initiative to curtail illegal drug use has resulted in a marked increase in inmates of both genders serving time for drug offenses. Finally, they cite an increase in sentence length as a factor keeping women in prisons for a longer period of time. A substantial portion of this increase can be explained by drug offenses (U.S. Department of Justice [USDJ], 1998). Particularly, the "War on Drugs" that began in 1986 demanded mandatory sentences for all drug crimes, including possession. Drug possession alone accounted for over 35% of women serving time for drug offenses in 2001 (Covington, 2001). Other explanations for the increase in female offenders include poverty, the women's movement, and the overall increase in crime (Walker, 2000). The women's movement resulted in more women taking on traditionally male roles: working outside the home, expressing themselves and

their independence like their male counterparts, and arguably, to commit more traditionally male crimes.

Additionally, there has been an increase in recidivism among women, although most knowledge about criminal recidivism comes from studies on male inmates (Harm & Phillips, 2001; Long, Sultan, Kiefer, & Schrum, 1984). Factors that have been shown to predict recidivism in men have not been shown to be predictive of recidivism in women (e.g. Bonta, Pang, & Wallace-Capretta, 1995). Because female offenders have unique characteristics and needs, it is important to examine them separately from male offenders so that their needs can be adequately identified and targeted.

To reduce recidivism among female offenders, it is important to address dynamic factors that place an offender at risk for reoffending upon release from incarceration. Dynamic factors are those factors that can be changed, in contrast with static factors such as criminal history, which, although statistically predictive of recidivism, are impossible to change. Because the literature on predictors of female recidivism is scarce, however, conducting needs assessment of women offenders based solely upon proven recidivism risk factors would likely result in an incomplete assessment. A more thorough approach to assessing inmate needs would supplement the results of recidivism studies with the results of surveys of inmates and correctional workers. Another approach is to draw from literature on the dynamic factors that relate to successful community living, like a high school degree or a safe residence.

Although there have been relatively few recidivism studies on females, three factors have consistently been found to be related to reoffense among females, and only one of them is a dynamic factor. These factors, summarized in a literature review by Harm and Phillips (2001), include having less than a high school diploma, having served time for robbery, and having a prior conviction as an adult. One study that examined recidivism in female offenders found several predictive variables (Bonta, Pang, & Wallace-Capretta, 1995). Some static variables were predictive of recidivism in women, such as age and criminal history. Type of offense showed some relationship to recidivism, with unarmed robbery being predictive of recidivism. Drug charges alone, without other charges, have the lowest rate of recidivism. Most of the variables mentioned thus far are static variables, meaning that program planning in prison will not alter recidivism risk related to these variables. Some of the variables that have been shown to be

predictive of recidivism in men, such as histories of juvenile delinquency, use of a weapon during a crime, having a co-defendant, and substance abuse, were not found to be predictive of recidivism in women, although this is based upon a scant amount of information.

Another study sought to compare the emotional state of female first time offenders and recidivists upon entry into prison (Long, Sultan, Kiefer, & Schrum, 1984). The authors found many similarities between first offenders and recidivists with respect to mental health symptomatology and psychological adjustment factors. The variables that distinguished between the first offender and recidivist in their female sample were marital status, number of children, and trauma history. Specifically, the current psychological and behavioral manifestation of trauma history is dynamic, or changeable, and can be addressed during incarceration. Similarly, family dissolution or reformation can be addressed, especially on issues such as effective parenting and conflict management.

Unique Characteristics and Needs of Female Inmates

Women inmates are different from their male counterparts. Females are more outspoken about their feelings, are more likely to ask for help, and are more likely to develop emotional attachments to other inmates and staff (DeBell, 2001). With respect to supervision issues while in custody, correctional staff have remarked that female inmates are emotional, manipulative, and vocal (DeBell, 2001). Women have special needs that call for a different management style than men require. They respond better to a correctional staff that is sensitive to their emotional needs, less authoritarian, and more openly communicative (Morash, Bynum, & Koons, 1998). The Executive Director of the American Correctional Association, J. A. Gondles, Jr., aptly stated, “We are charged to create a justice system that is equal, but at the same time, sensitive to the special needs of female offenders” (2001, p. 6). The results from a survey conducted by the H.M. Chief Inspector of Prisons (1997, in Byrne & Howells, 2002) indicate that “Women have different physical, psychological, dietary, social, vocational and health needs and they should be managed accordingly (p. 28).”

Women should be afforded the same opportunities while incarcerated that men receive in areas such as career services, healthcare, and legal resources. Because women have different circumstances under which they commit crimes, however, Carlen (1998) has argued that decisions regarding an offender should take into account not only the crime and its associated

sentence, but also the gender-specific needs and circumstances of the individual committing the crime.

Program opportunities for all prisoners are lacking, and this is especially true for women (Covington, 2001). It is important to note that while women in jails have similar problems and needs as women in prisons, their experience is different. The problem of responding to the needs of women inmates is more pronounced in jails than in prisons. Inmates are generally housed in jails for a much shorter period of time than in prisons, and they usually have fewer resources available to them (Koons, Burrow, Morash, & Bynum, 1997).

Awareness of women's special needs not only sets the stage for ethical and effective management of female offenders, but it is also important in planning for an offender's transition back into society. If a goal of incarceration is to rehabilitate inmates and prevent recidivism, then identifying and addressing inmates' needs during incarceration is crucial (Morris & Wilkinson, 1995). This requires accurate identification of gaps in readiness for transition.

Programs that are helpful for women prisoners include those that address mental health issues, substance abuse, trauma, parenting skills, educational/vocational development, and independent living skills (e.g. Alemagno, 2001; O'Brien, 2001; Pimlott & Sarri, 2002; Richie, 2001). Other programs that may benefit female inmates include multicultural education, leisure programs, interpersonal/relationship skills training, health and physical fitness programs, to name just a few. Several of these need areas have appeared throughout the literature with some frequency, and are the focus of this study.

Substance Abuse

The main reason women enter prison is substance abuse (Henderson, 1997). More than half of women inmates reported problems with drugs or alcohol, which was slightly higher than that of male inmates (Dowden & Andrews, 1999; Morash et al., 1998). It is clear that substance abuse is a significant issue in the inmate population compared to the general population, with a 7.1% illicit substance abuse rate and 5.7% heavy alcohol use rate in persons aged 12 and older (NHSDA, 2001). The marked increase in female incarcerations over the past decade is largely due to sentence length increases for drug-related crimes and the "War on Drugs" that began in the mid 1980s (Browne, Miller, & Maguin, 1999; Henderson, 1998).

The research on substance abuse and recidivism in females is not entirely clear. Lambert and Madden (1976) found that a history of substance abuse is a predictor of criminal recidivism for women, whereas Bonta, Pang, and Wallace-Capretta (1995) found no significant relationship between substance abuse and recidivism in females. Similar findings were reported by Martin, Cloninger, and Guze (1978), who noted the difficulty in isolating the effects of substance abuse from other mental health problems. Because mental health symptoms are commonly self-medicated with illegal drugs and other substances (e.g. Byrne & Howells, 2002), and since substance abuse is prevalent among female offenders, it is difficult to determine whether the mental illness or the drug abuse was the main precursor to a woman's reoffense.

Considering the scope of the substance abuse problem among female offenders and the association between substance use and incarceration, it is clear that substance abuse needs to be addressed with this population. Substance abuse education and treatment were most often mentioned by surveyed correctional administrators as important for female inmates (Koons, Burrow, Morash, & Bynum 1997). Female inmates rated substance abuse treatment as one of the three most important services they needed while incarcerated (ACA, 1990; in Zaitzow & Thomas, 2003). Recovery programs such as Alcoholics Anonymous and Narcotics Anonymous exist in some prisons and can pave the way to continued substance abstinence after imprisonment.

There is some evidence that programs that are commonly offered to both men and women may need to be modified to accommodate the unique characteristics and needs of women. For example, the HMCIP (1997, in Byrne & Howells, 2002) report suggested that the circumstances preceding and characterizing substance abuse may differ for women. This indicates that modification is in order for standard prison substance abuse treatment programs that were originally created for use with male prisoners. Sadly, many women never receive treatment at all in prison, nor do they receive substance abuse aftercare in their community upon release (Prendergast, Wellisch, & Falkin, 1995).

Physical Health

A survey of 1,198 men and women beginning incarceration revealed that there is a high rate of self-reported health problems among prisoners (Conklin, Lincoln, & Tuthill, 2000). Women prisoners have more complex health concerns than their male counterparts, not only

because women's reproductive health requires more care, but also because of sexually transmitted diseases, health concerns associated with lifestyles such as drug abuse and prostitution, and pregnancy (Wilsnack & Wilsnack, 1990, Wooldredge & Masters, 1993, in Pimlott & Sarri, 2002). A troublesome by-product of unprotected sex and intravenous drug abuse is that the rate of HIV infection is a full seven times higher among prisoners as a whole than in the civilian population (Henderson, 1998), and female prisoners are twice as likely as male prisoners to have contracted HIV (USDJ, 1997). Pimlott & Sarri (2002) point out that the median age of prisoners is rising, and thus age-related physical problems are more commonplace. Female prisoners serving eighteen months or longer in prison report an average weight gain of twenty pounds while incarcerated (DeBell, 2001), which poses a number of health risks.

The National Commission on Correctional Health Care (1994; in Pimlott & Sarri, 2002) outlined suggestions for health care standards of women prisoners, asserting that policies written by the correctional system should be written in partnership with women's advocacy groups (p. 72). They state that women should have comprehensive medical evaluations upon entrance into the prison system. They stress that the standards for health care in the institution should be as high as the standards for health care in the community, and women with serious illnesses should be treated by specialists in the community when possible. The Commission points out that women have complex medical, psychological, and psychosocial issues that should be addressed in a comprehensive manner.

In reality, however, women inmates have not been afforded the specialized health care that they need (ACA, 1990; in Zaitzow & Thomas, 2003). Obstetric and gynecological care is provided by only 53 percent of jails. Only half of prisons and jails have twenty four hour medical care available to the inmates, and women's medical emergencies are not responded to in the timely and serious manner that they are in the community.

Mental Health

Studies have shown that there is a higher incidence of mental illness among female inmates than male inmates (Daniel, Robins, Reid & Wilfrey, 1988; Gorsuch, 1998; Morash, Bynum & Koons, 1998; in Byrne & Howells, 2002). More than half of women prisoners have a diagnosable mental illness (Hurley & Dunne, 1991; in Byrne & Howells, 2002). Particularly significant is the rate of self-harm (Gorsuch, 1998) and attempted suicide, at 40% of cases (H.M.

Chief Inspector of Prisons; HMCIP, 1997, in Byrne & Howells, 2002), which is quite high and exceeds self-inflicted abuse by males.

Common mental health issues among women offenders include depression, anxiety, substance abuse, and personality disorders (Hurley & Dunne, 1991; Keaveny & Zauszniewski, 1999; in Byrne & Howells, 2002). Posttraumatic Stress Disorder (PTSD) is rampant in female inmates, with one study reporting an 81% incidence (Raeside, 1994; in Byrne & Howells, 2002). PTSD is common following a history of victimization, and often leads to self-medication with alcohol or drugs. Personality disorders are frequently seen among women offenders, particularly Borderline Personality Disorder (Coid, Wilkins, Coid, & Everitt, 1992; Gorsuch, 1998; Hurley & Dunne, 1991; Raeside, 1994; in Byrne & Howells, 2002).

A phenomenon that may affect all inmates is pre-release stress, which may occur as an inmate approaches her release date. One study suggested that women inmates may actually recidivate because of this pre-release stress, which they termed the “short-term jitters” (Mogal, 1969, p. 249). Not having been prepared to face the free world, they are pushed from the protective environment of prison to the streets and simply cannot cope. They determine that prison life was in effect easier than life on the streets, and so they recidivate. Identifying and targeting release readiness needs during incarceration would aid in addressing pre-release stress and its associated risk of recidivism. This phenomenon of regression at discharge time is a serious challenge and one very familiar to persons who have been hospitalized in psychiatric institutions.

Prior victimization is a common issue for incarcerated women. One study reported that 43 percent of female inmates in the state system had previously been victims of physical or sexual abuse, compared with only 12 percent of incarcerated males (Morash, Bynum, & Koons; 1998). A 55% sexual abuse rate was reported by Raeside (1994; in Byrne & Howells, 2002). The most vulnerable victims of sexual abuse, with a reported incidence of 85%, are females with disabilities (Disability Action, Inc., 1997). Physical and sexual abuse in adulthood was reported by 69% of the participants in one study (Fletcher, Rolison, & Moon, 1993). Domestic violence is not only a common factor for the female offenders themselves, but many of them also witnessed domestic violence as children (Brett, 1993; in Koons, Burrow, Morash, & Bynum, 1997).

Prior victimization indeed often leads to criminal behavior (Bill, 1998), and female recidivists reported more sexual abuse during adulthood than did first offenders (Bonta, Pang, & Wallace-Capretta, 1995). Women who have been abused as children, whether physically, sexually, or through neglect, develop skills to cope with the abuse that may be functional at the time but can later translate into criminal activity. For example, behaviors such as truancy, running away, and drug use were employed by the child to protect her against the physical and emotional pain of abuse, but can be criminal behaviors in themselves and can lead to similar styles later in life (Girshick, 2003). These maladaptive behaviors, while initially developed as a means for survival, appear to contribute to an aberrant criminal lifestyle for marginalized victims. It is clear that addressing issues relating to a female inmate's trauma history is an important need.

Given the rampant trauma history that women inmates report, it is no surprise that a harsh, dehumanizing correctional environment contributes to the already present feelings of powerlessness and vulnerability (Bill, 1998). The disempowerment and depersonalizing nature of the correctional environment can be retraumatizing for women. DeBell (2001) points out that women have a strong need for privacy and urges prisons to provide women with opaque coverings for showers and bathrooms. This is especially important for women who have been sexually victimized and carry a burden of post-traumatic stress that has compromised their growth.

The issue of prior trauma has implications for the management of female offenders during incarceration so as to avoid exacerbating already present mental health needs. One way to respond to the needs of women survivors of trauma is to staff a female facility with a significant number of female employees. A female inmate with a significant history of abuse may be reluctant to see a male health care worker, or to have a male correctional officer patrolling the shower area. A ratio of 4:1 female-to-male staff is suggested by Casale (1998; in Byrne & Howells, 2002) to reduce the vulnerability that women abuse survivors may feel in prison.

Ongoing mental health treatment is crucial for the high percentage of female inmates who suffer from a mental illness. Offenders are expected to live crime-free in the community upon release from incarceration. Returning to a life of poverty, familial turmoil, unemployment, with a more extensive criminal record is difficult, and the addition of a mental illness only compounds

these problems (Draine & Solomon, 1994; Morris, Steadman, & Veysey, 1997; Rice & Harris, 1997). Surprisingly, psychiatric care is available in only 30% of women's jails, although it is cited by female inmates as the single most important service they needed upon entry into custody (ACA, 1990; in Zaitzow & Thomas, 2003).

This strongly suggests that psychological wellness and healing from trauma should be at the top of best practices in preparing female inmates for successful community transition. For example, Canestrini (1994; in Byrne & Howells, 2002) found that women who participated in a program for survivors of abuse had less than half the recidivism rate of the women who did not participate in such a program. As Ferraro and Moe (2003) point out, counseling is important for the empowerment of abused women, which can possibly reduce the risk of further crime.

A sense of self-love and confidence has been identified as a necessary ingredient for successful re-entry into society after incarceration (O'Brien, 2001). It is difficult to navigate the challenges of an unstructured, competitive world without the belief that one has the capacity to be successful. Becoming an involved member of the community is helpful in building self-esteem if the releasee surrounds herself with responsible, positive people. Service to others is a well-traveled path to heightened self-efficacy in performance.

It is imperative that the criminal justice system provide comprehensive mental health services to offenders. Many institutions, especially jails, lack adequate programming in this area. Morash et al. (1988) observes that there are no current "best practices" for women inmates with respect to classification, screening, and assessment. Women need to be screened for trauma needs upon entry into the correctional system. Considering the aforementioned high rate of mental illness among female criminals, comprehensive psychiatric and psychological assessment upon entry into prison is crucial (Byrne & Howells, 2002; Denton, 1995). Ongoing peer mentoring, such as in Alcoholics Anonymous, can be very beneficial. With the significant proportion of inmates with major mental illness, psychosocial education and psychiatric care is important for inmates to function both in prison and upon release. Psychological services in the form of individual therapy and group counseling are important for inmates with a history of trauma, as well as for other common concerns such as adjustment, anxiety, depression, separation from children and other family, and suicidal ideations, to name just a few. There should be no interruption in services upon release from incarceration.

Education

Low education and poor employment history is characteristic of female offenders (H.M. Chief Inspector of Prisons; HMCIP, 1997, in Byrne & Howells, 2002). At least half of incarcerated women in 1994 lacked a high school diploma (Hartwell, 2001), making it difficult to find legal employment. One source reported that the average female offender has only an eighth grade education and has been essentially on her own since adolescence (DeBell, 2001). A review of the literature conducted by Harm and Phillips (2001) revealed that lacking a high school diploma is consistently related to recidivism among female offenders. The American Correctional Association stressed that the most beneficial service to female inmates is education (ACA, 1990).

Employment

Incarcerated women often report a poor employment history. Fifty-three percent of women in state prisons reported unemployment prior to their arrest (Bureau of Justice Statistics, 1991), and many women were dependent upon social service agencies to meet their financial needs (Hartwell, 2001). Paid employment after release from incarceration has been shown to be associated with lower rates of recidivism in female offenders (Jurik, 1983; Lambert & Madden, 1976; Long, Sultan, Kiefer, & Schrun, 1983). Considering that women often have children to care for upon their release from prison, and considering that a high proportion of women are being convicted of financial crimes such as drug trafficking and credit card fraud, it is clear that legal employment is an initial need for women offenders.

Many women inmates possess inadequate skills and experience for success in the world of work (Scott, 1977). A full 60 percent of women inmates were on some form of government assistance in the past, have minor children to care for upon release, and have poor employment histories and minimal skills (Zaitzow & Thomas, 2003). Unfortunately, job training programs for women inmates are lacking, especially in jails, with only 27% providing vocational training (Ferraro & Moe, 2003). While inmates tend to serve relatively short sentences in jails as compared to prisons, female jail inmates cite job training and job seeking preparation as important to them (ACA, 1990).

Assessing job skills and employment finding skills of female offenders would identify those who are most in need of assistance in preparing to find legal work upon their release. Many

of these needs can be met during incarceration in the form of resume writing workshops, job hunting skills, and interviewing skills. A high need for many female inmates is the acquisition of job skills, both to find and keep jobs. Women need skills in areas other than traditional female jobs such as cosmetology and sewing to be competitive in the world of work (Zaitzow, 2003). This point was stressed as far back as 1977 in an article detailing an employment program advocating nontraditional jobs and independence for women offenders (Kestenbaum, 1977). Although job programs are needed, the ideal best practice includes assessment and preparation for professional careers.

Female inmates need work experience in addition to vocational skills training so that they are well prepared for the reality of regular work hours and day to day functioning in a work environment (Ferraro & Moe, 2003). Many jails do not require inmates to perform a work detail, and those that are available are often limited to menial tasks that do not teach the skills needed to function in the world of work (ACA, 1990). Many inmate work details require far less actual performance than what would be expected of them in a job in the community. For example, a job such as landscape may involve ten minutes of raking leaves in the morning and idle time on the yard for the remainder of the day.

Support

An emphasis on relationships was identified as an important area for female inmates by 37.1% of correctional administrators in a survey conducted by Koons, Burrow, Morash, and Bynum (1997). This importance is even apparent inside the prison, as women inmates tend to continue to nurture relationships they had on the outside. Furthermore, women in prison are more likely than male prisoners to develop “fictive families”, pseudo-families, or “state families” while incarcerated (DeBell, 2001; Zaitzow, 2003). These inmate families supply the support, validation, security, nurturing, and companionship that the women long for. Inmates in these families take on the roles of mothers, wives, daughters, grandmothers, sisters, aunts, cousins, and even fathers and husbands. Most commonly found in a female prison is the mother-daughter pseudo-family.

Intimate relationships between female inmates are not uncommon in correctional institutions. One study showed that approximately half of a sample of female inmates were involved in either a love relationship, a sexual relationship, or both (Huggins, 2000; in Girshick,

2003). These women cited love and affection as the major reasons for being in these same-sex relationships in prison.

Correctional staff members acknowledge that more sensitivity is in order when working with female prisoners. They frequently find that the women inmates regard them as parental figures rather than correctional officers and staff, which is uncommon in male prisons (DeBell, 2001). This phenomenon is testament to the importance of supportive relationships among female offenders. DeBell cautions, however, that staff should encourage the female inmate to solve her own problems rather than be tempted to “rescue” her and make decisions for her. This is certainly a difficult issue to navigate in a setting where security is the highest priority, but it is important nonetheless.

Women who lack supportive relationships outside prison are more likely to recidivate than those who have support (Lambert & Madden, 1976). Additionally, women who were involved in friendships or relationships with criminals were more likely to recidivate. It is clear that a strong, law-abiding support system is important in a woman’s successful transition back into the community following incarceration. Learning about triggers to aberrant behavior and constructive or destructive persons, places, and things is critical. Mentors are critical.

Additionally, women who were successful in society after release from prison indicated that repairing damaged familial relationships was a priority (O’Brien, 2001). This is especially true for women whose children were being cared for by a family member during incarceration. They may need to reconstruct their support systems to gain the support they need. They indicated that not only relationships, but also being a member of a community were important for encouraging success.

Spirituality

Female inmates have used religion and other expressions of spirituality as a significant source of coping and strength. A U.S. Department of Justice (1993) survey found that approximately a third of state prisoners participated in religious programming while incarcerated.

Finding purpose or meaning while incarcerated is a difficult process, and many women have found it helpful to turn their experiences over to a higher power (Ferraro & Moe, 2003). Women turning to spirituality may find meaning and peace by believing that they committed their crimes and were sent to prison as a message that they were not following the right path in

life. Women with long sentences may hold onto the belief that God has a different plan for them and they will be released sooner. These are just some of the ways that faith in a higher power, as individuals understand it, has helped women as they cope with incarceration.

There is some evidence that religious programming is effective with prison inmates during both their initial adjustment to prison and their success in the community upon release (Johnson, Larson, & Pitts, 1997; Young, Gartner, O'Connor, Larson, & Wright, 1995). The prison chaplain has proven to be an integral part of the offender rehabilitation process (Sundt, Dammer, & Cullen, 2002). Prison chaplains not only oversee the religious programs, but often provide more secular services to inmates, such as counseling and aftercare planning, which also contribute to an inmate's readiness for transition from prison back into society. Chaplains are illustrative of constructive life role models, as are sponsors in various recovery programs.

Life Skills and Resources

A significant need of women being released from incarceration is housing, especially for those with mental illness. Hartwell (2001) reported that approximately a third of the prisoners in her study, male and female mentally ill offenders, anticipate homelessness upon release from imprisonment. Housing was identified as a crucial need in a study of women who had been successful in society after release (O'Brien, 2001).

Forty-two percent of correctional administrators identified "life skills" as a promising focus of treatment for female inmates (Koons, Burrow, Morash, & Bynum, 1997). Many female offenders have poor problem-solving and decision-making skills, perhaps as a result of being in abusive relationships where they were not permitted to learn these important life skills (DeBell, 2001). Unfortunately, women prisoners are not afforded much opportunity to learn these skills or practice them in a criminal justice setting, where many of the decisions concerning their lives are made for them (DeBell, 2001). In order to be successful after release from incarceration, women need to know how to open and manage a bank account, negotiate financial difficulties, and make decisions that promote their own welfare.

Parenting

Women inmates have many challenges with respect to parenting. Two-thirds of incarcerated women in 1991 were mothers of minor children (Morash et al., 1998). In fact, twenty five percent of women entering incarceration are either pregnant or have recently given

birth (Inglehart & Stein, 1985; Snell, 1993, in Hartwell, 2001). Institutional programming that addresses parenting concerns was identified as important for female inmates by 43.5% of correctional administrators in a survey conducted by Koons, Burrow, Morash, and Bynum (1997). They also identified prenatal care, the well-being of their children, institutional visitation issues, and custody issues as major concerns for female inmates.

The 25% of women entering prison who are pregnant or recently gave birth must face the emotional challenges of pregnancy and postpartum care in a prison environment. While pregnant inmates are provided with accommodations such as prenatal care, a special diet, a lower bunk, special security procedures (such as being handcuffed in front when necessary) and relief from physical work assignments, they still must navigate the restrictions of a secure facility. They certainly do not have access to some of the luxuries that expecting mothers often rely upon, such as a supportive mattress, warm baths, and even childbirth preparation classes. They often must attend off-site obstetrical appointments in uncomfortable handcuffs and leg irons, and although they often give birth at a civilian hospital near the prison, they must do so in the presence of officers.

Upon delivery, a female inmate must hand the infant over to a relative or the foster care system and return to prison. Some prisons have a mother-infant bonding program, allowing the mother and her child to be incarcerated in a special facility designed to promote the maternal bond, but these programs only last eighteen months. Women with sentences longer than that still must surrender their child to someone to serve the remainder of their sentence.

The single most difficult part of imprisonment for a mother is the separation from her children (Rasche, 2000). Women inmates experience anxiety, depression, and despair relating to this separation (Crawford, 1990; Dodge & Pogrebin, 2001). As a whole, they do not surrender their roles as parents when they become incarcerated, but rather hold onto their parental status throughout their incarceration. Men, on the other hand, may surrender their parental status when they become incarcerated without difficulty (Scott, 1977). Among state prison inmates with minor children, only 25% of the women stated that their children's father(s) were caring for the children during the mother's incarceration, as compared to 90% of the men reporting that the mother was caring for their children during the father's incarceration (USDJ, 1991). As a prison superintendent observed, men tend to cope with incarceration by turning inward and focusing all

their strength on themselves, while incarcerated women continue their close relationships with their families and especially their children (Lord, 1995).

Zaitzow (2003) notes that far more female than male prisoners were the primary provider of emotional and financial support for their children prior to incarceration. In fact, while ninety percent of male prisoners' children are taken care of by the mother during the incarceration, only twenty-three percent of female prisoners' children are being cared for by their fathers (Schafer & Dellinger, 1999). In the best case scenario, the children end up with the maternal grandmother or another relative while the mother is in custody. Some end up in foster care, and the mother must struggle to keep in contact with them. Many women do not even receive visits from their children while incarcerated, whether due to geographical separation, familial poverty, or lack of a concerned adult family member willing to bring the children to visit the incarcerated mother. The issue of parenting with female inmates is a complex and serious one, as maternal separation has damaging psychological effects on children and grandmothers as well as the mother (O'Brien, 2001).

Reunification with their children is a high priority for women when they are released, and is a major incentive to achieving successful community living. Dodge and Pogrebin (2001) reported that the single most important issue for incarcerated women is the well-being of their children. More than half of women inmates are mothers, and most were the primary caregiver and main supporter at the time of their arrest (Baunach, 1985; Chesney-Lind, 1997; Datesman & Cales, 1983; Greenfeld & Minor-Harper, 1991; Henriques, 1982, 1996, in Dodge & Pogrebin, 2001). Many face fears of losing custody of their children because of their criminal behavior and parenting history (Bloom, 1995; Fletcher, Shaver, & Moon, 1993; Knight, 1992; Pollock-Byrne, 1990, in Dodge & Pogrebin, 2001).

Interrelatedness of issues

The issues described thus far are interrelated. A history of victimization may cause PTSD, depression, anxiety, and/or a personality disorder, which leads to comfort seeking through substance abuse (Byrne & Howells, 2002). A woman who is a substance abuser is likely to be charged with a drug-related offense (Daly 1987, LeClair 1990; Rhode Island Justice Alliance 1990; in Koons, Burrow, Morash, & Bynum, 1997), but often there are multiple offenses such as prostitution and drug abuse. Trauma victims are more likely to engage in prostitution and to be

less able to hold a job (Girshick, 2003). Mentally ill inmates often lack shelter, family, and friends, and community mental health treatment alone does not appear to predict success in mentally ill offenders (Lovell, Gagliardi, & Peterson, 2002). In fact, successful rehabilitation is almost always reflective of multiple forms of interventions and resources.

Female inmates who perceive a need for substance abuse treatment may be more likely to need additional services than those who do not feel they need substance abuse treatment (Alemagno, 2001). A study of 165 women revealed that those who reported a need for substance abuse treatment ($n = 83$, or 50%) were significantly more likely to also need “housing, medical care, education, mental health services, family support, and parenting assistance” (Alemagno, 2001, p. 799). This study provides evidence that female inmates’ perception of their own needs appear to be subject to a snowball effect. A need in the area of substance abuse treatment is associated with needs in many other areas, likely because abusing drugs and alcohol leads to neglect in many other areas of functioning. Morash and Robinson (1998) state that existing classification instruments are not sufficient for assessing the nature of a female inmate’s substance abuse. They assert that there must be an assessment of precipitating conditions, as well as the needs and resources of female inmates. Guidelines for a comprehensive assessment of the needs of female substance abusers were outlined by the Center for Substance Abuse Treatment (1999; in Covington, 2001) that include all of the issues discussed thus far concerning female inmates. Increased complexity in the number and severity of problems interfaces naturally with the need to design multiple forms of intervention services.

Another way in which the interrelatedness of issues plays out with female offenders is in their health concerns. Women with chronic physical health problems may have more trouble acquiring and sustaining work. Even those who can work may have more sick days if their physical health is not maintained. Unemployment keeps women in a state of poverty, denies them healthcare benefits, and increases the probability of recidivism. Chronic physical health problems not only have an impact on employability, but it can affect a woman’s effectiveness as a parent, can wreak havoc on her mental health, and can be a risk factor in relapse into drug abuse as she attempts to cope with her physical ailments and pain. Other issues that affect a woman’s employability upon release from prison include having minor children, lacking

education, substance abuse, being single, and having willing and able parenting help (Pimlott & Sarri, 2002).

Clearly, childbirth in prison brings forth a number of emotional, medical, financial, and familial issues that require an orchestra of services to come together on the new mother's behalf. Prenatal care is needed, as well as assistance in formulating a plan for the child's care while the mother is imprisoned. Emotional issues inevitably surround having a child while incarcerated, as well as due to the normal hormonal fluctuations of pregnancy and childbirth. There are financial and familial concerns regarding the care of the child. Finally, having a child makes issues of substance abuse recovery, education, and employment readiness all the more salient.

Bill (1998) stresses that mental health programs should be combined into a global "empowerment" model rather than separated into specific topic groups, since the themes such as drug dependence, domestic violence, and childhood sexual abuse are interconnected in the effects they have on women's lives. She advocates for a multidimensional model that addresses how all the issues women prisoners face interact and compound to complicate successful, healthy living. The theme with this approach is that, in assisting female inmates to heal and to piece their lives back together, the whole is greater than the sum of its parts. As S.E. Kestenbaum (1977) states, "Clients are...more than problems or even the sums of problems. They are people with lives as full, as complicated, as varied, and as multidimensional as all other citizens (p. 77)." Unfortunately, the most common scenario seems to involve high levels of complexity of need combined with low levels of coping skills and few resources.

Girshick (2003) advocates for an integrated model of service delivery in female correctional facilities. She asserts that needs areas in female inmates should not be addressed separately, but rather in an interconnected fashion. She adds that it is important for female inmates to be treated with respect as they go about participating in correctional programming. Covington (2001) notes that the programs currently available in prisons lack integration and coordination and can lead to relapse. Moreover, there is rarely a strong interface or link between recovery activities and resources in prison and those in communities. A valuable exception to this weakness is a program like AA that can begin in prison and continue almost unchanged in the inmate's community.

Readiness Assessment

No literature was found that specifically addresses the topic of readiness assessment in female inmates in the United States. The concept of readiness assessment in this population lacks operationalization. While there exist current practices in the assessment of female offender needs, most are focused on preventing failure rather than encouraging success. Further, “success” is often defined as not returning to prison, which ignores the many struggles that women face even if they do not recidivate.

Current Theories in Psychiatric Readiness Assessment

While there has been little research done on inmate-focused assessment of readiness for transition into society following incarceration, there have been some compelling arguments for a client-focused approach to assessing readiness for service delivery in the psychiatric rehabilitation arena. Providing services to individuals who display an awareness of need and a commitment to utilizing services to help them change is more cost efficient than providing services to individuals who are objectively judged by providers to “need” service but who may not be ready to benefit from such services (Cohen, Anthony, & Farkas, 1997). This same concept can be applied to inmates, many of whom are judged by clinicians to “need” treatment or be “at risk” for recidivism, but a judgement of need or risk does not render these individuals ready to participate in rehabilitative programming.

Cohen et al. (1997) writes:

“People differ in their rehabilitation readiness just as they differ in their readiness for college, for a physical fitness program, or for a vacation. It is up to practitioners to help potential recipients of rehabilitation services determine their level of readiness so that when rehabilitation interventions are made, they begin where the person is, not where the program is (p. 644).”

While the authors were referring to a person’s readiness to begin psychiatric rehabilitation specifically, the philosophy may be extended to assessing readiness for release into society after incarceration. Providing all inmates in a correctional facility with the same rehabilitative programming is neither cost efficient nor client-appropriate considering the diversity among individual inmates. Inmates enter correctional facilities at different levels of readiness to function well in society, and it is the task of psychologists to assist each inmate in

determining the level of readiness and thus the level and type of needs the inmate possesses. Cohen et al. (1997) defines “readiness” as being “a reflection of consumers’ interest in rehabilitation and their self-confidence, not of their capacity to complete a rehabilitation program (p. 644).” The authors caution, however, “readiness for rehabilitation is not a stable characteristic, and thus assessments should be repeated periodically (p. 645).”

The idea of a self-report instrument to assess readiness for release into society after incarceration is based upon this theory that individuals who will benefit from interventions are those who are aware of their gaps in readiness and who are committed to overcoming or filling these gaps prior to release. Under this model, inmates are neither required to participate in rote, nonspecific programming nor are they required to self-diagnose their needs and level of readiness and self-prescribe programs. Using the Transition Readiness Scale, inmates are assisted by psychology professionals in identifying their needs, and programming is then based on the inmate’s perception of her needs assessed with the assistance of the instrument. It is a collaborative diagnostic and prescriptive system between psychology professionals and inmate clients.

Research in psychiatric rehabilitation has also found that successful rehabilitation is based upon the client’s skills as well as having supportive community resources (MacDonald-Wilson, Nemec, Anthony, & Cohen, 2001). The authors describe an assessment procedure that de-emphasizes psychiatric diagnosis and focuses on determining an overall rehabilitation goal, a functional assessment, and a resource assessment (p. 425). In the present study, the overall goal is already determined: readiness to function successfully in society upon release from incarceration. The functional and resource assessments described in the work of MacDonald-Wilson et al. (2001) are analogous to the concepts of capability and complexity, respectively, in the present study.

MacDonald-Wilson et al. (2001) encourage practitioner of psychiatric rehabilitation assessment to involve the client as much as possible in assessment and treatment planning, citing that client involvement increases “ownership” of the assessment (p. 427). They advocate the use of valid and reliable assessment instruments for a more time-, cost-, and effort-efficient assessment. The authors maintain that assessment instruments can provide some standardization in assessment, which is useful in comparing clients either to one another or to themselves at

various points in rehabilitation. An assessment instrument is a helpful addition to an interview in assessing need areas, especially in the case of novice interviewers who may miss important areas or for clients with limited communication or verbal skills. These ideas are in line with the rationale for the creation of a readiness assessment for female inmates.

MacDonald-Wilson et al. (2001) assert that an instrument must be specific to the population being assessed. They also cite some “critical characteristics” of psychiatric rehabilitation assessment instruments that would be helpful in selecting a readiness measure for inmates as well. An assessment instrument should be clear, brief, environmentally specific, and skill/resource focused. It is also critical for practitioners to keep in mind that data collected by assessment instruments must be used conservatively; the results should be considered as a part of the overall assessment that includes other sources of data (interviews, etc.). They state, “It is the focus and conduct of the assessment process, rather than the assessment instruments, that are the foundation for a valid assessment (p. 429).”

Current Theories in Criminal Recidivism Prediction and Prevention

Recidivism has been a hot topic in the literature, and many of the studies having to do with the self-improvement of inmates are presented under the motivation of reducing the crime rate. While this is certainly a reasonable goal, it may ignore some of the needs of inmates that are salient to their quality of life but have not been statistically shown to reduce recidivism. That said, the studies concerning recidivism should certainly be examined for their salience in readiness assessment and in replacing aberrant need fulfillment with healthy avenues of fulfillment. For example, emptiness from substance abstinence can be filled with wholesome friendships, better physical health, increased energy, and numerous tools to cope with emotional challenges. These profound tools are peer mentoring/service, following a spiritual path, and actively working a recovery program.

One theory of recidivism was outlined by Zamble and Porporino (1988; in Zamble & Quinsey, 1997): the “coping-criminality” hypothesis. This states that recidivism in criminals can be explained by inadequate coping resources. Offenders lack the resources to overcome certain life obstacles, such as mental health problems, unemployment, lack of familial support, or poor education, and consequently end up reoffending. Resources are certainly critical to recovery, but

must be augmented by tenacious work, acquiring and using relevant skills, and substantive change in self and in personal lifestyle.

Andrews and Bonta (1994) outline four principles of offender classification that may be used to guide needs assessment:

- “1. Risk Principle: Higher-risk cases benefit from intensive intervention; lower-risk cases benefit most from low (or no) levels of service.
2. Need Principle: We can achieve the greatest reductions in recidivism by targeting criminogenic needs for treatment and supervision.
3. Responsivity Principle: Our treatment programs and supervision approaches will be most effective when geared to the offender’s own abilities and learning style.
4. Principle of Professional Discretion: Careful use of professional judgment and discretion can improve the structured assessment and management of risk (in Taylor, 1998, online).”

A meta-analysis by Dowden and Andrews (1999) found support for the principles of risk, need, and responsivity. They found that institutions whose programs focused on the criminogenic needs of women inmates and focused more intently on high risk women had lower rates of recidivism. The outcome measure of recidivism alone, however, is limited in that it does not examine individual differences among those who had recidivated and among those who had not. It also defines “success” narrowly, as staying out of prison, which ignores the degree of successful functioning in the community and quality of life.

Current Practices

In many prison systems, readiness assessment is nonexistent. Instead, only “risk factors” are assessed, which are often seen as threats to the security of the institution rather than readiness of transitioning individuals (Girshick; in Zaitzow & Thomas, 2003). For example, a woman who is outwardly concerned about the welfare of her children may be seen as an escape risk rather than a woman in need of a variety of services to help her both cope with the separation and prepare for resuming parental leadership of children upon release.

Another example of the “risk factor” approach to needs assessment was described in a Canadian study of the adult female offender (Lambert & Madden, 1976). It was suggested that

one way of classifying inmates is to assign them to risk categories based upon whether they were “high risk” and “low risk”, and classification and treatment planning was prescribed accordingly.

While such a model may have been excusable during the time period in which this article was written, it appears that at least some institutions are still using this model of assessing the needs of female inmates. The problem with the recidivism risk classification system is twofold. First, it fails to consider each inmate as unique and in need of a holistic, individualized approach to needs assessment rather than based strictly upon society’s needs (reduced recidivism). Secondly, it focuses solely on statistically proven recidivism risk factors that have been “expert-identified” rather than considering factors identified as important by inmates themselves in surveys and interviews (see Thomas, 2003).

Thomas (2003) believes that research on female inmates and program planning is not complete without considering the opinion of the inmates themselves. Focusing on statistically proven recidivism risk predictors alone is simply doing the absolute minimum in addressing the problem of female criminality. In fact, ignoring the inmate when researching the inmate is a parallel to and perpetuates one of the main contributors to female criminality: the disempowerment of women.

The Correctional Service of Canada, or CSC, conducts a needs assessment upon admission called Offender Intake Assessment, or OIA (Taylor, 1998). This approach compiles information from various criminal justice sources, friends, family, victims, and previous employers. The offender is also directly assessed for needs in several areas, including but not limited to: psychological needs, educational needs, social needs, vocational needs, and trauma history. Using a multidisciplinary team approach, the information is integrated and the offender is placed into a risk/need category ranging from high/high to low/low. This approach is partially based upon risk areas related to recidivism, but it also considers need areas in the following domains that may or may not be related to recidivism risk: employment, marital/family, associates/social interaction, substance abuse, community functioning, personal/emotional orientation, and attitude.

The OIA approach to needs assessment is structured and comprehensive. It considers both criminogenic and noncriminogenic needs, is individualized, and appears to be success-focused. Only the recidivism risk area is assessed actuarially; the other domains are assessed

during a case management type meeting where the inmate is placed into a category based upon a team decision. While this method is a step in the right direction, it relies too heavily on clinical judgement at the expense of objective measurement of need in the noncriminogenic areas and the inmate's perception of his or her own needs. The system uses an actuarial risk/needs assessment, the Community Intervention Scale, to structure the level of service and intervention needed in probationers (Taylor, 1998).

In 1997, the Correctional Service of Canada formed the Task Force on Reintegration of Offenders (CSC, 1997). The Task Force recommended that the CSC focus on the assessment and management of risk and needs. While the Task Force placed a high value on addressing recidivism risk, it also acknowledged that offender needs may not always correspond directly with risk and should still be addressed during incarceration. Comprehensive assessment, individualized case management, and regular monitoring of inmate progress were outlined as crucial components of a reintegration program. Further, the use of risk and need assessment scales were encouraged. This system is unified, holistic, and individualized, although it lacks full comprehensiveness.

Complexity vs. Capability Model

Peterson, Lenz, & Sampson (2003) defined "readiness needs" as the "gap between an existing level of proficiency to successfully manage complexity factors and the level desired (p. 107)." The goal of readiness assessment is to identify specific readiness needs so that they may be targeted quickly and accurately and so that scarce resources will be allocated to those who need them the most. Readiness needs in the inmate population would include those that are most salient in reducing recidivism, the criminogenic needs, and those that are not associated with recidivism but are nevertheless important for successful living in society, or the noncriminogenic needs (Andrews, Bonta, & Hoge, 1990).

The use of a readiness assessment model would be useful in identifying where the gaps exist in a female inmate's readiness for transition from incarceration into society. It would also help to reduce the need for inmates to identify their own strengths and weaknesses when they may not be aware of them. Peterson, Lenz, & Sampson (2003) used a two-factor complexity vs. capability model to assess readiness for student learning in college. They noted that this model increases the efficiency of service delivery by identifying strengths and weaknesses quickly so

that services can be targeted and applied sooner. Readiness can not only be assessed at entry using this model, but can be used to re-evaluate readiness as an individual's sentence progresses and be used to refine treatment planning as an individual's needs change.

The "complexity" factor refers to the individual's environment, or circumstances. Research has identified environmental factors that are associated with a reduction in recidivism. Some of these environmental factors include family support, financial aid and housing programs, affordable childcare, and employment (e.g. Bonta, Pang, & Wallace-Capretta, 1995; Long, Sultan, Kiefer, & Schrun, 1984). Environmental need areas have also been outlined in inmate and correctional staff surveys (e.g. O'Brien, 2001).

Peterson et al. (2003) stress that individuals' perception of their environmental circumstances is actually more important than apparent reality of the situation. For example, if an inmate believes there are no jobs in her community, this concern should not be ignored in the face of evidence to the contrary. The concern should still be addressed so that the inmate does not leave prison and set out to self-fulfill this prophecy. Thus, the best source of information in the assessment of complexity may be the inmate herself, as her perceptions of her environment and her ability to interact with that environment are the most salient factors. This phenomenological perspective of perception strongly shaping realities, including behavior, is well established in various theoretical systems, most notably person-centered counseling.

The factor of "capability" as it relates to female inmates may be defined as abilities or competencies needed to live successfully in society. The literature has identified which personal characteristics are related to successful crime-free living. If these characteristics can be improved upon or instilled in an inmate during her incarceration, it is hoped that she will re-enter society with the tools that will maximize her chances for success.

The factors of complexity and capability interact to form a complete model of an inmate's life situation. The complexity vs. capability model may be illustrated graphically in terms of levels of each factor along a continuum, with each factor represented by a straight line perpendicular to the other, forming four quadrants (see Fig. 1). The four quadrants may be described as follows: High Capability/Low Complexity; High Capability/High Complexity; Low Capability/Low Complexity; and Low Capability/High Complexity. A description of the characteristics and level of need of inmates in each quadrant are discussed below.

	Complexity	
Capability	Low Complexity	High Complexity
	High Capability	High Capability
Capability	Low Capability	Low Capability
	Low Complexity	High Complexity

Figure 1. Complexity and Capability

The first combination is the most desired situation, where an inmate possesses the personal abilities that are associated with successful crime-free living, combined with a support system and community that is safe, stable, supportive, and where opportunities exist. An inmate may strive to enter this quadrant as she moves through her prison sentence, participates in self-improvement programs, and makes decisions regarding her release. Inmates in this quadrant require the least amount of intervention during incarceration. It would be wise, however, to periodically assess inmates during their sentences to determine whether their readiness needs are still being met or if new needs have arisen (e.g. healthcare needs, changes in support system, etc.). Readiness needs perhaps vary during an inmate's incarceration, especially as an inmate approaches release.

The second combination, High Capability/High Complexity, represents an inmate who is doing well internally (having good physical and mental health, life skills, education, and job skills, for example), but comes from a difficult environment. Such an inmate is unlikely to need much in the way of prison programs such as education, vocational skills training, financial skills training, parenting classes, or psychological services. However, it may be that she lacks supportive or law-abiding family and friends or is returning to live with an abusive partner. She may be returning to a community where jobs are scarce, or drugs are commonplace. This type of inmate will need more case management to help set up community services or arrange for her to find a different community in which to live upon release.

The Low Capability/Low Complexity inmate has multiple skill deficits and personal challenges but a constructive environmental situation. She may need substance abuse treatment in prison, and psychological services, and parenting skills training. She may need all the educational and vocational programs she can get during her incarceration. However, she may not

need much case management in the way of release planning, because she is returning to a simplistic, empowering environment. An inmate with a low complexity factor likely has good family support, education, job skills, and she may even have a job waiting for her. She is likely to be returning to a community where human services programs are adequate.

The most intensive intervention will be necessary for the Low Capability/High Complexity inmate. This inmate is at an especially high risk for recidivism. She has many deficits and needs, but moreover she is headed toward a dangerous release destination characterized by poverty, lack of community programs, lack of family support, and high unemployment. She will require a variety of correctional programs to meet her needs, and she will also need to consider whether her intended release destination is the environment that will give her the best odds for staying out of prison. Most likely she also needs intensive case management to help her prepare for transition into society when she is released.

Instrument Development

Crocker & Algina (1986) state that the goal of test construction is to “arrive at a test of minimum length that will yield scores with the necessary degree of reliability and validity for the intended uses (p. 311).” The first step in test construction is to identify the primary purpose(s) for which the test scores will be used (Crocker & Algina, 1986). Next, the domain must be defined. One way of accomplishing this is through the use of content analysis, which involves posing open-ended questions to subjects relating to the construct of interest and sorting their responses into categories. Another way is to review the research that has been done in the area of interest, concentrating on one particular theorist or using an eclectic approach to identify categories representing the construct. Flanagan (1954; in Crocker & Algina, 1986), described a method of generating a list of “critical behaviors” (p. 68) that characterize the extremes of the construct’s continuum. Another useful method of generating content areas is by obtaining input from one or more individuals who have first-hand experience with the construct.

Likert (1932, in Crocker and Algina, 1986) scales involve items that are clearly positive or clearly negative with respect to the construct of interest. Statements neutral in affect are not included. The respondent reads each statement and selects a response from a five-point continuum ranging from “Strongly agree” to “Strongly disagree”.

Guidelines for items on a Likert type scale follow (Likert, 1932; in Crocker and Algina, 1986, p. 80):

1. Put statements in present tense.
2. Do not use statements that are factual or capable of being interpreted as factual.
3. Avoid statements that can be interpreted in more than one way.
4. Avoid statements that are likely to be endorsed by almost everyone or almost nobody.
5. Try to have an almost equal number of statements in the positive as in the negative.
6. Statements should be shorter than 20 words.
7. Each statement should be a proper grammatical sentence.
8. Avoid universals such as all, always, none, and never.
9. Avoid indefinite qualifiers such as only, just, merely, many, few, or seldom.
10. Keep statements in simple sentences, avoid “if” or “because” clauses.
11. Use easy to understand vocabulary.
12. Avoid use of negatives (not, none, never)

Summary and Critique of the Literature

It is clear that there is a paucity of research on female inmates as compared to male inmates. Perhaps this is because females still represent a vast minority of total prisoners (Flavin, 2001; in Sharp & Eriksen, 2003). Nevertheless, since the population of female prisoners is increasing rapidly, it is time for the professional community to study female offenders thoroughly and carefully so that they may provide them with the services they need and to help curtail this rapid growth.

Much of the existing research concerning the needs of female inmates is in the form of inmate surveys and opinion pieces. There is little in the way of empirical research on assessing and addressing needs in this population. No formal assessment measures have been developed that are empirically validated and that encompass the range of need areas that are specific to women.

Another flaw in the current literature on female inmates is that much of the literature focuses on risk, whether that of relapse or recidivism. This stance places the focus on the likelihood of failure rather than the probability for success. It is a trend of moving away from an undesirable state of affairs rather than moving toward a desirable state of affairs. The only

sources found that focused on the ingredients for successful integration of female inmates into society were those that utilized inmate surveys alone. Not one empirical study regarding predictive factors for success was found in the review of the literature.

It was difficult to locate studies with which to compare the current study, since this is a model of readiness for success rather than one of the prediction of failure. Further, this study's focus is on the question of what constitutes readiness itself, not whether or not success is achieved. The recidivism risk model involves a dichotomous outcome variable: failed or did not fail. It does not imply success in that a female offender who does not recidivate during whatever follow-up period the recidivism study utilized is not necessarily a success case. She may be struggling to keep her head above water, or may end up back in an abusive relationship, may relapse into substance abuse without acquiring a new charge, or may end up in psychiatric treatment, to name a few alternatives. These are hardly "success" cases, but they would nevertheless fit into the "did not fail" category in a recidivism study.

A paradigm shift is needed in the way the literature views offenders. The focus should be on how to assess inmates' readiness for transition into society and how to prepare them for that transition rather than how to predict failure. It is a shift from society's needs back to the inmate's needs. As evidenced by the literature, recidivism statistics are high. It is likely that the focus on failure in the research has not served inmates well.

CHAPTER 3

METHODOLOGY

This chapter is devoted to the methods and statistical procedures utilized in this research. The purpose, population, and sample to be used are described. Next, three phases of data collection and analysis are outlined. Phase I involved the construction of the instrument, followed by Phase II, which was an initial tryout of the items generated in the first phase. Phase III was the comprehensive field trial of items retained from the previous phase.

Purpose

The purpose of this research was to develop a reliable and valid measure of readiness for transition to the community for female inmates, called the Transition Readiness Scale (TRS). The TRS was designed to assess the readiness inmates possess to successfully re-enter society. Measures of readiness can be used in prison programs to identify problems to address for successful re-entry and can be used in aftercare planning and services.

Population

The population represented by the subjects in this study is English speaking adult female inmates serving a sentence in a federal United States criminal justice facility.

Samples

Subjects for this study included English speaking adult female offenders currently serving a prison sentence at a low-medium security federal women's prison with approximately 1200 beds in a mid-size city in the southeastern United States.

Phase I: Instrument Construction

The TRS was written following the theoretical constructs of "complexity" and "capability" (Sampson, Peterson, Reardon, & Lenz, 2000). These are related constructs where capability refers to an individual's abilities or competencies needed for success in a life domain, and complexity refers to environmental or circumstantial factors that need to be overcome in order to be successful in a life domain of interest.

Instrument Specifications

The initial version of the TRS was limited to one hundred items in consideration of the extent to which voluntary inmate participation could be realistically expected (see Appendix E). This number was chosen because it was estimated to be the maximum number of items that

would be met by full inmate cooperation in the study. A four point Likert scale was used for this orthogonal measure with the following options: Completely True, Partially True, Partially False, and Completely False. A choice of Does Not Apply To Me was also included on TRS items, although respondents were encouraged to make little use of this option. The four point scale was chosen so that examinees would be forced into polar categories of complexity and capability to avoid the possibility of a neutral choice situation occurring.

The TRS was written to correspond to approximately a sixth grade reading level so that prison inmates with less than a high school education but at least a basic reading level could understand the items and respond appropriately. This was verified by a reviewer skilled in judging reading level and by the reading level analysis tool on Microsoft Word, 2000 edition. The items were written to be applicable to adult female inmates only. The TRS can be administered in either an individual or group format.

Item Generation

The content domains of the TRS were included as relevant constructs based on current research related to inmate transition readiness needs and recidivism (e.g. Byrne & Howells, 2002; Ferraro & Moe, 2003; Harm & Phillips, 2001; Koons, Burrow, Morash, & Bynum, 1997; O'Brien, 2001; Pimlott & Sarri, 2002). A review of the research on female inmates revealed content domains that represent issues tied to transition from a correctional environment to community living.

Drawing from Sampson et al. (2000), the readiness constructs of “complexity” and “capability” were matched to the nine content domains. Using the complexity vs. capability model, the extremes of least to most complex and least to most capable were examined during the literature review. Of note, Flanagan (1954; in Crocker & Algina, 1986), described a method of generating a list of “critical behaviors” (p. 68) that characterize the extremes of the construct’s continuum.

The principal investigator, another doctoral student, and two professors wrote items that represent these areas. The items were reviewed and modified by two members of the dissertation supervision committee. The items were written to not only fit into the categories of capability and complexity, but also to represent the nine content domains identified in the literature review as critical areas of need for women transitioning from incarceration back into society. The nine

content domains as well as the number of items written for the initial (tryout) version of the Transition Readiness Scale are listed in Table 1. The nine content domains are presented in the same order as they were presented in the literature review.

Some content domains ended up with more initial items than others. The authors judged that some content domains were sufficiently represented by just a few items, while others needed more items to adequately represent the domain. For example, “mental health” was thought to be a more broadly defined category than “spirituality”, so more items were needed.

Table 1. Number of Items Per Content Domain in Tryout Version of TRS.

Content Domain	Number of Items		
	Capability	Complexity	Total
Substance Abuse	5	5	10
Physical Health	5	5	10
Mental Health	10	5	15
Education	6	5	11
Employment	7	5	12
Support	6	4	10
Spirituality	4	4	8
Life Skills & Resources	6	8	14
Parenting	5	5	10
Total	54	46	100

Item Review

Once the initial pool of items was written, the items underwent serial editing and revisions. Items were clarified to represent capability and complexity and the nine content domains. These changes were based on recommendations proposed by four professionals. The reviewers included one of the primary creators of the theoretical concepts of complexity and capability, a professional skilled in judging reading level, and two other professionals in applied psychology. The number of items was not changed during item review, only the wording of individual items.

Phase II: Tryout Procedures (n=50)

The purpose of the initial instrument tryout was to examine item characteristics (skew, variance), and each item's contribution to the alpha coefficient of its respective content domain. For all phases of data collection, potential subjects were drawn from the Bureau of Prisons' Sentry inmate data computer system by the principal researcher. Using incarceration identifiers of inmates, a spreadsheet was used to monitor inmate participation. To avoid overlap and possible contamination, subjects only participated in one of the two phases. Only inmates who are fluent in English were selected as potential subjects, which was another safeguard to contamination.

Potential subjects were placed on the institutional callout, which is an automated system of summoning an inmate for an appointment within the prison. They were approached in groups of approximately fifty due to space constraints regarding participation in this study. While inmates are required to report to callouts, they were free to refuse participation in the study without penalty from the prison. Upon request of participation, inmates were informed that their participation was voluntary and that they may terminate their participation at anytime during the process without penalty. Potential subjects' incentives were receipt of a certificate of appreciation, being excused for a short time from their regular assignment, and the knowledge that this research will benefit future prisoners. Inmates who agreed to participate were asked to read and sign the project consent form (see Appendix B).

Subjects met in the large conference room of the psychology department within the Federal Correctional Institution in Tallahassee, FL. The conference room is adequately lit, well ventilated, and has an emergency exit door as well as an internal access door. A restroom and water fountain is just down the hall from the conference room and was accessible to inmates during their participation. For the tryout phase, the principal researcher selected an initial group of fifty inmates that agreed to participate and signed the consent form. Subjects completed a 100-item paper and pencil self-report instrument called the Transition Readiness Scale (see Appendix E). The researcher was available to address any questions or concerns that arose during testing.

Tryout analyses focused on inter-item relationships, item discrimination strength, and the general distribution of response sets. Inter-item relationships were examined such that those

items kept were large enough to reflect items that measure the same general construct (readiness) but varied enough to indicate that items discriminate between individuals.

Alpha reliability coefficients were derived on each of the nine content domains across both complexity and capability. Individual items that negatively influenced the overall alpha coefficient for that content factor were eliminated from the instrument. If the item to total correlation was less than 0.2 or negative, that item was either re-worded or eliminated. Fifteen of the original one hundred items were eliminated and are listed in Table 2. This list is in the same order as the content domains were identified in the literature, with the capability items listed first, followed by complexity.

Table 2. Items Eliminated In Phase I: Tryout

	Item	Flaw
Capability		
Substance Abuse	10. I am responsible for my actions when I use drugs or alcohol.	Item to total correlation was .0088
Mental Health	31. I would ask for help if I had a mental or emotional problem on the outside.	Item to total correlation was -.0365
Employment	80. My criminal record will make it difficult for me to get a job.	Alpha improved from .8074 to .8305 when item removed
Support	77. I know how to be a good, loyal friend.	Item to total correlation was .1282
Spirituality	15. I believe in a spiritual higher power.	Item to total correlation was -.2116
Life Skills & Resources	60. I am good at solving everyday problems.	Item to total correlation was .1009
Parenting	65. I maintain a good relationship with my children.	No variance in item responses.

Table 2 continued

Complexity

Substance Abuse	8. Drugs are common in my neighborhood.	Item to total correlation was .0457
Physical Health	6. I rarely had to go without medical treatment or medication when I really needed it when I was on the outside.	Item to total correlation was -.0839
Mental Health	53. I have close family and friends who regularly ask me how I am doing.	Item to total correlation was .0224
Education	24. The education I have completed has been worthwhile.	Item to total correlation was -.0543
Employment	7. There are jobs available on the outside where I live, it is just a matter of finding one I like.	Alpha improved from .7312 to .7666 when item removed
Spirituality	11. Religious people are very judgmental of me.	Item to total correlation was .1663
Life Skills & Resources	32. The cost of living is high in my community.	Item to total correlation was .1004
	52. On the outside, family and close friends often rely on me for financial support.	Item to total correlation was .0799

Phase III: Field Trial (n=324)

The purpose of the field trial was to perform a confirmatory factor analysis and further examine scale characteristics. At this phase, the factor validity of the instrument was determined.

Participants

Please see Appendix C for the Background Data Questionnaire that was administered to the inmate subjects. The sample composing the field trial data had a mean age of 36.2 and ranged from 19 to 68. Regarding race, 51.7% checked “Black” and 38.7% checked “White”,

with 93.8% of subjects responding in that category. It is suspected, however, that some subjects checked “Black” when they meant to check “White” because the two items were in close proximity to each other. The number of black respondents may be artificially high. Only 13% of subjects checked an ethnicity category. Only 9% of the subjects checked “Hispanic”, which is a gross underestimate of the number of Hispanic subjects who were incarcerated in the sampling institution. There are a couple of explanations for this low number of Hispanic respondents. First, subjects may have been confused by the separate “ethnicity” and “race” categories. Secondly, only English speaking inmates were permitted to participate, which excluded many Hispanic inmates from the study.

With respect to the current offense, 65.3% of subjects indicated that their current offense was “Drug Related Only (ex. Conspiracy, Possession, Importation)”. 16.4% of subjects endorsed “Robbery, Burglary, or Other Property Crime” as their current offense, 9% endorsed “Violent Crime Such As Assault, Battery, or Murder”, and 7.4% endorsed “Other”. The average sentence was 118.37 months, about ten years, for their current offense (standard deviation of 103.59) ranging from 4 to 780 months, with 95.4% of subjects answering this item. The number of subjects in various sentence length categories is listed in Table 3. The average time served so far for the subjects’ current offense was 38.36 months, ranging from 1 to 290 months, with 88.2% of subjects reporting this information.

Table 3. Sentence Length of Sample

Sentence Length Interval	Number of Subjects in Category
Less than 1 year	11
1-5 years	122
5-10 years	65
10-20 years	78
20-66 years	32
Life sentence	5

The subjects had been incarcerated an average of 1.72 times, including the current incarceration, with 84.5% of subjects answering this item. Please note that many subjects answered “0” on this item, presumably because they did not count the current incarceration. These were coded as “1”, since they had to have been incarcerated currently to participate in the

study. Because many first-time inmates misunderstood this item, it is likely that people on their second or later incarceration did not count the current incarceration as well and therefore understated their number of incarcerations by one. The average of 1.72 incarcerations is likely a low estimate for this sample.

With respect to substance abuse, subjects were presented with twelve categories of substances as well as an “other” option and were asked to place a check mark beside each substance that they used in the two years prior to their current arrest. The results are presented in Table 4, and more than 99% of subjects responded to this item. It is noted that the “other” category most often was the drug Ecstasy. The categories used in Table 4 are the same categories that exist on the intake questionnaire that the inmate subjects filled out upon their arrival at the institution, and it was thought that the language would be familiar to them.

Table 4. Substances Used in the Two Years Prior to Arrest

Substance Category	Percent Endorsing Use
Marijuana	50.2
Alcohol	48.3
Tobacco	42.4
Cocaine/Crack	32.2
Amphetamines	18.6
Narcotics/Pain Pills	15.8
Sleeping Pills/Sedatives	13.9
Tranquilizers/Valium	10.8
LSD/Psychedelics	5.6
Heroin/Morphine	5.3
Other	2.5
PCP	1.2
Glue, Solvent, Inhalants	0.3

The subjects had an average of 2.06 children, with a range of 0 to 11. The median number of children was 2.0, and the mode was also 2.0, with 98.8% of subjects responding to this item. 58.8% of the total sample reported having at least one minor child, and 48.3% of the

sample reported that they would have at least one minor child in their custody upon release from incarceration.

Approximately half of the sample, or 40.6%, reported that their last legal job was a trade or day labor, and 45% reported having either a paraprofessional or professional type of job prior to incarceration. The breakdown of the sample's reported level of education are presented in Table 5.

Table 5. Level of Education of Sample

Level of Education	Percent Endorsing
GED or High School Diploma	44.3
Less than GED or High School Diploma	26.6
Completed Trade School, AA Degree, or Other Job Training Program	19.2
Graduated College (Bachelor's Degree or Higher)	5.9

The type of community to which the respondents anticipate going upon release from incarceration is presented in Table 6. Twelve percent of the sample indicated that they would be leaving the United States upon release.

Table 6. Type of Community

Community Size	Percent Endorsing
Large City such as Chicago or Miami	34.1
Medium City such as Tallahassee	27.6
Small Town	23.2
Rural or Farm Community	11.5

Phase III Procedures

Potential subjects were drawn from the Bureau of Prisons' Sentry inmate data computer system by the principal investigator, excluding any inmate who participated in the item Tryout phase. They were placed on the prison callout, which is an automated system of summoning an inmate for an appointment within the prison. They were called in groups of fifty or less, and were provided the same orientation and informed consent process as in the tryout phase. The revised version of the Transition Readiness Scale was administered. This phase of data collection

ceased when data were collected from three hundred and fifty subjects. A sample size of 300 is considered the minimum acceptable for this type of factor analysis (Tabachnick & Fidell, 1996).

Of the 350 subjects who participated, 324 (or 93%) produced usable responses. Some subjects were eliminated because the instrument was completed incorrectly. For example, some instruments contained only check marks next to some items rather than numbers representing responses on the Likert scale. A few had “yes” or “no” written next to the items rather than the Likert scale responses. Subjects were also eliminated if they turned in a blank or partially blank instrument.

Statistical Procedures

A confirmatory factor analysis was performed on this set of data. This analysis was chosen because hypotheses have been generated *a priori* and are strongly supported with current research (Tabachnick & Fidell, 1996). Confirmatory factor analysis allows one to test specific hypotheses about factor structure. The primary objective was to determine whether the observed set of data from the field trial fits the proposed factor model or possible alternative models. Factors were considered for deletion if they did not enhance the goodness of fit indices.

The model adequacy was evaluated using the Chi square ratio, Chi square/degrees of freedom, goodness of fit (GFI), adjusted goodness of fit (AGFI), and the Root Mean Square (RMSEA). The alternative hypothesis is that there is not a significant discrepancy between the *a priori* model and the data. The cutoff values for the goodness of fit indices are outlined in Table 7 (Tabachnick & Fidell, 1996). There were two isomorphic models tested, one for capability and one for complexity (see Figure 2).

Table 7. Minimum Values for Goodness of Fit Indices

Goodness of Fit Indices	Cutoff Value
Chi square	$p > 0.05$
Chi square/degrees of freedom	< 2.0
Goodness of fit (GFI)	> 0.90
Normed Fit Index (NFI)	> 0.90
Adjusted goodness of fit (AGFI)	> 0.90
Root mean square (RMSEA)	< 0.10

Figure 2. Proposed Models

Item-to-domain analyses were computed to provide additional information about the content domains at the item level. The models tested at this level are shown in Appendices I and J, with the numbers indicating item numbers on the field trial version of the TRS.

CHAPTER 4

RESULTS

The results of this research are presented in this chapter. First, the descriptive statistics of the items on the Transition Readiness Scale from the field trial are presented. The results of the content validity study are then outlined, followed by the internal consistency findings. Finally, the factor structure of the instrument is detailed.

Item Characteristics

The items were randomly varied in polarity to avoid response sets. The items that had a negative connotation were coded in the reverse of how the subjects responded such that a response of “1” would represent the most positive situation and a “4” would represent the most negative situation for that item. A response of “Does Not Apply To Me” was counted as an omission of that item. For example, #47 reads, “I regret my prior educational choices.” Responses of “1” (Completely True) were coded as a “4” so that the response would be consistent with items that were phrased in a positive light, such as #9 “I have good math skills.” The descriptive statistics of the items from the field trial are outlined in Tables 8 and 9, with negatively worded items scored in the reverse as described above. Note that “Item-Total Correlation” is within the respective content domain for that item (i.e. “total” refers to the total of that item’s content domain, not the total capability or complexity factor or overall total for the instrument).

Table 8. Descriptive Statistics of Items: Capability (n=324)

Content Domain	Item	Mean	SD	# omits	Skew
Substance Abuse	21. I know my triggers for using drugs and alcohol.	1.36	.742	84	2.358
	25. I am confident that I will be able to avoid using drugs or alcohol on the outside.	1.30	.714	43	2.704

Table 8 continued

Physical Health	49. When I was on the outside, I had the willpower to avoid drugs and alcohol.	2.29	1.227	28	0.303
	76. I am probably going to use drugs or alcohol again.	1.38	.803	71	1.989
	85. I take care of my health by eating well and exercising.	1.74	.890	2	1.120
	27. I do not go to the doctor when I should when I'm on the outside.	1.77	1.057	17	0.928
	73. When I am on the outside, I know how to select over-the-counter medications.	1.25	.633	10	3.016
	4. I go for regular checkups with a doctor when I'm on the outside.	1.56	.840	8	1.564
Mental Health	51. When I was on the outside, I always followed my doctor's recommendations.	1.71	.878	7	1.191
	64. I feel good about myself as a person.	1.39	.637	1	2.003
	72. I can express my emotions to others when I feel sad or angry.	1.77	.883	2	1.078
	38. I know how to find help for a personal or family problem.	1.47	.805	1	1.794
	45. When I was on the outside, I had trouble sustaining a close relationship that was not sexual.	1.71	1.066	30	1.122
	2. I have hobbies.	1.30	.615	10	2.362

Table 8 continued

	36. I know how to be my own best friend.	1.40	.721	0	2.045
	30. I am struggling emotionally.	2.52	1.127	26	-0.190
	60. I am able to deal with anxiety and depression.	2.08	.979	18	0.632
	59. I cannot handle a lot of stress in my life.	2.53	1.074	12	-0.221
Education	62. I have the education I need to get jobs I want when I am released.	2.00	.986	4	0.760
	28. I know how to find and enroll in school or job training programs in my community.	1.34	.714	7	2.414
	55. I have good reading skills.	1.26	.609	2	2.636
	9. I have good math skills.	1.77	.875	3	1.111
	40. I enjoy going to the library.	1.57	.859	13	1.528
	47. I regret my prior educational choices.	2.92	1.234	15	-0.675
Employment	35. Writing a resume for a job application is difficult for me.	2.06	1.203	0	0.499
	75. I know how to find and apply for jobs on the outside.	1.21	.477	7	2.476
	32. When I was on the outside, I had trouble filling out job applications.	1.40	.858	32	2.010
	54. When I was on the outside, I was a dependable worker.	1.46	.815	13	1.845
	48. On the outside, I had trouble keeping a job.	1.97	1.159	26	0.616

Table 8 continued

Support	5. On the outside, I had difficulty following orders from my supervisors on the job.	1.44	.857	59	1.785
	33. I can maintain supportive relationships with my family and friends.	1.29	.663	5	2.671
	69. People often come to me with their problems.	1.48	.644	5	1.284
	20. I am not good at making friends.	1.75	1.013	23	0.992
	15. Often I cannot trust that my family and friends have my best interests at heart.	1.83	1.081	30	0.802
Spirituality	66. I keep in close contact with my family and friends.	1.34	.727	0	2.458
	57. When I was on the outside, I attended spiritual or religious services.	2.05	1.083	3	0.740
	82. I regularly attend spiritual or church fellowship services when I'm on the outside.	2.15	1.078	9	0.560
Life Skills & Resources	37. I do not have any particular religious or spiritual beliefs.	1.43	.920	26	2.008
	83. On the outside, I had trouble managing money and paying bills on time.	2.25	1.132	20	0.170
	50. I am good at making important decisions.	1.71	.791	3	1.095

Table 8 continued

	41. When I was on the outside, I could plan ahead for expenses and bills that were coming up.	1.69	.939	2	1.305
	46. I could make a budget and follow it when I was on the outside.	2.08	1.119	8	0.653
	43. I can find acceptable housing in my community.	1.61	.921	26	1.489
Parenting	22. I need to improve my parenting skills.	2.49	1.161	107	-0.175
	58. I was able to care for my children on my own when I was on the outside.	1.58	.914	75	1.539
	14. When I was on the outside, I had trouble caring for my children without help.	1.78	1.075	112	0.896
	11. When I was on the outside, I had difficulty getting my children to behave.	1.52	.841	112	1.351

Table 9. Descriptive Statistics of Items: Complexity (n=324)

Content Domain	Item	Mean	SD	# omits	Skew
Substance Abuse	39. On the outside, I was often tempted by friends to use or sell drugs.	2.29	1.264	42	0.191
	17. Wherever I go, drugs or alcohol always seem to find me.	2.01	1.154	38	0.596

Table 9 continued

Physical Health	34. On the outside, it is hard to avoid people and places associated with drugs.	1.97	1.132	45	0.606
	29. There are substance abuse aftercare programs in my community that I can attend.	1.28	.689	64	2.721
	56. Access to quality healthcare in my community is easy.	1.93	.983	6	0.850
	79. There is a health department or other place I can go to in my community when I am sick.	1.31	.675	6	2.507
	31. I have trouble getting medical care on the outside unless I have a job with health benefits.	2.30	1.228	26	0.161
	68. Medical care is easily available on the outside if I get sick.	1.90	1.060	6	0.910
Mental Health	12. There are counselors in my community who can help me even if I do not have much money.	1.93	1.075	35	0.909
	65. When I was on the outside, there was nobody with whom I shared my emotional problems.	2.10	1.147	10	0.401
	84. There are people on the outside who I can relax with.	1.29	.629	3	2.562
	77. I will be returning to a stressful environment when I am released.	2.02	1.097	24	0.488

Table 9 continued

Education	10. I have access to quality educational programs in my community.	1.49	.831	13	1.858
	19. It would be difficult for me to pay for school or a job training program on the outside.	2.80	1.175	20	-0.479
	81. My family can help me attend school.	1.95	1.135	29	0.842
	6. There are too many barriers in my life to attend school regularly on the outside.	1.79	1.031	32	0.840
Employment	26. There are few jobs in my community for which I qualify.	2.49	1.117	21	-0.119
	23. The job market in my area of interest is poor.	2.15	1.132	19	0.393
	13. As a former felon, my job options are limited.	3.10	1.038	28	-0.958
	80. Nobody will hire me with my criminal record.	2.12	.995	19	0.105
Support	53. My family is supportive of me in anything I do.	1.63	.921	0	1.444
	7. I do not have many people on the outside who are close to me.	2.02	1.220	36	0.541
	52. I have friends and family I can go to when I am released.	1.16	.534	1	3.830
	1. Support from others often has strings attached.	2.78	.982	45	-0.593

Table 9 continued

Spirituality	16. Spirituality and religion are not important among my friends and family.	1.63	.948	18	1.198
	3. Spirituality is important in my family.	1.40	.660	5	1.945
	63. Some of my family and friends have the same spiritual beliefs as me.	1.46	.734	5	1.789
Life Skills & Resources	74. Sometimes the demands of life on the outside were too much.	2.67	1.051	16	-0.373
	61. I lead a simple life on the outside.	1.84	.981	4	1.042
	71. Good, affordable housing is available in my community.	1.88	.975	11	0.945
	78. On the outside, crime seemed to be the only way to pay the bills.	1.72	1.077	31	1.118
	18. I know I will have a place to live when I am released.	1.23	.693	5	3.265
	24. The people in my life do not think I can make it on my own financially on the outside.	1.59	.976	26	1.375
Parenting	8. I have quality childcare available for when I go back to work.	1.39	.854	163	2.227
	42. One or more of my children requires special assistance.	1.82	1.237	118	0.976
	44. When I was on the outside, I had family or friends who helped me out with my children.	1.37	.815	90	2.401

Table 9 continued

70. When I was on the outside, one or more of my children was difficult to deal with.	1.84	1.127	109	0.814
67. I am having child custody problems.	1.70	1.139	162	1.173

Content Validity of Capability and Complexity

The final pool of items was judged by three mental health professionals with backgrounds in forensic psychology. These judges independently sorted the remaining items into two groups: complexity and capability. A kappa coefficient was used as an indicator of inter-rater agreement. The kappa coefficient was chosen because it takes into account chance agreement between rater and the instrument (Tabachnick & Fidell, 1996). The mean percent agreement among raters was 85.1, and the mean kappa coefficient was .7686. This indicates that the TRS possesses sound inter-rater reliability, as a kappa coefficient of .75 or higher is considered to be a favorable level of agreement. The results of this analysis are presented in Tables 10 and 11.

Table 10. Percent Agreement of Raters

	Rater 1	Rater 2	Rater 3
Rater 1	-		
Rater 2	82.35	-	
Rater 3	78.82	94.12	-

Table 11. Kappa Coefficients Between Raters

	Rater 1	Rater 2	Rater 3
Rater 1	-		
Rater 2	.6470	-	
Rater 3	.7764	.8824	-

The three raters were able to differentiate capability items from complexity items with a fair degree of reliability.

Internal Consistency

The precision with which the items measure the content domains was investigated. The standardized alpha coefficient was used to estimate the degree of precision. The alpha coefficient is positively influenced by homogeneity of the items and by the heterogeneity of the sample (Crocker & Algina, 1986).

Table 12. Internal Consistency of Content Domains and Capability Factor (n=324)

Content Domain	# Items	Mean	SD	Inter-Item Correlations	Standardized Alpha
Substance Abuse	4	1.6512	.6236	.0922	.289
Physical Health	5	1.6042	.2090	.2863	.667
Mental Health	9	1.8216	.4624	.2136	.710
Education	6	1.8096	.6051	.1727	.556
Employment	6	1.5576	.3116	.3059	.725
Support	5	1.5427	.2230	.2097	.570
Spirituality	3	1.883	.4207	.3960	.466
Life Skills & Resources	5	1.9047	.2700	.3802	.754
Parenting	4	1.8366	.4720	.3230	.656
Capability (overall)	47	1.7289	.4332	.1478	.890

Table 13. Internal Consistency of Content Domains and Complexity Factor (n=324)

Content Domain	# Items	Mean	SD	Inter-Item Correlations	Standardized Alpha
Substance Abuse	4	1.9923	.4935	.2626	.588
Physical Health	4	1.8858	.4090	.4897	.793
Mental Health	4	1.8434	.3519	.2564	.580
Education	4	2.0239	.5194	.2718	.599
Employment	4	2.4638	.4850	.3025	.634
Support	4	1.8943	.6742	.2349	.551
Spirituality	3	1.493	.1140	.4320	.692
Life Skills & Resources	6	1.8314	.4634	.2275	.639

Table 13 continued

Parenting	5	1.6018	.2278	.1466	.462
Complexity (overall)	38	1.9527	.4732	.2065	.908

The internal consistency of capability (.89) and complexity (.91) were high, therefore the total score on each factor meet precision requirements and can be used as scales to measure the degree to which individuals possess capability and the degree to which individuals' environments possess complexity. Some of the content domains showed better internal consistency than others, but all of the content domains were retained because the literature has shown each to be of clinical importance. The alpha coefficients of each content domain, its respective factor (capability or complexity), and the overall factor reliability coefficients are represented in Tables 12 and 13. Any coefficient below .70 should be used with caution (Tabachnick & Fidell, 1996). For example, a diagnosis of the presence or absence of a substance abuse problem on the capability factor should not be made using the TRS alone with its alpha of .289. Instead, a high score in this area may indicate that further assessment is needed to determine the presence and/or level of need in substance abuse programming.

The content domains under the capability factor that had a reliability coefficient of greater than .70 were Mental Health, Employment, and Life Skills and Resources. The only domain of the complexity factor that had this level of reliability was Physical Health. This suggests that only these few content domains can be treated as subscales.

Factor Validity

A confirmatory factor analysis was used to investigate the factor structure of the Transition Readiness Scale. This was used because of the strong theoretical basis for the proposed factor structure of the instrument (Tabachnick & Fidell, 1996). Indices of goodness of fit of the hypothetical models were tested.

The capability nine variable model yielded a chi-square of 51.69 ($p=0.00289$). Normed fit, goodness of fit, and adjusted goodness of fit indices were all above .90 with respective values of 0.95, 0.96, and 0.93. Based on the theoretical underpinnings tied to clinical application of this instrument and given the statistical support of the hypothesized initial model, no post-hoc modifications were made. The complexity model yielded a chi square of 48.11 ($p=0.00747$). Normed fit, goodness of fit, and adjusted goodness of fit indices were all above .90 with

respective values of 0.96, 0.96, and 0.93. As with capability, post hoc modifications were recommended but based on theory and the positive results in support of the initial model, no modifications were made.

The inter-correlation matrices for the content domains are presented in Tables 14 and 16 for capability and complexity. Note that the content domains are abbreviated horizontally and correspond to the content domains that are listed vertically. The path models for capability and complexity after the factor analysis are presented in Figures 3 and 4. The values on the leftmost side of the path models represent the theta delta coefficients, which are the covariances among errors associated with the determined dependent variables predicted from the independent variables. The values to the right of each content domain represent the amount of variance that each content domain accounts for with respect to its associated factor (capability or complexity). The goodness of fit indices for each factor are presented in Tables 15 and 17.

Two confirmatory factor analyses, based on data from female inmates, were performed using LISREL. The hypothesized models are presented in Figure 3. The rectangles represent measured variables or content domains and the oval for each model represents each unique latent variable. Absence of a line connecting content domains implies no hypothesized direct effect. The proposed models of capability and complexity represent two one-factor models.

While both models share content domain names, each content domain is as differentiated as the two latent variables. For example, the measured content domain of physical health as it relates to capability contains questions about an individual's inclination to engage in pro-active health behaviors. The measured content domain of physical health as it relates to complexity contains questions about an individual's access to community health centers and other health agencies. While both latent variables share content domain names, the actual measured variables linked to both are distinctly different. The nine measured variables, or content domains, are substance abuse, physical health, mental health, education, employment, support, life skills and resources, spirituality, and parenting.

Table 14. Inter-Correlation Matrix for Capability

Content Domain	Correlation Coefficient
Substance Abuse (SA)	-

Table 14 continued

Physical Health (PH)	.270	-							
Mental Health (MH)	.292	.482	-						
Education (ED)	.287	.433	.408	-					
Employment (EM)	.278	.405	.432	.530	-				
Support (SU)	.149	.303	.520	.215	.249	-			
Life Skills & Resources (LS)	.357	.463	.570	.409	.416	.353	-		
Spirituality (SP)	.230	.355	.353	.271	.309	.371	.277	-	
Parenting (PA)	.188	.304	.312	.221	.295	.260	.384	.208	-
	SA	PH	MH	ED	EM	SU	LS	SP	PA

Table 15. Goodness of Fit Indices for Content Domain to Factor: Capability

Index	Chi Square	Chi Square/df	NFI	GFI	AGFI	RMSEA	Decision
Value	51.69 (p=0.00289)	1.914	0.95	0.96	0.93	0.06	Accept

Figure 3. Path Model Content Domain to Factor: Capability

Table 16. Inter-correlation Matrix for Complexity

Content Domain	Correlation Coefficient									
Substance Abuse (SA)	-									
Physical Health (PH)	.356	-								
Mental Health (MH)	.326	.479	-							
Education (ED)	.386	.499	.457	-						
Employment (EM)	.283	.442	.435	.527	-					
Support (SU)	.330	.356	.515	.439	.283	-				
Life Skills & Resources (LS)	.470	.462	.569	.504	.406	.496	-			
Spirituality (SP)	.339	.313	.277	.384	.161	.330	.374	-		
Parenting (PA)	.163	.100	.229	.196	.186	.229	.222	.174	-	
	SA	PH	MH	ED	EM	SU	LS	SP	PA	

Table 17. Goodness of Fit Indices for Content Domain to Factor: Complexity

Index	Chi Square	Chi Square/df	NFI	GFI	AGFI	RMSEA	Decision
Value	48.11 (p=0.00747)	1.782	0.96	0.96	0.93	0.06	Accept

Figure 4. Path Model for Content Domain to Factor: Complexity

Additional confirmatory factor analyses were performed to examine item-to-domain characteristics. Subjects with missing data were removed from these analyses. The models and results are presented in Figures 5 and 6.

Table 18. Goodness of Fit Indices for Item to Content Domain Model: Capability

Content Domain	Chi Square	Chi Square/df	NFI	GFI	AGFI	RMSEA
Substance Abuse	37.68 (p=0.00)	19.84	0.02	0.92	0.59	0.29
Physical Health	10.05 (p=0.074)	2.01	0.97	0.99	0.96	0.059
Mental Health	84.34 (p=0.00)	3.12	0.87	0.93	0.89	0.089
Education	10.23 (p=0.33)	1.14	0.94	0.99	0.97	0.022
Employment	92.75 (p=0.00)	10.31	0.80	0.89	0.74	0.20
Support		0	1.0	1.0	1.0	0

Table 18 continued

Life Skills & Resources	6.87 (p=0.23)	1.37	0.99	0.99	0.97	0.037
Spirituality	-	0	1.0	1.0	1.0	0
Parenting	13.25 (p=0.0013)	6.625	0.90	0.96	0.82	0.18

Substance Abuse. This model was rejected as a content domain that can stand on its own, since most of the fit indices failed to meet minimum criteria. Specifically, the p-value for the chi square statistic was below 0.05, chi Square/df was greater than 2.0, NFI and AGFI were both below 0.90, and RMSEA was above 0.10.

Physical Health. This model was accepted, as it met most of the minimum criteria set forth for the goodness of fit indices. The chi square/df value (2.01) did not meet minimum criteria, but the model was accepted based upon its other indices.

Mental Health. The mental health model was rejected. Although it met minimum criteria for GFI and RMSEA, it failed to meet minimum criteria for chi square/df, NFI, p-value, and AGFI.

Education. This model was accepted on the basis that it met the minimum criteria for all of the goodness of fit indices.

Employment. The employment model was rejected because it failed to meet minimum criteria for all of the goodness of fit indices.

Support. This model was not able to be tested. The model was saturated and the fit was perfect, indicating that there were not enough items to evaluate this model.

Life Skills & Resources. This model was accepted, as it met the minimum criteria for all of the goodness of fit indices.

Spirituality. This model could not be tested, as it was saturated. There were not enough items on the instrument to be able to evaluate this model as a stand-alone content domain.

Parenting. This model was rejected, as it failed to meet minimum criteria on the following goodness of fit indices: the p-value of the chi square statistic, the chi square/df, AGFI, and RMSEA.

Figure 5. Item to Domain model: Capability

Figure 5 continued

Figure 5 continued

Figure 5 continued

Table 19. Goodness of Fit Indices for Item to Content Domain Model: Complexity

Content Domain	Chi Square	Chi Square/df	NFI	GFI	AGFI	RMSEA
Substance Abuse	6.21 (p=0.045)	3.11	0.96	0.99	0.93	0.096
Physical Health	0.44 (p=0.80)	0.22	1.0	1.0	1.0	0.0
Mental Health	7.59 (p=0.022)	3.80	0.93	0.99	0.93	0.10
Education	3.99 (p=0.14)	2.00	0.97	0.99	0.96	0.064
Employment	4.13 (p=0.13)	2.07	0.97	0.99	0.96	0.063
Support	6.58 (p=0.037)	3.29	0.94	0.99	0.94	0.095
Life Skills & Resources	9.85 (p=0.36)	1.09	0.96	0.99	0.97	0.019
Spirituality	0	0	1.0	1.0	1.0	0
Parenting	9.25 (p=0.100)	1.85	0.87	0.97	0.90	0.087

Substance Abuse. This model was rejected as a content domain that can stand on its own. The p-value was greater than 0.05, and the chi square/df was greater than 2.0, indicating a poor fit to the proposed model.

Physical Health. This model could not be tested. The model was saturated and the fit was perfect, indicating that there were not enough items to evaluate this model.

Mental Health. The mental health model was rejected. The model failed to meet minimum criteria for p-value of the chi square statistic and the chi square/df index.

Education. This model was accepted on the basis that it met the minimum criteria for all of the goodness of fit indices.

Employment. The employment model was accepted because it met the minimum criteria for all of the goodness of fit indices except chi square/df.

Support. This model was rejected because it failed to meet minimum criteria for the p-value of the chi square statistic.

Life Skills & Resources. This model was accepted, as it met the minimum criteria for all of the goodness of fit indices.

Spirituality. This model could not be tested, as it was saturated. There were not enough items on the instrument to be able to evaluate this model as a stand-alone content domain.

Parenting. This model was accepted. It met the minimum criteria for all of the goodness of fit indices except the Normed Fit Index.

Figure 6. Item to Domain model: Complexity

Figure 6 continued

Figure 6 continued

Additional Analysis

Upon examination of the results of this dissertation, a further analysis was suggested by the doctoral committee. Specifically, an additional confirmatory factor analysis was recommended and performed containing both of the factors, capability and complexity, with the content domains as observed variables. This was recommended to test whether “readiness” could be thought of as a latent variable and also to examine the correlation between the factors of capability and complexity. The results of this analysis are presented in Table 20.

Table 20. Goodness of Fit Indices for Content Domain to Factor: Capability and Complexity

Index	Chi Square	Chi Square/df	NFI	GFI	AGFI	RMSEA
Value	592.65 (p=0.00000)	4.42	0.91	0.83	0.78	0.10

The goodness of fit indices that were examined with the initial factor analyses were assessed with this model. The NFI met inclusion criteria but none of the other goodness of fit indices fell within cutoff range. Further, the correlation between capability and complexity was 0.89, which indicates that the two factors are highly correlated. The analysis raised theoretical issues about the constructs of capability and complexity at the operational level. This finding raised several questions regarding future research. For instance, further research may confirm that capability and complexity are independent constructs, or it may suggest that the two comprise one unidimensional factor.

CHAPTER 5

DISCUSSION

Introduction

The purpose of this study was to develop a screening instrument to be used with adult female inmates to assess readiness for transition from incarceration back into society. The instrument was based on a theory of readiness first outlined by Sampson et al. (2000) involving two constructs: capability and complexity. Capability refers to the individual's competencies or abilities to manage complexity factors, or environmental circumstances. The instrument was intended to be a self-report measure requiring subjects to rate themselves in a number of content domains. Nine content domains were identified through a comprehensive analysis of the available literature on female inmates that are thought to represent the most important areas of functioning for women to transition back into society and adjust to life in the community. These areas are substance abuse, physical health, mental health, education, employment, support, spirituality, life skills and resources, and parenting.

One hundred initial items were written to correspond to the factors of capability and complexity across the nine content domains, and these items underwent serial editing by the principal researcher and several colleagues. The initial pool of items was administered in an item tryout phase of fifty female correctional inmates. Based upon the results of the initial tryout of items, fifteen items were eliminated and some other items were reworded. The final pool of 85 items was given to 350 female inmates, which yielded 324 usable sets of data.

The findings of the research questions revealed support for the constructs of capability and complexity as represented by the Transition Readiness Scale. The findings also supported a number of the content domains, but several of them were not supported as subscales that can stand alone. All content domains were retained, however, because of the research supporting each domain's importance in determining readiness in female inmates.

Limitations of the Study

Participants were required to report to the psychology department to be asked to participate in the study, but no adverse consequences were applied if an inmate did not show. Therefore, this study may have excluded inmates who may have had certain characteristics in

common such as a strong antisocial personality, or an aversion to visiting the psychology department of the prison.

The information regarding the race and ethnicity of the participants may be inaccurate. The proportion of Hispanic inmates was underrepresented, as only those inmates who could read and understand English were qualified to participate. Additionally, it is suspected that the wording of the background data form with respect to the categories of “race” and “ethnicity” confused inmates. Some inmates may have misread the background data form and mistakenly checked that they were “Black” when they meant to check “White” due to the placement of the spaces (see Appendix C).

The mean responses to the Transition Readiness Scale (TRS) items were generally low, meaning that participants tended to portray themselves in a positive light. There could be several reasons for this. Inmate participants could have engaged in impression management, which would inflate responses in a positive direction. The items are highly personal, and although care was taken to ensure the participants’ anonymity, it is likely that some participants underreported their gaps in readiness due to unwillingness to disclose personal information. It is possible that some participants lacked the ability to realistically appraise their personal capability factors. They may have also had an unrealistically positive view of the environment to which they will be returning.

Many participants engaged in avoidance by either leaving certain items blank or responding “Does Not Apply to Me”. Any item that was left blank or had a response of “Does Not Apply to Me” was treated as an omitted item. This missing data was eliminated from the sample rather than estimated. The number of omits for each item are presented in Tables 8 and 9. An omission not only resulted in less information being gathered regarding the participants’ level of capability and complexity, it also eliminated the participant from the sample for each omitted item.

Implications for Practice

Certain constraints are advised in the use of the Transition Readiness Scale. The TRS was designed for use with female inmates to assess readiness for transition from incarceration into the community. The results of the factor analysis support the use of the TRS as a screening tool to efficiently identify those inmates who may need more extensive and/or intensive

intervention during incarceration. Psychology departments in correctional institutions could use this instrument as an initial screening tool upon admission into an institution to screen inmates for levels of need. It could also be used periodically during an inmate's sentence to assess improvements in readiness and to reassess needs.

The TRS was designed to be used with female inmates only and should not be used on male inmates or on any individual who is not in a correctional environment at the time of assessment. This instrument was developed on women inmates in a low-medium federal prison in the southeastern United States, and may not generalize to maximum security correctional institutions or other geographical areas. The TRS is to be considered a screening measure only. It should not be used to make any mental health diagnosis, although it can be used with inmates who are mentally ill. This instrument does not claim to predict future behavior, and should not be used to make decisions about security level, disciplinary action, parole, release, or any other type of legal decision. It also should not be used with adolescents or in non-prison settings. Additionally, the TRS is a self-report instrument, meaning that the individual must have self-awareness and be able to realistically appraise her situation in order for the measure to be of value in determining readiness for transition into society. The TRS assesses only inmates' perception of themselves and their environment, and does not take into account factors such as denial or lack of insight.

Implications for Further Research

This dissertation contains the preliminary steps in the development of the Transition Readiness Scale. It is not intended to produce an instrument ready for marketing and use in prisons as is. More standardization and reliability analyses are needed before the TRS is ready to be used in correctional settings. The instrument needs to undergo additional validation in order to be used with female inmates in a correctional setting. The following are suggestions for additional research that are essential for this instrument.

1. The background data form should be revised so that it is less ambiguous. Specifically, the race and ethnicity categories were too close together on the original form, resulting in some participants choosing the wrong race. The question regarding number of times incarcerated was apparently misunderstood as well, as many participants said they had been incarcerated "0" times. This item should be reworded with the addition "including your current incarceration".

Gathering background data directly from participants' inmate classification records may result in more accurate demographic data; however, this may compromise confidentiality between the participants and researcher.

2. The content domains need modifications in order to improve the alpha reliability coefficients and factor loadings. The content domains under the capability factor that had reliabilities under 0.6 were Substance Abuse, Education, Support, and Spirituality. The content domains under complexity with low reliabilities were Substance Abuse, Mental Health, Support, and Parenting. It is suggested that modifications in wording, addition, and/or elimination of items within these content domains be made and the model tested again with a new field trial with the goal of producing alpha reliability coefficients of 0.6 or higher within each content domain.

3. While the confirmatory factor analysis provided some support for the latent variables of capability and complexity, a number of the content domains were rejected for failing to meet minimum criteria set forth for the associated goodness of fit indices. These content domains, while of clinical importance to the use of the TRS, should not be used as subscales of capability and complexity. The content domains rejected on the capability factor included Substance Abuse, Mental Health, Employment, Support, Spirituality, and Parenting. Note that Support and Spirituality could not be tested because these content domains had too few items to represent the domain and resulted in saturation of the model. The content domains on the complexity factor that were rejected included Substance Abuse, Physical Health, Mental Health, Support, and Spirituality. Again, two of the content domains under complexity, Physical Health and Spirituality, could not be tested due to a saturated model.

4. The content domains that failed to meet minimum criteria for the goodness of fit indices should not be eliminated, as the literature review showed each to be of importance in enhancing readiness for transition into society for female inmates. Rather, additional items should be written for these content domains, and the existing items should be examined for possible rewording. The model should then be retested in the same manner as in the current research. Finally, the content domains should undergo a content validity analysis.

5. Criterion validity studies are important in the development of an instrument. An examination of the predictive validity of the TRS would be helpful in determining whether an

assessment of readiness using the instrument is correlated with successful outcomes once female inmates transition back into society. Follow-up periods as short as a few months would be helpful, but ideally would include one, five, and ten year intervals as well. While the outcome of interest is “successful transition to society”, it should be clearly defined, and include more than the simple avoidance of criminal recidivism. An ultimate ideal would be to establish that the use of the TRS actually enhances rehabilitation of inmates and substantially contributes to successful transition from incarceration to high quality community living.

6. The development sample of the TRS excluded non-English speaking individuals. Additionally, although a verbal version of the instrument was offered to potential subjects, none accepted a verbal administration. Some data were excluded due to nonsensical responses (i.e. responding with check marks instead of using the Likert scale responses requested in the instructions); therefore, it is suspected that those inmates who could not read well either did not participate or may have pretended to participate. This study should therefore be replicated with non-English speaking inmates and illiterate inmates, as both of these subgroups of female inmates are inherently at high levels of need due to their language and/or literacy deficits.

7. This dissertation did not establish convergent or discriminant validity. Self-report instruments that require the subject to assess his or her own life situation may be subject to response sets based upon mood. Specifically, it would be helpful to determine whether the TRS is correlated with a clinical construct such as depression or locus of control. Finally, norms should be established for the TRS with age related females who are living quality everyday lives in the community.

8. The additional confirmatory factor analysis that was performed with both capability and complexity as factors and the content domains as observed variables raised new questions. With the high correlation between the capability and complexity factors (0.89), it is possible that the two factors are actually measuring the same construct. Although the theory dictates that capability is fundamentally different from complexity, this would indicate that a capability score indicating poor personal adjustment would almost always be associated with a complexity score indicating a problematic environment as well.

It is also possible that clear evidence of independence of the capability and complexity factors would occur in a replication study of a stratified random sample of female inmates. For

instance, it is hypothesized that a clearer distinction between factors would be observed if a sample of inmates was taken only at admission, or only at six months prior to release.

A practical example of the conjecture of a unidimensional focus of the TRS can be illustrated using one of the content domains. If an individual scored in a problematic range on Capability – Substance Abuse, that individual may feel that she would have difficulty avoiding drugs if she were in the community. She may feel as though she does not have her addiction under control. The correlation between capability and complexity would indicate that she is almost certain to have some environmental factors contributing to her substance abuse problem as well, whether it be a support network who is tolerant of drug use, or a neighborhood where drugs are readily available.

One argument for retaining capability and complexity as two separate factors is the notion that although the two are highly correlated in this initial study, the specific interventions for capability issues and complexity issues are largely distinct. Interventions on Capability – Substance Abuse, for example, might include intensive substance abuse treatment while in prison. Interventions on Complexity – Substance Abuse, however, would focus more on release planning, such as obtaining stable housing away from the previous drug-hazardous environment and referrals to substance abuse support groups and aftercare services in the inmate's community. Moreover, test development research is a longitudinal process and it is believed to be presumptive and inappropriate to collapse the two constructs after one exploratory study.

Although the TRS can be used upon entry into incarceration, during incarceration, and as an inmate approaches her release date, it is apparent that the two scales of capability and complexity are each more relevant at different points in an inmate's sentence. Capability issues may be addressed immediately upon incarceration through the use of such prison services as medical care, psychological interventions, spiritual services, and vocational training.

Complexity issues may be best attended to in an inmate's last year of her sentence, as those environmental issues are likely to change over time. This is especially true for those inmates who must serve a long sentence. Assisting an inmate with complexity issues such as securing safe housing, health care, and mental health care would be much more reasonable if done as the inmate approaches release rather than years before her release. This temporal gap in the relevance of capability and complexity also support retaining both as separate factors. Future

research in this area should focus on answering the question of whether the two factors should be retained or collapsed into one.

9. Another suggestion for future research involving the Transition Readiness Scale is to conduct several case studies in a women's prison using the instrument. In the creation of this instrument, the inmate participants provided some valuable feedback and support for the TRS. In general, they praised the instrument for its focus on specific inmate needs and for allowing the inmate to rate herself on the items rather than having prison personnel judge how problematic each area was for her. In the case studies, the instrument would be administered upon admission, at specific points during the inmates' incarceration, and six to nine months before each inmate's release date. It is hoped that a case study would provide more information regarding how the instrument behaves in practice and possibly point out some practical problems that could be resolved. Replication studies are seemingly called for after case study research.

10. Finally, the TRS may be a catalyst for new research with male offenders. Although the constructs of capability and complexity are likely to be applicable to male inmates, a new literature review will need to be conducted to hypothesize content domains. The content domains identified for this research were based on literature concerning female offenders only, and much of the research asserted that male and female offenders often differ from each other and thus have different readiness factors.

Summary and Discussion of Results

The results suggest that there is some support for the TRS and the constructs of capability and complexity, although the additional analysis raised new questions regarding the independence of the two. The Transition Readiness Scale has a sound theoretical basis, and the instrument reliably represents the constructs of capability and complexity. Although the overall model was shown to be valid based upon the factor analysis, some of the content domains require further development before they can be used independently. There is less support for the individual content domains, but it is clear that the TRS is supported for use as a screening instrument. The TRS shows promise for use in selection, treatment planning, and intervention design and implementation. It may also be useful for the prediction of successful post-release adjustment upon further investigation of the instrument. Also, the TRS results may aid in shoring up and targeting case management practices that will help establish a more nurturing and

positive environment for inmates returning to community living. Further continued study may lead to the TRS having predictive validity for successful community transition and be supported as a measure to guide rehabilitation treatment during and after incarceration.

APPENDIX A
VITA OF PRINCIPAL RESEARCHER

Curriculum Vita

MARY ANNE ETHERIDGE

ADDRESS:

2489 Sunburst Place
Tallahassee, FL 32301

TELEPHONES:

Home: (850) 219-0146
Cellular: (850) 249-5248

PROFESSIONAL PREPARATION:

<u>Years</u>	<u>Degree(s)</u>	<u>University; Major</u>
1999-2005	Ph.D.	Florida State University; Counseling Psychology and School Psychology
1996-1998	M.S., Ed.S.	Florida State University; Counseling and Human Systems, Specializing in Mental Health Counseling
1991-1995	B.S.	Florida State University; Psychology, minor emphasis in Biology

PROFESSIONAL INTEREST:

My primary professional interest lies in assessment and clinical intervention with adults, especially those with major mental illness and/or a history of criminal behavior.

PROFESSIONAL EXPERIENCE / EMPLOYMENT:

2004-2005 **Adjunct Instructor**, Tallahassee Community College, Tallahassee, FL

Duties: Teach a course entitled "Personal and Social Adjustment" in a community college setting.

2003-2004 **Psychology Intern**, Federal Correctional Institution, Tallahassee, FL

Duties: Pre-doctoral internship accredited by the American Psychological Association providing psychological services to male and female federal correctional inmates. Ongoing duties included providing individual therapy, psychometric assessment, crisis intervention, suicide assessment and intervention, conducting intake interviews and trauma screenings, serving as psychological provider and consultant for a 220-bed correctional housing unit and associated unit team, and ongoing monitoring of inmates with major mental illness and/or a recent history of suicidal behavior.

Major rotations included:

Drug Abuse: taught a substance abuse education class, led a chemical dependency group, and conducted weekly admission and orientation lecture to newly arriving inmates

Federal Detention Center: crisis intervention, suicide assessment and intervention, mental status examinations for inmates in segregation

Trauma/Group Therapy: trauma-focused treatment, various group therapy

Mental Health: worked with inmates receiving psychiatric care, also involved program planning/evaluation and a comprehensive case study and presentation

2003-2004 **Psychology Intern**, Tallahassee Memorial Behavioral Healthcare Center and Tallahassee Memorial Regional Medical Center Memory Disorders Clinic, Tallahassee, FL

Duties: A one day per week outplacement performing a range of psychological and neuropsychological assessment, evaluation, and diagnosis services for children, adolescents, and adults in both an inpatient and outpatient psychiatric and neurological setting.

1999-2003 **Psychological Specialist**, Department of Children and Families, Sexually Violent Predators Program, Tallahassee, FL.

Duties: Critically reviewed criminal and clinical records of sexual offenders. Gathered pertinent client information from law enforcement agencies and court systems nationwide. Summarized clinical and forensic data for each referral. Participated in professional multidisciplinary team to make recommendations regarding civil commitment of sexual offenders. Represented the clinical team in the design of client database that collects essential clinical data. Completed literature reviews and conducted research involving risk assessment of sexually violent predators. Supervised criminology interns from Florida State University. Performed ongoing organizational development, evaluation, and improvement.

1998 **Therapist**, Osceola Mental Health, Kissimmee, FL.

Duties: Provided individual and group therapy to adult clients with major mental illness in an outpatient day treatment setting. Group topics included, but were not limited to, Anger Management, Coping with Mental Illness, Anxiety and Depression, and Music Therapy. Kept detailed clinical records. Created and implemented treatment plans. Participated in clinical staffing.

1997-1998 **Evaluations and Admissions Counselor**, Apalachee Center for Human Services, Tallahassee, FL.

Duties: Conducted clinical evaluations in an inpatient crisis stabilization unit, providing intake services and crisis intervention in receiving unit. Provided case management, individual and group therapy, and admissions and discharge services in two psychiatric units and one detoxification unit. Created and implemented treatment plans. Kept detailed clinical records. Recorded clinical hours for insurance billing and collaborated with insurance companies regarding admission, length of treatment, and discharge. Participated in clinical staffing.

1995-1997 **Case Manager**, Apalachee Center for Human Services, Tallahassee, FL.

Duties: Provided individual therapy and crisis counseling for adult clients with major mental illness in an outpatient setting. Provided case management services by serving as client advocate and coordinating clients' medical and social services, thereby assisting clients to remain members of the outpatient community. Served as chaperone for agency-sponsored overnight client field trips. Kept detailed clinical records. Recorded case management services for insurance billing purposes. Created and implemented treatment plans. Provided vocational rehabilitation services. Participated in clinical staffing.

1995-2001 **On-Call Supervisor**, Telephone Counseling and Referral Service, Tallahassee, FL.

Duties: Provided supervision, support, and training to crisis hotline counselors staffing five local and statewide hotlines: Helpline 24 crisis hotline, statewide HIV/AIDS hotline, Parents Anonymous statewide hotline for parents, statewide Healthy Baby Hotline for new and expecting mothers, and Phone Friend hotline for "latch-key" children. Responded to high-risk suicide, homicide, or abuse calls on the hotlines. Provided real-time support to counselors on such high risk calls. Responsible for making immediate clinical decisions regarding intervention on these calls, such as reporting abuse or tracing a call that may otherwise result in a death. Served as emotional support for counselors regarding personal concerns or processing a difficult call. Provided oral and written feedback to crisis counselors regarding clinical performance.

1995-2001 **Counselor**, Telephone Counseling and Referral Service, Tallahassee, FL.

Duties: Provided telephone crisis intervention and referral services for the general population of a seven-county area on Helpline 24 crisis hotline. Provided specific crisis intervention and referral services on Parents Anonymous for parents in crisis, on Healthy Baby Hotline for new and expecting mothers, and on Phone Friend for “latch-key” children. Provided referrals for medical, financial, mental health, and other social services. Examples of specific counseling concerns include suicide, depression, anxiety, substance abuse, relationship concerns, poverty, psychosis, and abuse.

COURSE INSTRUCTION AND TRAINING:

2004-2005 **Adjunct Instructor**, Tallahassee Community College, Department of History and Social Sciences, Tallahassee, FL

Duties: Teach a course entitled “Personal and Social Adjustment” in a community college setting.

2000, 2002 **Practicum Supervisor**, Florida State University, Department of Human Services and Studies, Tallahassee, FL.

Duties: Supervised graduate students enrolled in human services practicum. Observed client sessions, provided feedback and guidance regarding counseling techniques. Assisted students with treatment planning, case conceptualization, diagnosis, and treatment strategies.

1997-1998 **Instructor**, Helping Strategies in Case Management, Florida State University, Department of Human Services and Studies, Tallahassee, FL.

Duties: Taught basic counseling skills to undergraduate students in a small group setting. Instruction included lecture, class discussion, and role playing. Taught two semesters of this course.

1997 **Instructor**, Pre-Practicum, Florida State University, Department of Human Services and Studies, Tallahassee, FL.

Duties: Taught specific counseling skills to first year graduate students in preparation for counseling practicum. Covered topics such as counselor/client relationship, body language, intake, psychosocial assessment, and treatment planning, as well as specific counseling concerns such as suicide, homicide, abuse, psychosis, depression, anxiety, substance abuse, and relationship problems.

CONTINUING EDUCATION / SHORT-TERM TRAINING:

2001	Selected Issues in the Treatment of the Sexually Violent Predator	3 days
2000	Violence, Risk, and Aggression	21.50 hours
2000	Strategies of Risk Assessment Using the Static-99	3 days
2000	The Assessment of the Sexually Violent Predator using the Minnesota Sex Offender Screening Tool-Revised	13 hours
2000	The Civil Commitment of the Sexually Violent Predator	10.25 hours
1999	The Civil Commitment of the Sexually Violent Predator	3 days
1999	Conducting Serious Incident Investigations	3 days
1997	American Society for Clinical Hypnosis	3 days
1997	Non-Violent Crisis Intervention	8 hours
1997	CPR	4 hours
1996	Infection Control	2 hours
1996	Abuse Reporting	1 hour
1996	High Risk Patient Management	1 hour
1996	CCMS Case Manager Certification	6 hours
1995	Baker/Marchman Acts	1:30 hours
1995	Cults and Satanism, Florida Alcohol and Drug Abuse Association, Inc.	4 hours
1995	Patient Confidentiality	1:40 hours
1995	Assessment/Treatment Planning	5 hours
1995	Writing Treatment Plans	1 hour
1995	Responding to Medical/Psychiatric Emergencies	1:40 hours
1995	Medicaid Documentation	1:50 hours
1994	AIDS/HIV	4 hours
1993	Crisis Intervention	100 hours

ACADEMIC PRACTICA:

2002 **Practicum Student**, Florida State Hospital, Forensic Services, Chattahoochee, FL.

Duties: Conducted intake assessments for residents adjudicated Incompetent to Proceed. Administered and scored psychometric instruments, including, but not limited to, the MMPI-2 and the WAIS-R. Conducted competency evaluations. Supervised by a licensed psychologist.

2001-2002 **Career Adviser**, Florida State University, Curricular Career and Information Service, Tallahassee, FL.

Duties: Provided career advisement services to university students at different levels of career indecision and need, utilizing a cognitive information processing approach.

Conducted psychological testing for the purposes of mental health and career diagnosis. Constructed and executed treatment plans, provided supportive counseling, and assisted clients in gaining the self and occupational knowledge needed to make effective career decisions. Supervised by licensed psychologists.

2000 **Practicum Student**, Mental Health Counseling Practicum, Florida State University, Human Services Center, Tallahassee, FL.

Duties: Conducted intake assessments, constructed and implemented treatment plans. Provided individual and group therapy to children and adults in an outpatient counseling center setting. Participated in group and individual supervision, conducted assessments, composed case notes. Supervised by two licensed psychologists.

1998. **Therapist**, Osceola Mental Health, Kissimmee, FL.

Duties: Provided individual and group therapy to adult clients with major mental illness in an outpatient day treatment setting. Group topics included, but were not limited to, Anger Management, Coping with Mental Illness, Anxiety and Depression, and Music Therapy. Kept detailed clinical records. Created and implemented treatment plans. Participated in clinical staffing. Supervised by both a licensed psychologist and a licensed mental health counselor.

1999. **Intern**, Apalachee Center for Human Services, Tallahassee, FL.

Duties: Conducted clinical evaluations in an inpatient crisis stabilization unit, providing intake services and crisis intervention in receiving unit. Provided case management, individual and group therapy, and admissions and discharge services in two psychiatric units and one detoxification unit. Created and implemented treatment plans. Kept detailed clinical records. Recorded clinical hours for insurance billing and collaborated with insurance companies regarding admission, length of treatment, and discharge. Participated in clinical staffing. Supervised by a licensed clinical social worker.

2000. **Intern**, Curriculum Intervention and Research Center, Tallahassee, FL.

Duties: Provided behavioral intervention services to at-risk middle school children in both a school and home environment. Taught effective behavioral techniques and coping skills to the teachers and parents or guardians of these at-risk youth. Constructed behavioral treatment plans, kept case notes of appointments. Supervised by a licensed clinical social worker.

1997 **Practicum Student**, Mental Health Counseling Practicum, Florida State University, Human Services Center, Tallahassee, FL.

Duties: Conducted intake interviews with community-based child and adult clients, both self-referred and court-ordered. Provided individual and couples therapy utilizing primarily a Rogerian approach to counseling. Created and implemented treatment plans, participated in group supervision and staffing, recorded case notes. Supervised by both a psychologist and a counseling psychology doctoral student.

RESEARCH:

“The Development of the Transition Readiness Scale for Female Inmates”.
Dissertation in partial fulfillment of the requirements of Doctor of Philosophy degree in Counseling Psychology and Human Systems, Florida State University.

“The Inter-rater Reliability of the Minnesota Sex Offender Screening Tool-Revised”.
Research conducted at the Department of Children and Families, Sexually Violent Predators Program and submitted for fulfillment of the supervised research requirement of doctoral program in Counseling Psychology and School Psychology at the Florida State University.

PROFESSIONAL / COMMUNITY SERVICE:

1996 Provided 25 hours of volunteer mentoring service to at-risk girls.

1993-1998 Provided over 600 hours of volunteer service providing telephone crisis intervention, short-term counseling, and referral services. Participated in fundraising activities and presented suicide prevention lectures at local high schools.

1995 Served as volunteer victim advocate for Leon County Sheriff’s Office, providing approximately 50 hours of volunteer crisis intervention and case management services to victims of crime.

PROFESSIONAL ORGANIZATIONS:

American Psychological Association
Florida Psychological Association

APPENDIX B
INFORMED CONSENT FOR INMATE PARTICIPANTS

Informed Consent for Inmate Participants

You are being asked to participate in a study called “**The Development of the Transition Readiness Scale for Female Inmates**”.

The following are some questions you might have about this study:

1. Who is the primary researcher?

Mary Anne Etheridge, M.S., Ed.S., a Psychology Intern at the Federal Correctional Institution in Tallahassee, Florida (or FCI Tallahassee) and a doctoral student at Florida State University has requested your voluntary participation in this survey.

2. What is the purpose of this survey?

This survey will be used to improve the identification of inmate needs.

3. What am I being asked to do?

You are asked to complete a survey called the Transition Readiness Scale where you will identify needs that you may have. You may also be asked to complete a background data form. Your participation will take about an hour.

4. Why am I being asked to do this?

The purpose of completing the survey is to determine if the Transition Rating Scale will help to assess inmates’ needs during incarceration. The background data form will provide group information for research reporting purposes.

5. How will the results be used?

This project will result in survey, the Transition Readiness Scale, that may be used in female jails and prisons to help in program planning and release preparation.

6. What do I get out of participating?

You will provide data that will help women’s correctional facilities improve program planning for female inmates. You will also receive a certificate of participation.

7. Can I refuse to participate?

You may refuse to participate or stop participating at any time during the research project with no penalty. Your participation or refusal to participate will not affect your eligibility to participate in programs at FCI Tallahassee. If you refuse to participate or withdraw consent at any time, you will be returned to your regular assignment or activity as soon as possible and your survey and/or background data form will not be used in the project.

8. Will my survey and background data form be kept private?

Your survey and background data form will be kept confidential to the extent allowed by law. You will not be identified on the survey or background data form, and your signed informed consent form will not be kept with your survey or background form. Mrs. Etheridge will keep your survey and background form in a locked filing cabinet in the Psychology Department at FCI Tallahassee. When the study is over, all records will be shredded. Confidentiality may not be guaranteed in some circumstances, such as if you state that you plan to commit a crime, plan to harm yourself or someone else, or plan to escape. The results of this research may be published, but your identity will not be revealed.

9. Will my participation affect my release date or parole eligibility?

Your participation or refusal to participate will not affect your release date or parole eligibility.

10. What if I have more questions about this study?

Any questions you have concerning the study or your participation in it, before or after your consent, will be answered by **Mary Anne Etheridge, Psychology Intern, Psychology Department at FCI in Tallahassee, FL**. If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact the **Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research at Florida State University at:** 2035 E. Paul Dirac

Drive, Box 16
100 Sliger Bldg., Innovation Park
Tallahassee, FL 32306-2763

The nature, demands, benefits, and any risks of the project have been explained to me. I knowingly assume any risks involved. I have read the above informed consent form. I understand that I may withdraw my consent and stop participating at any time without penalty. In signing this consent form, I am not waiving any legal claims, rights or remedies to which I am otherwise entitled. A copy of this form will be offered to me.

Printed Name of Participant

Register Number

Signature of Participant

Date

Witnessed by:

Mary Anne Etheridge, M.S., Ed.S.,
Principal Researcher

Date

APPENDIX C
BACKGROUND QUESTIONNAIRE FOR INMATE PARTICIPANTS

BACKGROUND DATA QUESTIONNAIRE

The Development of the Transition Readiness Scale for Female Inmates

1. Age: _____ Ethnicity: Hispanic___ Other___
Race: Black___ White___ Asian___ Am. Indian___ Other (list)_____
2. Current Offense (check as many as apply, current incarceration only):
___ Drug related only (ex. Conspiracy, Possession, Importation)
___ Robbery, burglary, or other property crime(s)
___ Violent crime such as assault, battery, or murder
___ Other (please list) _____
3. Sentence Length for current offense _____ months
Time served so far for current offense _____ months
How many different times have you been incarcerated? _____
4. Which of the following did you use in the two years before your arrest?
___ Amphetamines _____ Heroin/Morphine _____ Marijuana
___ Glue, Solvent, Inhalants _____ LSD/Psychedelics _____ Tobacco
___ Sleeping Pills/Sedatives _____ Cocaine/Crack _____ Alcohol
___ Tranquilizers/Valium _____ Narcotics/Pain Pills _____ PCP
___ Other (list): _____
5. Number of children: _____ Ages of children: _____
Will they be returning to your custody when you are released? _____
6. Level of education (check one):
___ less than GED or high school diploma
___ GED or high school diploma
___ completed trade school, AA degree, or other job training program
___ graduated college (bachelor's degree or higher)
7. Job title of last legal job held _____
I held this job from (year)_____ to (year)_____.
8. Type of community to which you will be returning upon release:

___ Large city such as Chicago or Miami, greater than 500,000 people
___ Medium city such as Tallahassee, 50,000-500,000 people
___ Small town, 10,000-50,000 people
___ Rural or farm community, less than 10,000 people
9. Will you be leaving the United States when you are released (for example, if you have an INS detainer)? ___ yes ___ no

APPENDIX D
TRANSITION READINESS SCALE (RESEARCH VERSION)

TRANSITION READINESS SCALE

Research Version Showing Capability/Complexity Factors and Content Domains

Category	Capability	Complexity
Substance Abuse	I am responsible for my actions when I use drugs or alcohol.	On the outside, I was often tempted by friends to use or sell drugs.
	I know my triggers for using drugs and alcohol.	Drugs are common in my neighborhood.
	I am confident that I will be able to avoid using drugs or alcohol on the outside.	Wherever I go, drugs or alcohol always seem to find me.
	When I was on the outside, I had the willpower to avoid drugs and alcohol.	On the outside, it is hard to avoid people and places associated with drugs.
	I am probably going to use drugs or alcohol again.	There are substance abuse aftercare programs in my community that I can attend.
Physical Health	I take care of my health by eating well and exercising.	Access to quality healthcare in my community is easy.
	I do not go to the doctor when I should when I'm on the outside.	There is a health department or other place I can go to in my community when I am sick.
	When I am on the outside, I know how to select over-the-counter medications.	I rarely had to go without medical treatment or medication when I really needed it when I was on the outside.
	I go for regular checkups with a doctor when I'm on the outside.	I have trouble getting medical care on the outside unless I have a job with health benefits.
	When I was on the outside, I always followed my doctor's recommendations.	Medical care is easily available on the outside if I get sick.
Mental Health	I feel good about myself as a person.	I have close family and friends who regularly ask me how I am doing.
	I can express my emotions to others when I feel sad or angry.	There are counselors in my community who can help me even if I do not have much money.
	I know how to find help for a personal or family problem.	When I was on the outside, there was nobody with whom I shared my emotional problems.

Category	Capability	Complexity
	When I was on the outside, I had trouble sustaining a close relationship that was not sexual.	There are people on the outside who I can relax with.
	I have hobbies.	I will be returning to a stressful environment when I am released.
	I would ask for help if I had a mental or emotional problem on the outside.	
	I know how to be my own best friend.	
	I am struggling emotionally.	
	I am able to deal with anxiety and depression.	
	I can not handle a lot of stress in my life.	
Education	I have the education I need to get jobs I want when I am released.	I have access to quality educational programs in my community.
	I know how to find and enroll in school or job training programs in my community.	It would be difficult for me to pay for school or a job training program on the outside.
	I have good reading skills.	The education I have completed has been worthwhile.
	I have good math skills.	My family can help me attend school.
	I enjoy going to the library.	There are too many barriers in my life to attend school regularly on the outside.
	I regret my prior educational choices.	
Employment	Writing a resume for a job application is difficult for me.	There are few jobs in my community for which I qualify.
	I know how to find and apply for jobs on the outside.	There are jobs available on the outside where I live, it is just a matter of finding one I like.
	When I was on the outside, I had trouble filling out job applications.	The job market in my area of interest is poor.
	My criminal record will make it difficult for me to get a job.	As a former felon, my job options are limited.
	When I was on the outside, I was a dependable worker.	Nobody will hire me with my criminal record.
	On the outside, I had trouble keeping a job.	

Category	Capability	Complexity
	On the outside, I had difficulty following orders from my supervisors on the job.	
Support	I can maintain supportive relationships with my family and friends.	My family is supportive of me in anything I do.
	I know how to be a good, loyal friend.	I do not have many people on the outside who are close to me.
	People often come to me with their problems.	I have friends and family I can go to when I am released.
	I am not good at making friends.	Support from others often has strings attached.
	Often I cannot trust that my family and friends have my best interests at heart.	
	I keep in close contact with my family and friends.	
Spirituality	I believe in a spiritual higher power.	Spirituality and religion are not important among my friends and family.
	I regularly attend spiritual or church fellowship services when I'm on the outside.	Some of my family and friends have the same spiritual beliefs as me.
	I do not have any particular religious or spiritual beliefs.	I am looking forward to attending spiritual or religious services when I am released.
		Religious people are very judgmental of me.
		Spirituality is important in my family.
Life Skills and Resources	When I was on the outside, I had trouble managing money and paying bills on time.	Sometimes the demands of life on the outside were too much.
	I am good at making important decisions.	I lead a simple life on the outside.
	I am good at solving everyday problems.	The cost of living is high in my community.
	When I was on the outside, I could plan ahead for expenses and bills that were coming up.	On the outside, family and close friends often relied on me for financial support.
	I could make a budget and follow it when I was on the outside.	Good, affordable housing is available in my community.
	I can find acceptable housing in my community.	On the outside, crime seemed to be the only way to pay the bills.

Category	Capability	Complexity
		I know I will have a place to live when I am released.
		The people in my life do not think I can make it on my own financially on the outside.
Parenting	I need to improve my parenting skills.	I have quality child care available for when I go back to work.
	I maintain a good relationship with my children.	One or more of my children requires special assistance.
	I was able to care for my children on my own when I was on the outside.	When I was on the outside, I had family or friends who helped me out with my children.
	When I was on the outside, I had trouble caring for my children without help.	When I was on the outside, one or more of my children was difficult to deal with.
	When I was on the outside, I had difficulty getting my children to behave.	I am having child custody problems.

APPENDIX E
TRANSITION READINESS SCALE (TRYOUT ADMINISTRATION VERSION)

TRANSITION READINESS SCALE

Think about your current situation and the community you plan to go to when you are released. Read each statement and write the letter of the most appropriate response on the line next to the statement.

Key:

1 = COMPLETELY TRUE

2 = PARTIALLY TRUE

3 = PARTIALLY FALSE

4 = COMPLETELY FALSE

5 = DOES NOT APPLY TO ME

1	_____ Support from others often has strings attached.
2	_____ I have hobbies.
3	_____ Spirituality is important in my family.
4	_____ I go for regular checkups with a doctor.
5	_____ I often have difficulty following orders from my supervisors on the job.
6	_____ I rarely have to go without medical treatment or medication when I really need it.
7	_____ There are jobs available where I live, it is just a matter of finding one I like.
8	_____ Drugs are common in my neighborhood.
9	_____ There are too many barriers in my life to attend school regularly.
10	_____ I am responsible for my actions when I use drugs or alcohol.
11	_____ Religious people are very judgemental of me.
12	_____ I do not have many people on the outside who are close to me.
13	_____ I have quality child care available for when I go back to work.
14	_____ I have good math skills.
15	_____ I believe in a spiritual higher power.
16	_____ I have access to quality educational programs in my community.
17	_____ I have difficulty getting my children to behave.
18	_____ There are counselors in my community who can help me even if I do not have much money.
19	_____ As a former felon, my job options are limited.
20	_____ I have trouble caring for my children without help.

Key:

1 = COMPLETELY TRUE

2 = PARTIALLY TRUE

3 = PARTIALLY FALSE

4 = COMPLETELY FALSE

5 = DOES NOT APPLY TO ME

21	_____ Often I cannot trust that my family and friends have my best interests at heart.
22	_____ Spirituality and religion are not important among my friends and family.
23	_____ Wherever I go, drugs or alcohol always seem to find me.
24	_____ The education I have completed has been worthwhile.
25	_____ I know I will have a place to live when I am released.
26	_____ It would be difficult for me to pay for school or a job training program.
27	_____ I am not good at making friends.
28	_____ I know my triggers for using drugs and alcohol.
29	_____ I need to improve my parenting skills.
30	_____ The job market in my area of interest is poor.
31	_____ I would ask for help if I had a mental or emotional problem.
32	_____ The cost of living is high in my community.
33	_____ The people in my life do not think I can make it on my own financially.
34	_____ I am confident that I will be able to avoid using drugs or alcohol.
35	_____ There are few jobs in my community for which I qualify.
36	_____ I do not go to the doctor when I should.
37	_____ I know how to find and enroll in school or job training programs in my community.
38	_____ There are substance abuse aftercare programs in my community that I can attend.
39	_____ I am struggling emotionally.
40	_____ I have trouble getting medical care unless I have a job with health benefits.

Key:

1 = COMPLETELY TRUE

2 = PARTIALLY TRUE

3 = PARTIALLY FALSE

4 = COMPLETELY FALSE

5 = DOES NOT APPLY TO ME

41	___ I have trouble filling out job applications.
42	___ I can maintain supportive relationships with my family and friends.
43	___ It is hard to avoid people and places associated with drugs.
44	___ I do not know how to write a resume and complete a job application.
45	___ I know how to be my own best friend.
46	___ I do not have any particular religious or spiritual beliefs.
47	___ I know how to find help for a personal or family problem.
48	___ I am often tempted by friends to use or sell drugs.
49	___ I enjoy going to the library.
50	___ I can plan ahead for expenses and bills that are coming up.
51	___ One or more of my children requires special assistance.
52	___ Family and close friends often rely on me for financial support.
53	___ I have close family and friends who regularly ask me how I am doing.
54	___ I can find acceptable housing in my community.
55	___ I have family or friends who help me out with my children.
56	___ I have trouble sustaining a close relationship that is not sexual.
57	___ I can make a budget and follow it.
58	___ I regret my prior educational choices.
59	___ I have trouble keeping a job.
60	___ I am good at solving everyday problems.

Key:

1 = COMPLETELY TRUE

2 = PARTIALLY TRUE

3 = PARTIALLY FALSE

4 = COMPLETELY FALSE

5 = DOES NOT APPLY TO ME

61	___ When tempted, I have the willpower to avoid drugs and alcohol.
62	___ I am good at making important decisions.
63	___ I follow my doctor's recommendations.
64	___ I have friends and family I can go to when I am released.
65	___ I maintain a good relationship with my children.
66	___ My family is supportive of me in anything I do.
67	___ I am a dependable worker.
68	___ I have good reading skills.
69	___ Access to quality healthcare in my community is easy.
70	___ I am looking forward to attending spiritual or religious services when I am released.
71	___ I am able to care for my children on my own.
72	___ I can not handle a lot of stress in my life.
73	___ I am able to deal with anxiety and depression.
74	___ I lead a simple life on the outside.
75	___ I have the education I need to get jobs I want.
76	___ Some of my family and friends have the same spiritual beliefs as me.
77	___ I know how to be a good, loyal friend.
78	___ I feel good about myself as a person.
79	___ There is nobody with whom I share my emotional problems.
80	___ My criminal record will make it difficult for me to get a job.

Key:

1 = COMPLETELY TRUE

2 = PARTIALLY TRUE

3 = PARTIALLY FALSE

4 = COMPLETELY FALSE

5 = DOES NOT APPLY TO ME

81	_____ I keep in close contact with my family and friends.
82	_____ I am having child custody problems.
83	_____ Medical care is easily available on the outside if I get sick.
84	_____ People often come to me with their problems.
85	_____ One or more of my children is difficult to deal with.
86	_____ Good, affordable housing is available in my community.
87	_____ I can express my emotions to others when I feel sad or angry.
88	_____ I know how to select over-the-counter medications.
89	_____ Sometimes the demands of life are too much.
90	_____ I know how to find and apply for jobs.
91	_____ I am probably going to use drugs or alcohol again.
92	_____ I will be returning to a stressful environment when I am released.
93	_____ At times, crime seems to be the only way to pay the bills.
94	_____ There is a health department or other place I can go to in my community when I am sick.
95	_____ Nobody will hire me with my criminal record.
96	_____ My family can help me attend school.
97	_____ I regularly attend spiritual or church fellowship services.
98	_____ I have trouble managing money and paying bills on time.
99	_____ There are people on the outside who I can relax with.
100	_____ I take care of my health by eating well and exercising.

APPENDIX F
TRANSITION READINESS SCALE (FIELD TRIAL ADMINISTRATION VERSION)

TRANSITION READINESS SCALE

Think about your current situation, the community you lived in before incarceration, and the community you plan to go to when you are released. Read each statement and write the number of the most appropriate response on the line next to the statement.

Key:

- 1 = COMPLETELY TRUE
- 2 = PARTIALLY TRUE
- 3 = PARTIALLY FALSE
- 4 = COMPLETELY FALSE
- 5 = DOES NOT APPLY TO ME

- 1 ___ Support from others often has strings attached.
- 2 ___ I have hobbies.
- 3 ___ Spirituality is important in my family.
- 4 ___ I go for regular checkups with a doctor when I'm on the outside.
- 5 ___ On the outside, I had difficulty following orders from my supervisors on the job.
- 6 ___ There are too many barriers in my life to attend school regularly on the outside.
- 7 ___ I do not have many people on the outside who are close to me.
- 8 ___ I have quality child care available for when I go back to work.
- 9 ___ I have good math skills.
- 10 ___ I have access to quality educational programs in my community.
- 11 ___ When I was on the outside, I had difficulty getting my children to behave.
- 12 ___ There are counselors in my community who can help me even if I do not have much money.
- 13 ___ As a former felon, my job options are limited.
- 14 ___ When I was on the outside, I had trouble caring for my children without help.
- 15 ___ Often I cannot trust that my family and friends have my best interests at heart.
- 16 ___ Spirituality and religion are not important among my friends and family.
- 17 ___ Wherever I go, drugs or alcohol always seem to find me.
- 18 ___ I know I will have a place to live when I am released.

19 ___ It would be difficult for me to pay for school or a job training program on the outside.

Key:

- 1 = COMPLETELY TRUE
- 2 = PARTIALLY TRUE
- 3 = PARTIALLY FALSE
- 4 = COMPLETELY FALSE
- 5 = DOES NOT APPLY TO ME

20 ___ I am not good at making friends.

21 ___ I know my triggers for using drugs and alcohol.

22 ___ I need to improve my parenting skills.

23 ___ The job market in my area of interest is poor.

24 ___ The people in my life do not think I can make it on my own financially on the outside.

25 ___ I am confident that I will be able to avoid using drugs or alcohol on the outside.

26 ___ There are few jobs in my community for which I qualify.

27 ___ I do not go to the doctor when I should when I'm on the outside.

28 ___ I know how to find and enroll in school or job training programs in my community.

29 ___ There are substance abuse aftercare programs in my community that I can attend.

30 ___ I am struggling emotionally.

31 ___ I have trouble getting medical care on the outside unless I have a job with health benefits.

32 ___ When I was on the outside, I had trouble filling out job applications.

33 ___ I can maintain supportive relationships with my family and friends.

34 ___ On the outside, It is hard to avoid people and places associated with drugs.

35 ___ Writing a resume for a job application is difficult for me.

36 ___ I know how to be my own best friend.

37 ___ I do not have any particular religious or spiritual beliefs.

38 ___ I know how to find help for a personal or family problem.

39 ____ On the outside, I was often tempted by friends to use or sell drugs.

40 ____ I enjoy going to the library.

Key:

1 = COMPLETELY TRUE

2 = PARTIALLY TRUE

3 = PARTIALLY FALSE

4 = COMPLETELY FALSE

5 = DOES NOT APPLY TO ME

41 ____ When I was on the outside, I could plan ahead for expenses and bills that were coming up.

42 ____ One or more of my children requires special assistance.

43 ____ I can find acceptable housing in my community.

44 ____ When I was on the outside, I had family or friends who helped me out with my children.

45 ____ When I was on the outside, I had trouble sustaining a close relationship that was not sexual.

46 ____ I could make a budget and follow it when I was on the outside.

47 ____ I regret my prior educational choices.

48 ____ On the outside, I had trouble keeping a job.

49 ____ When I was on the outside, I had the willpower to avoid drugs and alcohol.

50 ____ I am good at making important decisions.

51 ____ When I was on the outside, I always followed my doctor's recommendations.

52 ____ I have friends and family I can go to when I am released.

53 ____ My family is supportive of me in anything I do.

54 ____ When I was on the outside, I was a dependable worker.

55 ____ I have good reading skills.

56 ____ Access to quality healthcare in my community is easy.

57 ____ When I was on the outside, I attended spiritual or religious services.

58 ____ I was able to care for my children on my own when I was on the outside.

59 ____ I can not handle a lot of stress in my life.

- 60 ____ I am able to deal with anxiety and depression.
- 61 ____ I lead a simple life on the outside.
- 62 ____ I have the education I need to get jobs I want when I am released.

Key:

- 1 = COMPLETELY TRUE
- 2 = PARTIALLY TRUE
- 3 = PARTIALLY FALSE
- 4 = COMPLETELY FALSE
- 5 = DOES NOT APPLY TO ME

- 63 _____ Some of my family and friends have the same spiritual beliefs as me.
- 64 _____ I feel good about myself as a person.
- 65 _____ When I was on the outside, there was nobody with whom I shared my emotional problems.
- 66 _____ I keep in close contact with my family and friends.
- 67 _____ I am having child custody problems.
- 68 _____ Medical care is easily available on the outside if I get sick.
- 69 _____ People often come to me with their problems.
- 70 _____ When I was on the outside, one or more of my children was difficult to deal with.
- 71 _____ Good, affordable housing is available in my community.
- 72 _____ I can express my emotions to others when I feel sad or angry.
- 73 _____ When I am on the outside, I know how to select over-the-counter medications.
- 74 _____ Sometimes the demands of life on the outside were too much.
- 75 _____ I know how to find and apply for jobs on the outside.
- 76 _____ I am probably going to use drugs or alcohol again.
- 77 _____ I will be returning to a stressful environment when I am released.
- 78 _____ On the outside, crime seemed to be the only way to pay the bills.
- 79 _____ There is a health department or other place I can go to in my community when I am sick.
- 80 _____ Nobody will hire me with my criminal record.
- 81 _____ My family can help me attend school.

- 82 _____ I regularly attend spiritual or church fellowship services when I'm on the outside.
- 83 _____ On the outside, I had trouble managing money and paying bills on time.
- 84 _____ There are people on the outside who I can relax with.
- 85 _____ I take care of my health by eating well and exercising.

APPENDIX G

HUMAN SUBJECTS COMMITTEE APPROVAL LETTERS
OFFICE OF RESEARCH, FLORIDA STATE UNIVERSITY

Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2763
(850) 644-8633 · FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 5/13/2004

To:
Mary Anne Etheridge
2489 Sunburst Place
Tallahassee FL 32301

Dept.: EDUCATIONAL PSYCHOLOGY AND LEARNING SYSTEMS

From: John Tomkowiak, Chair

A handwritten signature in black ink, appearing to read "John Tomkowiak, Chair".

Re: Use of Human Subjects in Research
The development of the Transition Readiness Scale for Female Inmates

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Human Subjects Committee at its meeting on **5/12/2004**. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals which may be required.

If the project has not been completed by **5/11/2005** you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

cc: R. William
HSC No. 2004.318

Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2763
(850) 644-8673 · FAX (850) 644-4392

APPROVAL MEMORANDUM (for change in research protocol)

Date: 6/9/2004

To:
Mary Anne Etheridge
2489 Sunburst Place
Tallahassee FL 32301

Dept: EDUCATIONAL PSYCHOLOGY AND LEARNING SYSTEMS

From: John Tomkowiak, Chair

Re: Use of Human subjects in Research
Project entitled: The development of the Transition Readiness Scale for Female Inmates

The memorandum that you submitted to this office in regard to the requested change in your research protocol for the above-referenced project have been reviewed and approved. Thank you for informing the Committee of this change.

A reminder that if the project has not been completed by 5/11/2005, you must request renewed approval for continuation of the project.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

cc. R. William
APPLICATION NO. 2004.318

APPENDIX H

HUMAN SUBJECTS COMMITTEE APPROVAL LETTER
INFORMATION, POLICY, AND PUBLIC AFFAIRS DIVISION
FEDERAL BUREAU OF PRISONS

U.S. Department of Justice

Federal Bureau of Prisons

Washington, DC 20534

June 25, 2004

MEMORANDUM FOR R. E. HOLT, REGIONAL DIRECTOR
SOUTHEAST REGIONAL OFFICE

FROM:

Thomas R. Kane, Assistant Director
Information, Policy, and Public Affairs Division

SUBJECT:

Research Proposal from Ms. Mary Anne Etheridge

This is in response to a request by Ms. Mary Anne Etheridge to conduct a study, "The Development of the Transition Readiness Scale for Female Inmates."

I concur with your recommendation for approval, and the researcher is authorized to proceed with the study subject to the capability of FCI Tallahassee to accommodate her. This approval expires one year from the date of this memorandum.

When the project is complete, Ms. Etheridge should send a final report to the Bureau's Research Review Board (BRRB). If the project is not completed within the year, Ms. Etheridge should submit a progress report and request a project extension from the BRRB.

For any questions that arise or any unanticipated problems with the research, please contact Sue Allison at (202) 616-0236.

cc: Warden Jose M. Vazquez, FCI Tallahassee, FL
Dr. Allen Hanley, Chief Psychologist, FCI Tallahassee, FL
Ms. Mary Anne Etheridge, Psychology Intern, FCI Tallahassee, FL

APPENDIX I

ITEM TO DOMAIN MODEL: CAPABILITY

Item to Domain Model: Capability

APPENDIX J

ITEM TO DOMAIN MODEL: COMPLEXITY

Item to Domain Model: Complexity

APPENDIX K

RESPONSE FREQUENCIES FOR CAPABILITY (N=324)

Response Frequencies for Capability (n=324)

Content	Item	Response Frequencies			
Domain		(% subjects responding)			
		1	2	3	4
Substance Abuse	21. I know my triggers for using drugs and alcohol.	55.7	13.3	1.5	3.4
	25. I am confident that I will be able to avoid using drugs or alcohol on the outside.	70.3	10.8	1.9	3.7
	49. When I was on the outside, I had the willpower to avoid drugs and alcohol.	35.0	19.2	13.0	24.1
	76. I am probably going to use drugs or alcohol again.	61.0	6.8	7.4	2.8
Physical Health	85. I take care of my health by eating well and exercising.	48.6	34.7	9.3	6.8
	27. I do not go to the doctor when I should when I'm on the outside.	57.9	9.3	19.2	8.4
	73. When I am on the outside, I know how to select over-the-counter medications.	79.6	13.3	.9	3.1
	4. I go for regular checkups with a doctor when I'm on the outside.	59.8	26.6	5.6	5.6
	51. When I was on the outside, I always followed my doctor's recommendations.	49.2	34.1	8.0	6.5
Mental Health	64. I feel good about myself as a person.	67.2	29.1	.9	2.5
	72. I can express my emotions to others when I feel sad or angry.	46.1	37.2	9.3	6.8
	38. I know how to find help for a personal or family problem.	68.1	21.1	5.9	4.6
	45. When I was on the outside, I had trouble sustaining a close relationship that was not sexual.	58.5	9.3	13.3	9.6
	2. I have hobbies.	73.7	18.9	2.5	1.9

Education	36. I know how to be my own best friend.	70.9	22.0	3.7	3.4
	30. I am struggling emotionally.	26.3	11.8	33.4	20.4
	60. I am able to deal with anxiety and depression.	30.3	38.1	14.6	11.5
	59. I can not handle a lot of stress in my life.	24.5	15.2	37.8	18.9
	62. I have the education I need to get jobs I want when I am released.	36.2	38.4	12.4	11.8
	28. I know how to find and enroll in school or job training programs in my community.	75.2	16.1	2.8	3.7
	55. I have good reading skills.	79.9	14.6	3.1	1.9
	9. I have good math skills.	44.6	39.6	7.7	7.1
	40. I enjoy going to the library.	58.5	25.7	5.9	5.9
	47. I regret my prior educational choices.	24.8	2.5	24.1	44.0
Employment	35. Writing a resume for a job application is difficult for me.	49.2	7.7	21.4	16.7
	75. I know how to find and apply for jobs on the outside.	80.5	14.9	2.2	0.3
	32. When I was on the outside, I had trouble filling out job applications.	72.1	5.0	8.4	4.6
	54. When I was on the outside, I was a dependable worker.	65.9	19.8	5.0	5.0
	48. On the outside, I had trouble keeping a job.	49.5	8.7	20.4	13.3
Support	5. On the outside, I had difficulty following orders from my supervisors on the job.	61.6	7.7	8.7	3.7
	33. I can maintain supportive relationships with my family and friends.	78.3	14.9	2.2	3.1
	69. People often come to me with their problems.	57.9	35.0	4.3	1.2

	20. I am not good at making friends.	54.8	14.2	16.4	7.4
	15. Often I cannot trust that my family and friends have my best interests at heart.	53.3	8.4	20.4	8.7
	66. I keep in close contact with my family and friends.	77.1	16.4	2.2	4.3
Spirituality	57. When I was on the outside, I attended spiritual or religious services.	38.4	35.0	8.4	17.5
	82. I regularly attend spiritual or church fellowship services when I'm on the outside.	32.8	34.4	12.7	17.3
	37. I do not have any particular religious or spiritual beliefs.	72.8	6.5	5.3	7.4
Life Skills & Resources	83. On the outside, I had trouble managing money and paying bills on time.	35.9	13.6	29.1	15.2
	50. I am good at making important decisions.	44.9	42.1	7.7	4.3
	41. When I was on the outside, I could plan ahead for expenses and bills that were coming up.	54.5	29.7	6.2	9.0
	46. I could make a budget and follow it when I was on the outside.	39.0	30.0	10.2	18.3
	43. I can find acceptable housing in my community.	56.7	22.3	5.6	7.4
Parenting	22. I need to improve my parenting skills.	21.7	5.6	24.8	14.9
	58. I was able to care for my children on my own when I was on the outside.	48.9	17.0	5.0	5.9
	14. When I was on the outside, I had trouble caring for my children without help.	40.6	4.6	14.2	5.9
	11. When I was on the outside, I had difficulty getting my children to behave.	44.9	8.7	10.2	1.5

APPENDIX L

RESPONSE FREQUENCIES FOR COMPLEXITY (N=324)

Response Frequencies for Complexity (n=324)

Content	Item	Response Frequencies			
Domain		(% subjects responding)			
		1	2	3	4
Substance Abuse	39. On the outside, I was often tempted by friends to use or sell drugs.	38.7	6.2	20.4	21.7
	17. Wherever I go, drugs or alcohol always seem to find me.	44.6	12.1	18.0	13.6
	34. On the outside, it is hard to avoid people and places associated with drugs.	44.6	10.5	19.5	11.5
	29. There are substance abuse aftercare programs in my community that I can attend.	65.6	9.3	2.5	2.8
Physical Health	56. Access to quality healthcare in my community is easy.	40.2	35.6	11.5	10.8
	79. There is a health department or other place I can go to in my community when I am sick.	76.2	16.4	2.5	3.1
	31. I have trouble getting medical care on the outside unless I have a job with health benefits.	38.4	8.7	23.8	21.1
	68. Medical care is easily available on the outside if I get sick.	46.7	28.2	9.6	13.6
Mental Health	12. There are counselors in my community who can help me even if I do not have much money.	40.9	27.9	6.5	13.9
	65. When I was on the outside, there was nobody with whom I shared my emotional problems.	44.6	12.4	25.4	14.6
	84. There are people on the outside who I can relax with.	76.8	18.0	1.9	2.5
	77. I will be returning to a stressful environment when I am released.	44.3	13.0	24.8	10.5
Education	10. I have access to quality educational programs in my community.	63.5	23.8	2.5	6.2

	19. It would be difficult for me to pay for school or a job training program on the outside.	22.0	9.9	26.9	35.0
	81. My family can help me attend school.	44.3	23.2	7.1	16.4
	6. There are too many barriers in my life to attend school regularly on the outside.	48.9	9.9	18.9	6.2
Employment	26. There are few jobs in my community for which I qualify.	26.3	15.2	31.9	20.1
	23. The job market in my area of interest is poor.	38.7	18.3	21.7	15.5
	13. As a former felon, my job options are limited.	12.7	6.8	30.3	41.5
	80. Nobody will hire me with my criminal record.	36.2	15.8	36.8	5.3
Support	53. My family is supportive of me in anything I do.	59.1	26.9	5.6	8.4
	7. I do not have many people on the outside who are close to me.	49.5	3.4	20.4	15.5
	52. I have friends and family I can go to when I am released.	89.2	6.8	1.9	1.9
	1. Support from others often has strings attached.	13.9	10.8	41.2	20.1
Spirituality	16. Spirituality and religion are not important among my friends and family.	61.0	12.7	15.5	5.3
	3. Spirituality is important in my family.	66.6	27.2	2.2	2.5
	63. Some of my family and friends have the same spiritual beliefs as me.	64.4	26.6	4.0	3.4
Life Skills	74. Sometimes the demands of life on the outside were too much.	19.5	14.9	38.4	22.3
& Resources	61. I lead a simple life on the outside.	45.2	35.0	7.4	11.1
	71. Good, affordable housing is available in my community.	41.5	35.3	9.3	10.5

Parenting	78. On the outside, crime seemed to be the only way to pay the bills.	58.8	8.4	13.3	9.9
	18. I know I will have a place to live when I am released.	86.1	6.8	0.9	4.6
	24. The people in my life do not think I can make it on my own financially on the outside.	63.2	9.9	12.1	6.8
	8. I have quality child care available for when I go back to work.	39.0	5.3	1.9	3.4
	42. One or more of my children requires special assistance.	42.7	1.9	6.5	12.4
	44. When I was on the outside, I had family or friends who helped me out with my children.	56.0	10.5	0.6	5.0
	70. When I was on the outside, one or more of my children was difficult to deal with.	40.2	4.0	14.2	7.7
	67. I am having child custody problems.	35.0	1.5	6.5	6.8

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BIOGRAPHICAL SKETCH

Born Mary Anne Bradley in 1973 in Marietta, Georgia, the author was raised primarily in Bradenton, Florida. Her father is a pharmacist and was the owner of an independent drug store; her mother was both a homemaker and co-owner of the family business. The family enjoyed weekends boating the aqua waters off the coast of Anna Maria Island. Mary Anne attended public schools, excelling musically (playing violin in the high school orchestra). She graduated in 1991 and began her undergraduate studies at Florida State University.

Mary Anne made the Dean's List several semesters and volunteered for the local crisis hotline during her undergraduate years. She received a Bachelor of Science degree in Psychology with a minor emphasis in Biology in 1995. She then took a year away from school to work full time as a case manager for adults with major mental illness. She received a Master of Science and Educational Specialist degrees in Counseling and Human Systems in 1998, again from Florida State University. She spent another year away from school to work full time, this time as a Psychological Specialist under Florida's recent civil commitment law for sexually violent predators. She entered the combined doctoral program in Counseling Psychology and School Psychology at Florida State University in 1999, taking courses part time while working full time.

Mary Anne met her husband, Roy, in statistics class in early 2000. The two were married and had a son, William, in 2002. Her husband, a doctoral student in the same program, is strong in research and statistical knowledge. He served as her statistical consultant throughout this dissertation. They are expecting their second child in August 2005.