Health Issues Specific to Incarcerated Women:
Information for State Maternal and Child Health Programs

Over the last 15 years, the number of incarcerated women in the United States has increased dramatically. While the number of men in State and federal prisons has grown 67% since 1990, the number of incarcerated women has increased by 92% (Beck and Mumola, 1998). Offenses related to illegal drugs account for nearly 40% of this increase. Historically, offenses such as larceny, forgery, embezzlement and prostitution accounted for the majority of women's sentences (OJP Special Report, 1998). It is also important to note that the number of women receiving sentences of more than one year has increased by 80% since 1990 (Beck and Mumola, 1999).

Figure 1. Sentenced female prisoners in State and Federal institutions on December 31, 1997 -- United States, 1925-1997

This figure is not available on the PDF version of this document. To view the figure, please visit the Sourcebook of criminal justice statistics Online at http://www.albany.edu/sourcebook/1995/pdf/t6002.pdf

Source: Maguire and Pastore, 1999; p. 488

At the end of 1998**,** 84,427 women were under the jurisdiction of State or Federal correctional authority, and as of June 30, 1998, 63,791 women were in local jails (Beck and Mumola, 1999; Gilliard, 1999). These women were housed within a correctional system that includes 94 federal and 1,378 State prisons, and 2,994 local jails (FBOP Quickfacts, 1999; ACA, 1999). Of the 94 federal institutions, 4 house women only, 4 are female and male facilities and 9 are administrative facilities (Maguire and Pastore, 1999). There are approximately 65 State female-only facilities, and 56 State co-educational facilities. (ACA, 1999).

Figure 2. State and Federal female incarceration rates, per 100,000 U.S. residents, 1998

54 to 173 (17)
38 to 54 (17)
9 to 38 (17)

Drawn from: Greenfeld and Snell, 1999, Table 23

The U.S. Corrections System

The Bureau of Prisons is a component of the United States Department of Justice. It has six regional offices, nine divisions and the National Institute of Corrections under whose jurisdiction fall jails, prisons, community corrections and the Bureau's Academy. Federal prison inmates, with a few exceptions, are individuals who have been convicted of or are awaiting trial for violating Federal laws. Most persons convicted of violating State or local laws are sent to State prisons or city or county jails. Jails are locally-operated correctional facilities that confine persons before adjudication, or those with a sentence of a year or less. State and Federal Prisons usually hold persons with a sentence longer than one year.

Figure 3. States with less than 1,000 women prisoners, 1998

The 25 shaded states had less than 1,000 women prisoners in 1998.

Drawn from: Maguire and Pastore, 1999, Table 6.47

Women entering the correctional system represent a population already at high risk for communicable diseases, substance abuse and mental health problems (Hammett et al, 1998; Smith and Dailard, 1997; Cotten-Oldenburg et al, 1997; Fogel and Martin, 1992; Martin et al, 1995). Because the number of incarcerated men historically has far exceeded that of incarcerated women (women represented 6.5% of prison inmates at the end of 1998), limited attention has been paid to the unique health concerns of this population (Beck and Mumola, 1999). With increasing numbers of women entering and exiting the prison system, there is a compelling need to ensure that mechanisms are in place that can adequately address these health issues.

In order to assure that the unique health needs of incarcerated women are met, it is important that correctional facilities are equipped with appropriate information, staff and resources. Providing incarcerated women with comprehensive and appropriate health care services can be challenging because women represent such a small proportion of jail and prison inmates. In addition, the time available for intervention varies significantly. Despite these challenges, the period of incarceration, however long or short, provides a window of opportunity for improving the health status of this population. Successful collaborations between correctional and public health agencies can ensure that opportunities are taken. State and local MCH professionals may be able to assist in this regard through partnerships to plan and/or provide health services within correctional facilities as well as to arrange for follow up in the community upon a woman's release.

Characteristics of Incarcerated Women

The median age of women in Federal, State and local facilities is 36, 33 and 31 years respectively (Greenfeld and Snell, 1999). More than half of women in the correctional system have at least a high school education and are not married (Greenfeld and Snell, 1999). More than two thirds of women have children under the age of 18, most of whom are living with a grandparent or other relative (Snell and Morton, 1994). Women of color are disproportionately represented in the prison system – in 1998, women of color represented approximately 26% of women in the U.S., but represented 64%, 67% and 71% of women in jails, State prisons and federal prisons respectively (Greenfeld and Snell, 1999). Poverty and addiction appear to frequently motivate criminal acts by women. It has been reported that more than 50% of women in prison and almost 75% of women in jail are unemployed upon arrest and one in four women prisoners state they committed their offense to finance drug purchases (Snell, 1992; Snell and Morton, 1994).

Table 1. Offenses of women in prison or jail, 1998

Most Serious Offense	Percent of women offenders		
	State prison	Federal prison	Local jails
Violent offenses	28	7	12
Property offenses	27	12	34
Drug offenses	34	72	30
Public-order offenses	11	8	24

Drawn from: Greenfeld and Snell, 1999, Table 16

Drug-related crimes represent the most common offenses by women in Federal and State prisons (Federal: 72%; State: 34%), and the second most common offenses by women in local jails (30%) (Greenfeld and Snell, 1999). The most common offenses by women in local jails are property offenses (34%). As outlined in Table 1, violent and public order offenses are less common among women. The trends in most serious offenses for women in State prison have shifted significantly since 1979, as illustrated in Table 2. Between 1979 and 1997, the percent of women in State prison for violent offenses decreased from 48% to 28%, whereas the percent of women incarcerated for drug-related offenses increased from 12% to 34% (Greenfeld and Snell, 1999).

Table 2. Percent of female State prison inmates by crime

Crime	1979	1986	1991	1997
Violent	47.9%	40.7%	32.2%	28.2%
Property	36.1	41.2	28.7	26.6
Drug	12.3	12.0	32.8	34.4
Public-order	2.8	5.1	5.7	10.5

Source: Greenfeld and Snell, 1999, p. 14

Women entering State prison are less likely than men to have a violent criminal history (Snell and Morton, 1994). In 1991, 25% of incarcerated women were violent recidivists, compared with 50% of incarcerated men. Women are more likely than men to have no previous sentence (28% v. 18%). Maximum sentences received by women are generally less than those received by men for the same category of offense. For women in State prison, the average maximum sentence length is almost 9 years, compared with almost 13 years for men. Women sentenced for murder receive an average sentence of 25 years, compared with 32 years for men. State sentences for drug offenses average 6.5 years for women and 8 years for men (Snell and Morton, 1994). As noted in Table 3, although both male and female inmates often achieve release well prior to the end of their sentenced period of incarceration, women tend to be released earlier than men (Greenfeld and Snell, 1999).

Table 3. Median sentence and time served for women and men in State prison, by crime (in months), 1996

Offenses	Median sentence		Median time served	
	Women	Men	Women	Men
Violent	**60**	**72**	**20**	**28**
Property	**36**	**36**	**11**	**15**
Drugs	**36**	**42**	**12**	**14**
All other	**24**	**36**	**10**	**12**
Total	**36**	**48**	**12**	**16**

Drawn from: Greenfeld and Snell, 1999, Table 26

Sentences for women in Federal prison also tend to be shorter than those for men (Compendium of Federal Justice Statistics, 1997). The average sentence for all offenses is approximately 3 years for women and 5 years for men. For violent offenses and for drug-related offenses, the average sentences are 4 years for women and 7 years for men. As seen in Table 4, the longest Federal sentences are received for drug-related and violent crimes. Gender-specific information about time served for Federal sentences is not readily available.

Table 4. Mean sentence length for women and men in Federal prison, by crime (in months), 1997

Offenses	Women	Men
All offenses	36	62
Violent	51	87
Property		
Fraudulent	16	23
Other	18	37
Drug	53	84
Public Order		
Regulatory	14	28
Other	30	51
Misdemeanors	7	11

Drawn from: Compendium of Federal Justice Statistics, 1997, Table 4.5

In their 1997 NIC report, Brennan and Austin described seven unique attributes of female inmates:

- **Medical needs** -- Female inmates have special medical needs related to reproductive health that need to be identified and appropriately addressed (e.g. cervical and breast cancer screening, pregnancy, menopause).
- **Drug and alcohol abuse** --The vast majority of incarcerated women abuse alcohol and/or drugs (between 70% and 80%) (Smith and Dailard, 1997). Women have higher rates of drug use and they are more likely than men to be injection drug users and use "hard" drugs such as crack (Snell and Morton, 1994).
- **Sexual and physical abuse** -- In a Bureau of Justice Statistics Selected Findings Report, Harlow (1999) states that 1 in 4 women in State prison reported sexual abuse before age 18 compared with 1 in 20 men.
- **Children and family relationships** -- The majority of female inmates are mothers, who are concerned and perhaps anxious about maintaining relationships with children and other family members.
- **Institutional conduct** --Women are less likely to commit violent acts in prison, act out, or attempt escape. However, Burke and Adams (1991) found that women inmates needed more attention and assistance with personal problems.
- **Current offense and prior record**--Women are more likely to be serving a sentence for non-violent and minor crimes such as fraud, theft, drug offenses and larceny. Although an increasing number of women are convicted of serious crimes, they are often considered to be accessories rather than instigators of those crimes. Women are also less likely than men to have violence in their prior record.
- **Vocational, education and economic needs** -- Smith and Dailard (1997) attribute the fact that women almost exclusively commit nonviolent economically motivated crimes to high rates of poverty and unemployment among women.

In order to provide appropriate health care services for incarcerated women, it is important that these attributes be considered by correctional systems and facilities as they develop and/or implement health care standards and protocols.

Standards for Health Services

Although the facilities within the federal prison system are accredited and routinely surveyed by the Joint Commission on Accreditation in Health Care Organizations (JCAHO), national uniform standards are not applied across all State and local correctional facilities and community incarceration programs. Accreditation of facilities within individual states or local areas may be mandated by their respective governing bodies, but there is not one single agency or organization to which all U.S. facilities are accountable. As a result, health care services offered to incarcerated women (and men) outside the federal prison system vary significantly.

In addition to JCAHO, State and local correctional systems may seek accreditation from the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA). The National Commission on Correctional Health Care (NCCHC) is a not-for-profit organization that was established in 1983. The NCCHC develops and maintains standards for correctional health services and offers a voluntary accreditation program for correctional institutions that meet their standards. Other roles of the NCCHC include certifying correctional health professionals and offering continuing education programs for these professionals (Glaser and Greifinger, 1993). The NCCHC's 38-member board of directors includes representatives from such organizations as the American Medical Association, American Psychiatric Association, American Dental Association, and American Pharmaceutical Association. As of 1999, 445 correctional facilities are NCCHC accredited. Although U.S. correctional facilities are not uniformly required by law to follow the NCCHC standards, some facilities are under a mandate to do so by direction of the courts or as part of a contract requirement (NCCHC, 2000).

The NCCHC develops and publishes detailed health care standards for jails, prisons, and juvenile facilities. The domains covered by these standards include inmate care and treatment, health promotion and disease prevention, health records, medical-legal issues, special inmate needs and services, personnel and training, and health care services support. A 1999 NCCHC publication addresses mental health

services in correctional facilities. *Correctional mental health care: Standards and guidelines for delivering services* was developed with consultation from more than forty experts in correctional health care and mental health (www.ncchc.org).

The American Correctional Association (ACA) was founded in 1870. More than 1,500 correctional facilities and programs are involved in ACA accreditation, including approximately 80% of all State departments of corrections and youth services. Programs and facilities operated by the Federal Bureau of Prisons, the US Parole Commission and the private sector are also accredited by ACA (www.corrections.com/aca). Standards published by ACA include a section on health care, although it is not as detailed as the standards published by the NCCHC. According to the ACA standards, inmates are to receive a full health appraisal within 14 days of arrival (ACA Standards, 1990).

Significant Health Care Concerns

According to a recent survey, more than 80% of responding State departments of corrections screen incarcerated women for substance abuse, mental health problems, venereal disease and reading/math ability (Morash, Bynum and Koons, 1998). At the local level within reporting states, 60% of responding jails screen for substance abuse, mental health problems and venereal disease.

Since 1972, the Bureau of Justice Statistics has conducted periodic surveys -- fielded approximately every six years -- designed to obtain detailed information from a nationally representative sample of jail inmates (Harlow, 1998). In the most recent survey, conducted between October 1995 and March 1996, more than 6,000 inmates from 431 jails were interviewed for approximately one hour. In addition to information gathered in previous surveys about criminal history, substance abuse and treatment, family background, and conditions of confinement, the 1996 profile includes information on health assessments, medical and mental health needs and treatment, disabilities, welfare use, and jail conditions (Harlow, 1998).

According to the *Profile of Jail Inmates 1996*, eighty-two percent of women responding to the survey reported that they were asked about their health or medical history and 47% reported that they had received a medical examination upon admission. More than 50% of the women surveyed reported having a condition requiring medical attention, yet only 28% received medical care (Harlow, 1998).

Given the multiple issues surrounding communicable diseases, reproductive health, and the prevalence of substance abuse and mental health problems among incarcerated women, it is necessary to direct special attention to these areas.

STDs, HIV/AIDS, Hepatitis C and Tuberculosis (TB). Screening for STDs in correctional facilities is difficult because of the large number of persons admitted each day and the frequent shortage of medical staff and examination space (MMWR, September 1999). This is of particular concern because the prevalence of sexually transmitted diseases (STDs) and other communicable diseases is known to be high among women entering correctional facilities (Hammett et al., 1999; Puisis, Levine and Mertz, 1998). In a 1997 study, it was reported that mandatory or routine syphilis screening policies were in place in 88% of State/Federal prison systems and 41% of local jail systems (Hammett et al., 1999). While each female inmate is to receive a complete physical exam, the syphilis serology appears to be the only STD for which women are most consistently screened. Other infectious disease testing is conducted if clinically indicated (Profile of Female Offenders, May 1998; Hammett et al., 1999; MMWR, June 1998). Data from the 1997 study indicated that 28% of State/Federal systems and 27% of local jail systems screen incoming inmates for gonorrhea and 20% of State/Federal systems and 4% of local jail systems screen for chlamydia (Hammett et al., 1999). Following a treatment protocol based on clinical indication is not adequate because most women with chlamydia and gonococcal infections are asymptomatic (MMWR, September 1999). Left untreated, these two infectious diseases can lead to pelvic inflammatory disease, ectopic pregnancy, infertility, or chronic pelvic pain in women. They also are associated with increased risk for contracting the human immunodeficiency virus (HIV) (MMWR, September 1999).

HIV and acquired immunodeficiency syndrome (AIDS) are more prevalent among incarcerated women than incarcerated men (Hammett et al., 1999). Among State prison inmates in 1997, approximately 3% of women were HIV positive, compared to about 2% of men (Maruschak, 1999). At year end 1996, 2,135 (3.5%) female State prison inmates were known to be HIV positive and 34 women in State prisons died of AIDS. (Maguire and Pastore, 1999). Responses to a 1997 survey indicated that more than half (27) of 51 reporting State prisons test for HIV among high risk groups, inmates with symptoms, or upon inmate request. Sixteen State facilities screen all inmates, 5 screen only at inmate request, and 3 screen a random sample (Hammett et al., 1999). Thirty-one percent of State/Federal systems reported having policies regarding notification of an inmate's sexual partner of HIV test results and 27% had policies regarding notification of needle-sharing partners. Fifteen percent of local jail systems reported having policies regarding notification of sexual partners and 10% had policies for notifying needle-sharing partners (Hammett, Harmon, and Maruschak, 1999). According to this survey, HIV therapies are available in most correctional systems -- more than 90% of responding prison and jail systems reported availability of such therapies as protease inhibitors, combination therapy, Bactrim, and AZT for pregnant women. However, the important process of viral load monitoring is not as widely available (80% of prison and 59% of jail systems) (Hammett et al., 1999). Despite the appearance that most correctional systems offer these treatments, it should be noted that financial constraints as well as the lack of uniform standards may inhibit access to them.

Table 5. Percent HIV Positive, 1996

	Women	Men
State Prison	3.4%	2.2%
Local Jails	2.4	2.1
Federal Prison	0.6	0.6

Drawn from: Hammett et al., 1999, Table 8

Unlike Hepatitis B, for which there is a vaccine that is increasingly available to inmates and staff in correctional facilities, the prevalence of Hepatitis C continues to be a serious problem (Hammett, Harmon, and Maruschak, 1999). The Hepatitis C virus (HCV) is especially prevalent among persons infected with HIV and injection-drug users (Hammett, Harmon, and Maruschak, 1999). In 1994, a study conducted in California found that 41% of incoming inmates were antibody positive for HCV and the prevalence was greater among female inmates than among male inmates (55% v. 39%) (Ruiz and Mikanda, 1996). The same study found that 85% of HIV seropositive women were also HCV positive, compared with 61% of HIV infected male inmates.

Although rates of tuberculosis (TB) in the general population have been declining in the 1990s, the inmate population continues to be at significant risk of contracting the disease (Castro, 1998; MMWR, April 1998; Hammett et al, 1998; MMWR, August 1997). In 1997, 73% of

State/Federal and local jail systems screened all incoming inmates for TB disease. Inmate cases of TB represented 3.7% of all cases in the U.S. that year (Hammett et al., 1999).

Recognizing that women entering the correctional system are more likely to be affected by communicable diseases than women in the general population, it is of utmost importance to provide screening and appropriate treatment. Untreated women returning to the community following a period of incarceration may place themselves and others at risk for future health complications.

Reproductive Health. In addition to standard health care needs, pregnant women entering the correctional system have health concerns specific to prenatal, postpartum and infant care. Approximately 6% of female inmates are pregnant upon incarceration (Martin et al., 1997). This percentage is probably imprecise because as of 1997, less than half of correctional systems routinely screen incoming female inmates for pregnancy (Hammett et al., 1999).

The relationship between incarceration and birth outcomes has been the focus of several studies with varying results (Shelton, Armstrong and Cochran, 1983; Shelton and Gill, 1989; Cordero, et al., 1991; Egley, et al, 1992; Martin et al, 1997). Although it might be expected that birth outcomes for incarcerated women would be poor compared with women in the general population, recent studies report that birthweights among the two groups do not vary significantly (Martin et al., 1997; Egley, et al., 1992).

Some studies report higher birthweights among incarcerated pregnant women compared with high risk pregnant women in the general population. For example, a North Carolina study employed multivariate analyses to compare infant birthweight outcomes among three groups of women: 168 women incarcerated during pregnancy; 630 women incarcerated at some point other than during pregnancy; and 3,910 women never incarcerated (Martin et al, 1997). Birthweights of infants born to women incarcerated at some point other than during pregnancy were significantly lower than those of incarcerated women and women who had never been incarcerated. Another study found that compared with a control group matched for age, parity, race and date of entry into prenatal care, incarcerated pregnant women were less likely to deliver prematurely (Egley, et al., 1992). These findings suggest a protective effect of incarceration for high risk pregnant women. A possible explanation for this effect is that pregnant women in the correctional system have adequate shelter and nutrition, have more limited access to alcohol, cigarettes and other drugs and are more likely than high risk pregnant women in the general population to have access to routine prenatal care (Martin, et al., 1997; Cordero, et al., 1991).

Of great concern, however, are those pregnant women who are infected with HIV. Women who are pregnant and HIV positive require medical treatment and ZDV (AZT or Zidovudine) prophylaxis to reduce the risk of HIV transmission to their infants and optimally manage their HIV disease. Although treatment for HIV is available in most correctional facilities in the U.S., mandatory or routine HIV testing for pregnant inmates occurs in only 55% of reporting State/Federal systems and 17% of local jail systems (Hammett et al., 1999). There are also special needs for women who have decided to terminate the pregnancy, such as provision of counseling, medical treatment and family planning services. Although most pregnant incarcerated women would be considered at risk for complications, access to specialists including obstetricians and gynecologists is often limited in correctional systems because of cost and transportation issues (Smith and Dailard, 1997; Fogel, 1993).

Substance Abuse and Mental Health Problems. According to the Bureau of Justice Statistics, 73% of female prisoners in State institutions and 47% in federal institutions used drugs regularly prior to incarceration (Mumola, 1999). Forty percent of women in State institutions and 19% in federal institutions were using drugs at the time of offense. These percentages were higher than those found in men during the same period. Although alcohol abuse is more prevalent among male inmates, almost 30% of State female prisoners (15% Federal) were under the influence of alcohol at the time of their offense (Mumola, 1999). In 1996, fifty percent of females serving time in jails were using alcohol regularly (Harlow, 1998).

There is a paucity of epidemiologic data on psychiatric disorders of incarcerated women. However, data from recent studies suggest that as many as 80% of incarcerated women meet the criteria for at least one lifetime psychiatric disorder (Teplin et al, 1996; Jordan et al, 1996). Substance abuse or dependence, post traumatic stress disorder (PTSD), and depression appear to be some of the most common mental health problems for this population.

Women in the correctional population report higher rates of childhood abuse than women in the general population (37% v. 17%) (Harlow, 1999). According to a 1999 Bureau of Justice Statistics publication, 1 in 4 women in State prison reported experiencing physical abuse compared to 1 in 10 men in State prison. Among the same State prison population, sexual abuse was reported by 1 in 4 women and by 1 in 20 men (Harlow, 1999). In *A Profile of Jail Inmates, 1996*, it was reported that almost 50% of jailed women had experienced physical and/or sexual abuse at some point in their lives, but only 36% had ever received mental health services and just 20% received mental health services after admission (Harlow, 1998).

Stress related to family concerns is a significant factor to consider when providing mental health services to incarcerated women. In 1991, more than two thirds of women in prison had children under the age of 18, and among them only 25% (compared to 90% of men) said their children were living with the other parent (Morash, Bynum and Koons, 1998). Separation from family was described by Fogel and Martin (1992) and Austin et al. (1993) as being the most difficult aspect of incarceration for women. Fogel and Martin's study comparing incarcerated mothers with nonmothers found that the anxiety level of mothers remained high compared with that of nonmothers, which declined over time (1992).

Although a history of abuse and concerns related to family are very common issues among women inmates, less than 20% of responding jails and less than 60% of responding states screen for domestic violence, and less than 30% of responding jails and less than two thirds of responding states screen for childhood sexual abuse or needs related to children (Morash, Bynum and Koons, 1998). Parenting programs that emphasize strengthening and nurturing relationships and that allow women inmates regular access to their children can have a lasting effect (Fogel and Martin, 1992).

Identifying Areas for Improvement

To obtain the perspective of correctional institutions and administrators of correctional programs that include women, the National Institute of Justice implemented a national study in 1993 and 1994 and involved State-level correctional administrators, administrators of State and local correctional institutions, and administrators of correctional programs that include women (Morash, Bynum and Koons, 1998).

In the first phase, surveys were designed to acquire factual information from State departments of corrections and administrators of prisons and jails that house women. All State correctional departments and at least one prison in each state were surveyed, as well as jail administrators from 50 city/county jurisdictions. The response rate for the survey was impressive with all 50 State-level

administrators and 87% of program administrators completing the survey (Morash, Bynum and Koons, 1998). In the second phase, telephone interviews were conducted with a sample of 62 of the 242 reported "innovative" programs. The third phase involved site visits to 17 of these programs (Morash, Bynum and Koons, 1998). Key needs identified were:

- Improved classification and screening procedures for women in prison, with particular focus on needs related to children, domestic violence and childhood sexual abuse.
- Additional substance abuse treatment programs and mental health services.
- Enhanced inter-agency coordination of programs and services.

Classification and Screening. As the number of incarcerated women continues to rise, correctional institutions and related agencies have begun to focus more intently on the issue of classification (Brennan and Austin, 1997). The classification process determines the location and type of facility in which an offender is placed. Based on this placement, certain programs and treatment options may or may not be available, such as support groups, woman-oriented substance abuse treatment, or extended visitation with children.

The differences in circumstances and needs between incarcerated men and incarcerated women have implications for the classification process and subsequent treatment strategies for incarcerated women. Morash, Bynum and Koons (1998) found that although female inmates have unique programing and housing needs, the methods used for inmate classification tend to be identical for female and male offenders. This is especially the case for prisons housing less than 1,000 women. Only 3 states reported using a special classification instrument for women inmates. Thirty-nine states reported using the same instrument for women and men and 7 states reported using an adjusted men's instrument for women. Improved classification procedures, which take into account the differences between male and female inmates, can lead to more appropriate service provision.[1]

Substance Abuse Treatment and Mental Health Programs. Many women in the correctional system are coping with a complex constellation of issues that affect their health status. Some of these conditions are acute (e.g., infections) and some are chronic (e.g., addiction, depression). Given the prevalence of substance abuse and mental health issues among incarcerated women, quality programs designed for women are needed in order to take advantage of the "window of opportunity" provided by the period of incarceration.

In 1994 the National Institute of Corrections (NIC) Academy issued a report entitled *Profiles of Correctional Substance Abuse Treatment Programs: Women and Violent Youthful Offenders* summarizing information about 10 substance abuse treatment programs designed specifically for women (Profiles, 1994). Women substance abusers often come from abusive backgrounds and are more comfortable with a communal, non-competitive approach. Substance abuse treatment programs that are designed for women tend to be less confrontational than those designed for men. However, most programs in women's correctional facilities are based on models designed for men. In addition to individual and group counseling, creating therapeutic communities for incarcerated women is a key approach (Profiles, 1994). The NIC report, which includes the index of programs for women, can be found on the world wide web at http://www.nicic.org/pubs/prisons.htm.

The federal Office of Justice Programs produced a report entitled, *State Efforts to Reduce Substance Abuse Among Offenders.* This document provides state-by-state information on trends in prison, parole, and juvenile correctional populations, implementation of State drug testing, sanctions and treatment policies. The report, which can be found on the web at http://www.ojp.usdoj.gov, also includes information about federal resources available to states as formula block grants. These funds can be used to implement substance abuse testing, treatment and aftercare programs.

In 1995, the National GAINS Center was established for people in the justice system with co-occurring disorders related to mental health and substance abuse (Steadman HJ and Cocozza JJ, 1997). The GAINS Center developed from a federal partnership between the National Institute for Corrections (NIC/DOJ) and two offices within the Substance Abuse and Mental Health Services Administration (SAMHSA/HHS) -- the Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS). Among its many activities and services, the GAINS Center offers assistance with identifying gaps in services and provides a database for use in obtaining information about model programs and for facilitating linkages with experts in the field. One of the four goals of the GAINS Center is to focus attention on the special needs of women and juveniles within the criminal justice system.

Federal resources specific to substance abuse treatment available to states as formula grants:

- Residential Substance Abuse Treatment (RSAT) for State Prisoners Formula Grant Program
- Violent Offender Incarceration and Truth-in-Sentencing (VOI/TIS) Incentive Formula Grant Program
- Edward Byrne Memorial State and Local Law Enforcement Assistance Program
- Substance Abuse Prevention and Treatment (SAPT) Block Grant Program
- Juvenile Justice and Delinquency Prevention Formula Grant Program
- Juvenile Accountability Incentive Block Grant Program

As stated earlier, more than two thirds of incarcerated women have minor children and often suffer from anxiety and depression related to separation from them. Two programs that have been successful and which have been replicated in women's correctional facilities across the country are Girl Scouts Behind Bars, which brings incarcerated women together with their daughters two Saturdays a month and the Mothers With Infants Together (MINT) program, which is a community-based program for pregnant offenders that allows infants to stay with their mothers for up to two months after birth (OJP Special Report, 1998).

Interagency Collaboration. Correctional facilities may be under increasing pressure to offer more comprehensive services without the benefit of additional resources. Given the substantial increase in the number of women entering the criminal justice system, the fact that entitlements to publicly funded insurance coverage (such as Medicaid) are lost upon entry into this system, and the unique health issues of this population, interagency coordination is necessary to reduce the burden for correctional facilities that are attempting to address these issues. The absence of of interagency collaboration can greatly compromise the abilities of correctional institutions to develop appropriate discharge

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[1] Copies of the full report of this study, *Findings from the National Study of Innovative and Promising Programs for Women Offenders*, can be obtained from the National Criminal Justice Reference Service (800-851-3420). Ask for NCJ 171667.

plans and facilitate continuity of care arrangements (Hammett, 1998).

In their survey of agency administrators of State and local correctional institutions, Morash, Bynum and Koons (1998) asked about contracting out to the private sector and coordinating with other State agencies. The majority of respondents reported contracting out for some services for women, including drug treatment, education and mental health services. Most survey respondents were positive about interagency coordination to provide programs, stating benefits related to quality, effectiveness and flexibility. However, it appears that relatively few states have established such relationships. Coordination between State agencies and correctional institutions was primarily seen in the areas of education (17 states), vocational training (13 states) and mental health (12 states). Only six states reported interagency coordination of substance abuse treatment services.

In the National Institute of Justice/Centers for Disease Control and Prevention publication, *Public Health/Corrections Collaborations: Prevention and Treatment of HIV/AIDS, STDs and TB,* Hammett (1998), outlined five key factors in successful public health/corrections collaborations:

- *Availability of data supporting the need for collaboration*--data collected by public health departments and correctional facilities can be synthesized and disseminated to decisionmakers to support the need for further resources and inter-agency agreements.
- *Regulations or organizational policy that assigns responsibility for providing services and/or require monitoring of services provided*-- health directors can be given the legal authority to require and ensure monitoring of appropriate screening and interventions in correctional facilities.
- *Demonstrated commitment to collaboration at agency and facility levels* -- for example, willingness of correctional facilities to bring in programs and staff from outside organizations.
- *Health department support in the form of funding and liaison staff* -- in addition to providing funds for health care programs and services, State health agencies can designate a liaison to facilitate collaboration between public health and corrections facilities including, but not limited to locating local health department staff and programs in correctional facilities.
- *Regular and frequent opportunities for pertinent agencies to communicate and share information with one another*-- leadership and operational committees can be established with representatives from public health and corrections programs.

Model programs in New York and Rhode Island have initiated partnerships between correctional systems, public health departments, community-based organizations, service agencies, county jails, and academic medical centers (Hammett, 1998). For example, through successful interagency coordination, Rhode Island provides postrelease services for inmates infected with HIV, including medical treatment, housing assistance, substance abuse treatment, vocational assistance, and psycho-social support. The positive impact of this program is reflected in evaluation data that reveal lower recividism rates among participating female inmates as well as increased compliance in postrelease medical treatment. In New York, collaborative efforts by the Department of Health and county jails have resulted in the development of STD interventions that have been successful in reducing morbidity among inmates as well as county residents (Hammett, 1998).

Notwithstanding the presence of these and other emerging models for interagency collaboration, significant need and opportunity remains to develop and implement creative health promotion strategies for women in the correctional system.

Programs for Women

In 1998, the National Institute of Corrections (NIC) issued a report outlining the results of a written survey designed to gather information about correctional institutions housing women (Current Issues, 1998). Respondents for the survey included forty-nine State departments of corrections (DOCs), the DOCs for the District of Columbia and New York City, the Federal Bureau of Prisons and the Correctional Service of Canada. Almost all of the respondents (49) reported providing programs developed specifically for women. Most programs fell into the categories of: parenting (31), substance abuse (27), domestic violence (20) and life skills (18).

According to the NIC report, within these categories, there are four main types of programs:

- **Nursery programs** -- Programs operating in the Nebraska Correctional Center for Women, New York City's Rose Singer Center, and New York State's Bedford Hills Correctional Facility allow women inmates to keep their infants near them and care for them for a limited period. Child development courses are a required component of the programs.
- **Mentoring/self-esteem programs** -- These programs provide an opportunity for women to support one another and develop skills in such areas as interpersonal relationships, communication and leadership. One such program is offered in the Colorado Women's Correctional Facility.
- **Survivors groups** -- As of December 31, 1997, twenty (20) correctional institutions had programs in place for women who have survived domestic violence and 10 institutions offered programs for women survivors of sexual abuse. For example, a weekly support group for abused women is housed in the Oregon Women's Correctional Center.
- **Women's health education** -- Nine DOCs reported providing health education programs for women. Basic sex education classes are offered in some prisons and these classes often emphasize HIV prevention (Donovan, 1996).

Potential Public Health/MCH Roles

Public health agencies generally and maternal and child health professionals specifically can contribute to the system of health care for incarcerated women in several ways. Given the need for assistance in facilitating links between community services and institutional services at the individual and/or population/agency level, public health agencies can collaborate with correctional institutions on concerns related to:
1) Performing needs assessment and surveillance functions with respect to the health of incarcerated women; 2) Prevention programming and primary health care services (e.g., fitness activities, family planning, health education); 3) Screening and diagnosis services and treatment (e.g., STD screening and treatment, smoking cessation,, pregnancy care); and 4) Health service and professional standards and quality assurance.

Through consultation with correctional institutions, MCH professionals can play a key role in the development and implementation of women-specific interventions. For example, public health professionals can provide expertise to support and implement interventions oriented to women in such areas as pregnancy care, family planning, women-specific substance abuse treatment, communicable diseases (e.g., HPV) and chronic diseases (e.g., hypertension).

In addition, MCH professionals can apply their expertise to the training of correctional staff and to the development of appropriate

discharge plans. In order to ensure that arrangements are made and implemented for continued treatment and follow-up in the community, it is crucial that State MCH programs are aware of individuals returning to the community who are in need of these services. An example of a program following this model is in Hampden County, Massachusetts (Conklin, Lincoln and Flanigan, 1998). In cooperation with the Massachusetts Department of Public Health and the regional medical centers, the Hampden County Correctional Center has developed a community-based health care delivery system in which four community health centers contract with the correctional center to provide health care services to inmates within the center as well as in the community upon discharge (Conklin, Lincoln and Flanigan, 1998). Four unique aspects of the program include:

1) The physician/inmate relationship is maintained upon an inmate's release to the community.
2) Community health center case managers develop an individualized discharge plan for HIV positive inmates that follows them into the community.
3) A full-time discharge nurse provides after care in the community for all seriously or chronically ill patients.
4) The four community health centers contract with a mental health clinic in the community to continue mental health services for released inmates who had received mental health services in the correctional center.

Other key components of the program include inmate health education and an emphasis on providing training opportunities for students in the health sciences (Conklin, Lincoln and Flanigan, 1998).

Incarcerated women represent a population clearly at risk for health problems, including problems that may affect their children and eventually the general public. In addition, many women in the correctional system are caught in a cycle of crime and dependency. The period of confinement presents an opportunity to provide treatment and support that should not be missed. Offering public health assistance and expertise to correctional facilities is an important means for addressing the gaps in services and programs for women in the correctional system. In addition, such efforts will benefit the health of individuals in the communities to which these women return.

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Corrections-related Websites

- **American Correctional Association**
  http://www.corrections.com/aca/index.html/
- **American Correctional Health Services Association**
  http://www.corrections.com/achsa/
- **Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics**
  http://www.albany.edu/sourcebook/
- **Corrections Connections Network**
  http://www.corrections.com/healthnet/index/
- **State departments of corrections and other links**
  http://www.corrections.com/links/state/
- **State-by-state correctional facilities**
  http://www.corrections.com/links/correctionalfacilities/
- **Correctional HIV Consortium**
  http://www.silcom.com/~chc/
- **Family and Corrections Network**
  http://www.fcnetwork.org/
- **Federal Bureau of Prisons**
  http://www.bop.gov/
- **Justice Information Center**
  http://www.ncjrs.org/
- **Mental Health in Corrections Consortium**
  http://www.mhcca.org/
- **National Commission on Correctional Health Care**
  http://www.corrections.com/ncchc/
- **National GAINS Center**
  http://www.prainc.com/gains/
- **Public Health and Corrections**
  http://www.cdc.gov/nchstp/od/cccwg/
- **Substance Abuse and Mental Health Services Administration**
  http://samhsa.gov/
- **U.S. Department of Justice (DOJ)**
  http://www.usdoj.gov/
- **U.S. Department of Justice, Bureau of Justice Statistics**
  http://www.ojp.usdoj.gov/bjs/
- **U.S. Department of Justice, National Institute of Corrections (NIC)**
  http://www.nicic.org/inst/
- **U.S. Department of Justice, National Institute of Justice**
  http://www.ojp.usdoj.gov/nij/
- **U.S. Department of Justice, Office of Justice Programs**
  http://www.ojp.usdoj.gov/home.htm/

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Health Issues Specific to Incarcerated Women:

Information for State Maternal and Child Health Programs

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