U.S. Department of Justice
Federal Bureau of Prisons

Federal Prisons
JOURNAL

VOL. 1 NO. 1 Spring 1987

Special Issue: Focus on the **Female Offender**

Federal Bureau of Prisons Mission Statement

The Federal Bureau of Prisons protects society by confining offenders in the controlled environments of prisons and community-based facilities that are safe, humane, and appropriately secure, and which provide work and other self-improvement opportunities to assist offenders in becoming law-abiding citizens.

Cultural Anchors/Core Values

- ***Bureau family***

The Bureau of Prisons recognizes that staff are the most valuable resource in accomplishing its mission, and is committed to the personal welfare and professional development of each employee. A concept of "Family" is encouraged through healthy, supportive relationships among staff and organization responsiveness to staff needs. The active participation of staff at all levels is essential to the development and accomplishment of organizational objectives.

- ***Sound correctional management***

The Bureau of Prisons maintains effective security and control of its institutions utilizing the least restrictive means necessary. thus providing the essential foundation for sound correctional management programs.

- ***Correctional workers first***

All Bureau of Prisons staff sham a common role as correctional worker, which requires a mutual responsibility for maintaining safe and secure institutions and for modeling society's mainstream values and norms.

- ***Promotes integrity***

The Bureau of Prisons firmly adheres to a set of values that promotes honesty and integrity in the professional efforts of its staff to ensure public confidence in the Bureau's prudent use of its allocated resources.

- ***Recognizes the dignity of all***

Recognizing the inherent dignity of all human beings and their potential for change, the Bureau of Prisons treats inmates fairly and responsively and affords them opportunities for self-improvement to facilitate their successful re-entry into the community. The Bureau further recognizes that offenders are incarcerated as punishment, not for punishment.

- ***Career service orientation***

The Bureau of Prisons is a career-oriented service, which has enjoyed a consistent management philosophy and a continuity of leadership, enabling it to evolve as a stable, professional leader in the field of corrections.

- ***Community relations***

The Bureau of Prisons recognizes and facilitates the integral role of the community in effectuating the Bureau's mission, and works cooperatively with other law enforcement agencies, the courts, and other components of government.

- ***High standards***

The Bureau of Prisons requires high standards of safety, security, sanitation, and discipline, which promote a physically and emotionally sound environment for both staff and inmates.

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VOL. 3, NO. 1 ■ Spring 1992

Federal Prisons JOURNAL

Published quarterly by the
Federal Bureau of Prisons

The Attorney General has determined that the publication of this periodical is necessary in the transaction of the public business required by law of the Department of Justice.

Opinions expressed in this periodical are not necessarily those of the Federal Bureau of Prisons or of the U.S. Department of Justice.

Contributing artists: Bob Dahm, Fred DeVita, Michael Hill, Sherrell Medbery, Tim Teebken.

Cover photo: Foreman Denise Thomas (left) instructs an inmate worker, UNICOR cable factory, Federal Medical Center, Lexington, Kentucky. The factory manufactures cable for the Department of Defense. Photo by Craig Crawford/U.S. Department of Justice Photo Section.

This publication was printed at the UNICOR Print Plant, Federal Correctional Institution, Sandstone, Minnesota.

The *Federal Prisons Journal* welcomes your contributions and letters. Letters may be edited for reasons of space. Please contact:

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From the editor

This issue of the *Federal Prisons Journal* was a long time in planning and production. As we have discovered, there is little available on the subject of female offenders in prison; we hope this issue will not only fill a gap, but stimulate further research and reporting.

Our thanks to the wardens and staff members (and inmates) at four institutions the *Federal Prisons Journal* visited in fall 1991: the Federal Prison Camp, Alderson, West Virginia; the Federal Medical Center, Lexington, West Virginia; the Federal Correctional Institution, Marianna, Florida; and the Metropolitan Detention Center, Los Angeles, California. Our photographers received complete cooperation, and we were able to cover the full range of activities in institutions from minimum to maximum security. Thanks as well to all the contributors from both inside and outside the Federal Bureau of Prisons.

Our next issue will be non-thematic; the issue after that will focus on "management and leadership." We invite short (two-page) contributions from any of our readers, whether or not they work for the Bureau. Please send your submissions to the address listed at the left.

The Female Offender

A prologue

J. Michael Quinlan

Our society, which has periodically wrestled with women's issues, is only beginning to accept as fact that many women function differently, manage work and personal life differently, and communicate differently than men. It is all too likely that the perceived importance of the issues surrounding women in prison will lag behind those affecting women in other sectors of society, but I am hopeful that this special issue of the *Federal Prisons Journal* will help enhance synergy among corrections professonals, who can sharpen the focus on issues relating to women prisoners.

Historically, women offenders have been compared not just to male offenders, but to society's expectations for all women. Whether the woman offender was considered to be "fallen" or overly "liberated," she stood outside the traditional roles of mother and housewife. The criminal justice system was often given the task of bringing her back to "higher standards."

The war on drugs, increasing prison populations, and crowded prisons have again heightened the public interest in corrections. The increasing number of women sentenced to prison, the addicted pregnant offender, and the sad phenomenon of drug-addicted infants have raised public awareness of the female offender.

With the rapidly increasing numbers of female offenders—in June 1992, 7.4 percent of the Federal Bureau of Prisons' total offender population—we have also seen an increase in litigation aimed at forcing "equal treatment" for women. But does equal treatment

really mean treating all inmates the same? Or, rather, does it mean that their needs should be met at the same level as those of the male offender—even if through "different" programs and services?

Our staff, who want to do the right thing and at the same time follow good correctional practices, try to treat women prisoners "the same" as they do incarcerated men. But all too often, despite the great dedication of our staff, even employees with years of experience have trouble working effectively with a female population. Well-meaning staff who have been successful in all-male facilities have used their proven skills in facilities for women and have come away bewildered, wondering: Why is this so difficult?

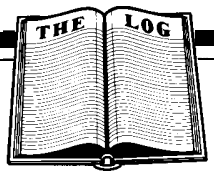
Perhaps this suggests that a change in our approach to the differences between men and women inmates is needed. Gender-specific treatment may suggest "special" treatment to some—and so we fear we may create a monster by attempting to create "special" treatment. Experience tells us that perhaps we need to make changes, but will that force us to make similar changes with male inmates? Will the men ask for the *same* treatment? Will we lose control if what we give the women, we then have to give the men? There are no easy answers to these questions.

In the Bureau of Prisons, we are continuing to examine our programs and services for women. Last year, we sponsored a successful "Issues Forum" on the female offender for correctional policymakers. This special issue of the *Federal Prisons Journal* represents another attempt to examine the spectrum of issues involving women inmates. We hope to raise the awareness of those—both administrators and line staff—in a position to make a difference. I would like to acknowledge the hard work of Ann D. Bartolo, Chief of the Female Offender Section, Correctional Programs Division, and guest editor of this issue, in assembling such a comprehensive and thought-provoking collection of articles.

We are moving toward an enhanced level of focus upon women inmates. Years from now, a new generation of criminal justice administrators will look back on our efforts. If they find a solid foundation to build upon, and a serious attempt to address the issues of the time—our time—we will not only have been leaders for today but will have established a model for the future.

I hope the articles in this issue will increase your awareness and stretch your understanding of the complex issues surrounding female offenders. ■

J. Michael Quinlan is Director of the Federal Bureau of Prisons.



The 5-South Unit at MCC New York

Marcia Baruch

Surrounded by Chinatown, Little Italy, taxicabs, and people traveling back and forth to work is the Metropolitan Correctional Center (MCC) New York—a building comfortably tucked away in the heart of downtown Manhattan. Those who walk past hurriedly see just another co-op—pleasant in appearance with good security. Few are aware that the officers patrolling the building are not protecting the tenants of another apartment building but guarding one of the Federal Bureau of Prisons' "high-rise" detention/correction centers.

About 900 inmates, most of them awaiting trial, live in this building in nine separate housing units—each with its own personality and problems. One of these units is more likely to produce shivers in officers when they are given it as a new assignment. It is not the segregation unit or a unit housing the most dangerous criminals. It is 5-South, a unit with about 120 females—the only female housing unit at MCC New York. During a recent roll call I observed an officer as he was informed that he would be working on 5-South. He handled the news eloquently; he rolled his eyes, put his head down on the table, and groaned to no one in particular, "Oh no!"

Why is 5-South considered to be one of the most difficult units to work on, or just to walk on? We might be able to

Illustrations by Michael Hill

answer that question by answering this one: What is it like to be a female incarcerated at MCC New York?

A typical day for a female on the unit is to wake up, dress, eat, and remain on the unit. Since there is an understandable concern regarding male and female inmates mingling in the prison, the majority rules—males have the privilege of leaving their unit with a pass or reporting to a daily work detail, while females must be escorted, and their movement is limited. While the male inmates can be transferred to another facility at Otisville, New York, that has more activities, females must remain at MCC New York until they are sentenced. This leads to greater restlessness, agitation, and depression. Some say women have a natural capacity to show their emotions more than do men—just as it is okay for them to cry in daily life, it is okay for them to cry in prison. Perhaps a combination of being more confined and more willing to express emotions leads to a unit in which there are more complaints, louder voices, and greater demands on staff.

When a staff member walks into the unit, he or she is hit with a rush of activity and a barrage of languages. 5-South is a microcosm of New York. Not only are there blacks, Hispanics, whites, and Asians, but there are subgroups of each. Hispanics are represented by Colombians, Puerto Ricans, Dominicans, and Cubans. Black groups include Afro-Americans, Nigerians, and a variety of other African groups. There is no culturally mixed unit like this one anywhere else in the Bureau.

This accounts for the immediate cultural and communication barriers—frustrating for the inmates who must live together as well as for staff members who must ensure that the inmates receive proper care. A visitor may be approached by several inmates complaining (in their own languages) of aches, pains, or weight gain due to lack of exercise, and demanding "When can I see my kids?" "When can I get what I need in the commissary?" "Can you get in touch with my lawyer?" "Can you help me?" It is a unit in which the inmates are forceful in their requests, which require extreme patience to understand and respond to.

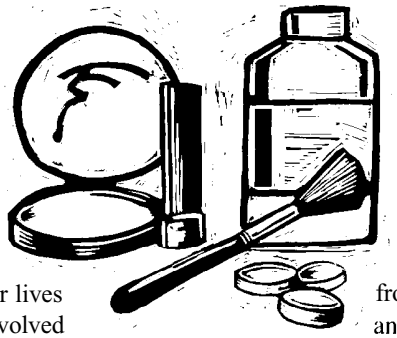
What are most of their requests and complaints about? Where the male inmates seek out counselors on issues regarding phone calls and visiting, according to 5-South's Unit Manager, Katherine Cant, female complaints center around issues such as a lack of

supplies. "They never have enough underwear or uniforms, and the commissary doesn't sell specific feminine items." Ms. Gant also believes that additional staffing is needed on the female unit because more time is necessary to handle the females' problems.

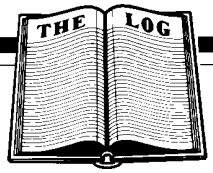
Since MCC New York is a holding facility where the women are taken immediately after arrest, they have not yet made provisions for child care. As many of them are sole caretakers, a typical problem entails attempting to contact child welfare or other appropriate agencies to ensure proper guardianship of a child. Furthermore, a woman who is pregnant needs additional care, attention, and assistance. Whereas a complaint from the male unit generally takes 5 to 10 minutes to handle, a counselor on the female unit may require 30 to 40 minutes to work out just one problem.

The psychology staff also deal with inmates' complaints and concerns and note the differences between those presented by males and females during therapeutic sessions. Generally, males discuss their fears and problems over being incarcerated, perhaps indicating a loss of power and independence. Female inmates talk more about their family, specifically their children and the guilt they feel over leaving them with others. According to Dr. Leslie Knutson, a staff psychologist at MCC New York, "Many of the women discuss the way they were abused in relationships and blame the men in their lives for manipulating them to get involved in illegal situations. They feel they are pawns in their relationships and are compelled to do what their boyfriend or husband tells them to. Their depression becomes more apparent as they verbalize their perceived victimization."

At times their depression is so deep that they have to be placed on a suicide watch (generally, they can be removed from a watch rather quickly since they are verbal about their feelings; the fact that they can vent their emotions leads to a quick resolution of their crisis). This, however, is not the main reason for suicide watches among women at MCC New York. While many suicide watches among men occur almost immediately upon incarceration as a result of their reaction to their arrest, most suicide watches among the women occur after they have been incarcerated for a time. Most of these women have deep psychological problems that are exacerbated by the stress of prison life. In 1990, out of 10 females placed on a suicide watch at MCC New York, 7 had serious psychological problems, such as psychosis, 2 were suffering from severe depression that required antidepressant medication, and 1 suffered from a severe anxiety disorder that produced self-destructive behavior and pseudoseizures. Because of the seriousness of their illnesses, four of these inmates were put on a watch more than once.



The hospital staff are also very familiar with the complaints of the female inmates. According to Douglas Reed, Hospital Administrator, "There is a large number of female medical complaints, most of which center around minor aches and pains, gynecological problems, and sleep disturbance. In fact," states Mr. Reed, "one-quarter of sick call, on a routine basis," is made up of women. Mr. Reed believes that this results from two factors: the women are seeking medical assistance that is not readily available to them outside prison, and are seeking a little extra attention. Unfortunately, this extra attention takes up much of the physician assistants' time—more of their time is spent on 5-South than on any other unit. Furthermore, health care for women is more expensive than that provided for males. The Bureau's hospital facility at Springfield, Missouri, can evaluate the general laboratory work for all inmates but cannot do so for some female tests, which must be sent to more costly local laboratories.



Despite the stress of living on 5-South, many of the women are friendly and talkative. They are helpful to other inmates who are experiencing problems. The women who make up the suicide watch team will express much concern over a troubled inmate and at times continue to watch over her even when the official watch has been terminated. In an attempt to adjust to their isolation and emotional deprivation, some females form symbolic "families" in which they nurture other "family members." Other inmates actually take on the role of mother, father, sister, brother, or child, as well as extended "family" members. This type of role-playing—an unhealthy form of dependency—is unique to female institutions.

Many women take advantage of the programs designed by staff at MCC New York to help them to adjust to their initial time in prison. Women can work in the kitchen during the midnight shift when there is little or no movement in the institution. The education and recreation departments also provide special programs: drama, arts and crafts, English as a Second Language, and exercise. The psychology department has created several women's groups—drug abuse groups, groups for mothers, and a general therapy group. The hospital staff, in an attempt to respond to the increasing needs of the female population, has begun to provide monthly educational sessions on medical issues such as AIDS, breast exams, and a variety of others.

If Shakespeare had seen 5-South he would never have suggested "Frailty, thy name is woman." He would have emphasized the toughness and strength that make these women survivors. Despite their surroundings—Wall Street, the South Street Seaport, and the Brooklyn Bridge—they are living in a confined space and adjusting to a variety of culturally diverse individuals as roommates, possibly for months. Their toughness mirrors that of the officers who must face the daily challenges of this unit. Working on 5-South requires perseverance, patience, creativity, and diligence to maintain order in a potentially turbulent environment.

Marcia Baruch is Chief Psychologist at the Metropolitan Correctional Center, New York.

Community Corrections and Female Offenders

Rita D. Hardy-Thompson

Community Correction Centers (CCC's) are more commonly referred to as "halfway houses." However, these facilities have expanded beyond the traditional halfway house to become a viable sentencing option in their own right. CCC's are used by the Federal Bureau of Prisons in three ways: to provide transitional services for inmates nearing their release date from Federal correctional institutions back into the community (usually the last 30 to 90 days of the incarceration period); as an option for direct commitment of inmates serving relatively short sentences who pose no public risk; and as an additional supervision resource for the courts in some probation and parole cases.

Nationally, the Federal Bureau of Prisons solicits through the competitive bid process (in accordance with the Federal Acquisition Regulations [FAR] and the Competition In Contracting Act [CICA] of 1984) for publicly and privately run CCC's to provide supervision and residential services. These contracting procedures have enabled the Bureau to contract with 198 privately operated facilities and 62 public facilities (operated by State, county, or local governments under Intergovernmental Agreements) by the end of 1991. Of the private facilities, 139 are nonprofit and 59 are for profit. In addition, 350 local and county jails have Intergovernmental Agreements with either the Bureau of Prisons or the U.S. Marshals Service to house Federal offenders.

With the implementation of sentencing guidelines and a trend toward a more conservative approach in the use of community corrections programs for prerelease preparation, the percentage of prerelease inmates in our centers has decreased; however, the number of direct short-term, low-risk commitment and supervision cases has increased.

Women tend to commit less serious crimes and have less serious offense histories than men—and therefore receive shorter sentences; often, direct placement in a CCC is recommended by the court. As of December 1991. there were 4,096 offenders in CCC's nationwide. Of these, 595 were female offenders: 17 percent direct court

commitments, 30 percent supervision cases, and 53 percent institution transfers.

Because there are fewer prison facilities for women, an incarcerated woman is ordinarily placed farther from her home and family—about 160 miles farther than a male inmate, on average. This distance between a female offender and her family often causes transportation problems and deprives the resident and her children of regular visits. The Bureau of Prisons, seeking to increase female offenders' preparedness for release, has begun to develop specialized services and programs for women in CCC's, Research has found that placing increased emphasis, through group and individual counseling, on such areas as self-esteem, parenting skills, substance abuse prevention, and money management, as well as on education and vocational training, will help female inmates return to society as productive citizens.

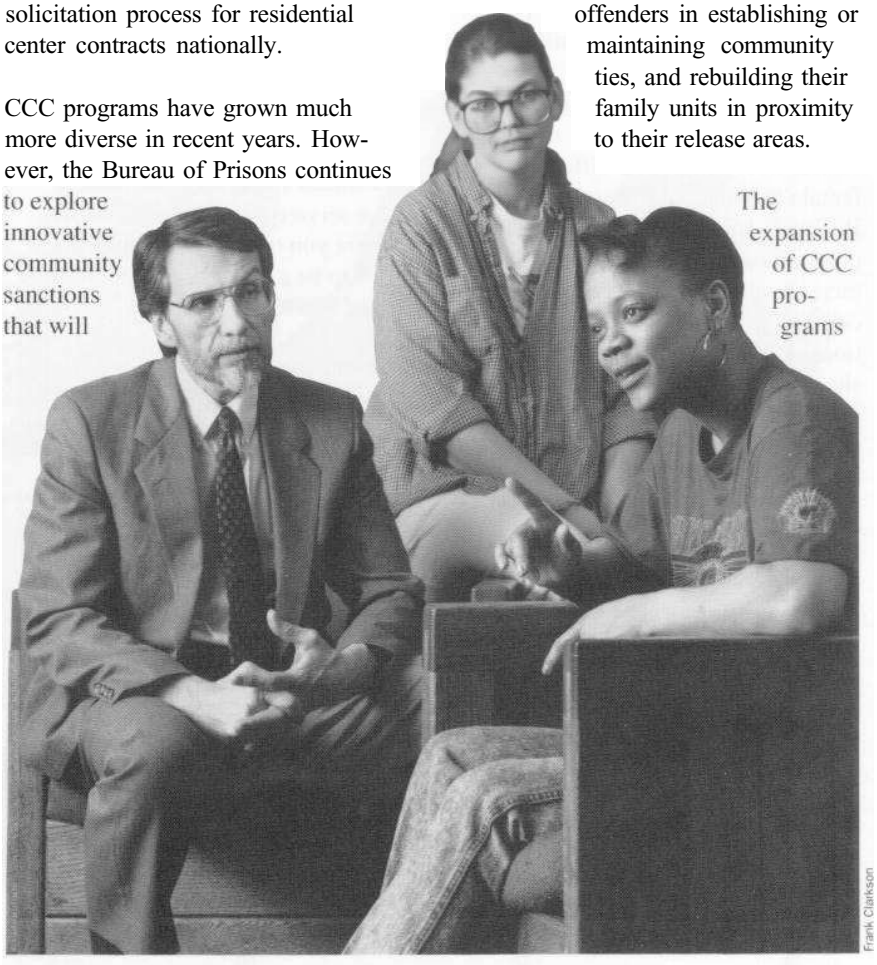
The Bureau has also began to address the needs of pregnant inmates through CCC placements. In February 1990, the Community Corrections Branch initiated a pilot CCC with the Mothers and Infant Together (MINT) program in Texas to provide pre- and postnatal services and programs for pregnant inmates. The success of this program was a major factor in the decision to establish alternative residential programs for pregnant inmates nationally.

Volunteers of America Regional Correctional Center, Minneapolis, Minnesota, operates under contract with the Bureau of Prisons.

In early 1990, the Bureau's Executive Staff approved the establishment of a residential program for pregnant inmates within a 50-mile radius of each correctional institution housing females. A policy statement has since been developed to outline the criteria and procedures for placing inmates in this program. The inmate must be pregnant upon commitment with an expected delivery date prior to release, must have community custody status prior to transfer to a CCC, and must agree to placement and full participation in the program. The Community Corrections Branch has begun the solicitation process for residential center contracts nationally.

CCC programs have grown much more diverse in recent years. However, the Bureau of Prisons continues to explore innovative community sanctions that will enhance release preparation for females. The Community Corrections Branch of the Bureau of Prisons has compiled special guidelines for developing contract facilities that specifically address female offender issues: parenting, substance abuse, career counseling, money management, and so on. The first such contract of this kind is being solicited in the Milwaukee area and is projected to be awarded in 1992. Once this pilot program is operational and its level of success can be determined, the Bureau of Prisons intends to establish this kind of CCC nationwide to assist female offenders in establishing or maintaining community ties, and rebuilding their family units in proximity to their release areas.

The expansion of CCC programs



Frank Clarkson

for both males and females has also meant an increase in the resources devoted to program evaluation. During fiscal year 1991, more than 1,200 onsite inspections were performed at CCC's by Bureau contract oversight specialists. The inclusion of their oversight has enhanced the overall performance of all CCC contract facilities; the information gathered during these evaluations (measuring the degree of compliance with contract requirements—inhouse programming, counseling, staffing, food service, safety, and so on), when analyzed by Bureau researchers, supports the conclusion that there is a need for specialized female CCC's nationwide.

The rate of female offender incarceration is increasing faster than that of males. Recognizing the difference in female and male offenders' needs, the Bureau is continuing to develop special programs and services for females. The increasing acceptance of community corrections as an alterative to traditional imprisonment—as well as the short sentences given most female offenders—warrant the increased attention that the Bureau is giving to community corrections programs for women.

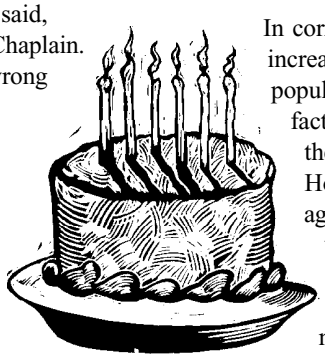
Rita D. Hardy-Thompson is a community corrections specialist with the Federul Bureau of Prisons.

Turning Up the Lights

Angela Church

"Turn up the lights...I don't want to go home in the dark."
—Last words of O. Henry, American short story writer

On a Sunday morning it was announced in chapel services at the Federal Correctional Institution in Lexington, Kentucky, that a Hospice group would be started. The Hispanic inmates, who sat off to the side with an interpreter, giggled nervously and looked at the chaplain as if she had said something a little off center. Later that day, the interpreter stopped the chaplain in Food Service and said, "I want to apologize to you, Chaplain. I translated something very wrong in the service this morning. I thought you told us there was going to be a Hostage group started here."



Thus began the experiences of the Hospice volunteer companions to the terminally ill women incarcerated at Lexington. In a way the translation was not all wrong; the volunteers have "become captive" to the belief that no one should go home in the dark without the light of compassion. Five inmates and four community volunteers have committed their time and talents to meeting the needs of women who are dying in prison.

"We are not different," said Terry Green, Hospice volunteer trainer, "from the group that met in living rooms 15 years ago, when a small group of people gathered to talk about a special kind of caring for the dying. We are alike in many ways—mostly women, probably sitting in a circle, sharing a belief that people should be allowed to die with dignity...."

The Hospice movement was started in 1967 by Dame Cicely Saunders, when she opened the Saint Christopher's Hospice in London. The first Hospice in the United States began in 1974 in New Haven, Connecticut. The movement has committed itself to providing support and care for people in the final stage of terminal disease—believing that, through personalized service and a caring community, patients and families can attain the necessary state of preparation for death.

In corrections, beyond the increases in the overall population, a number of factors have encouraged the development of Hospice programs: the aging of the population, increased sentence lengths, and the growing number of inmates who are medically "at risk," due to serious substance abuse, HIV infection, and other problems.

Recently, one of the Hospice patients, a young woman, celebrated a birthday. Her disease had left her with a childlike nature. She repeatedly told everyone her birthday was coming. The Hospice volunteers planned a surprise party to which the hospital unit would be

invited. Other inmates would play guitar and sing. The nursing staff kept the secret as the young woman went from one to the other saying, "Does anyone know about a party? Did you know my birthday is coming?" Finally the hour arrived. She was invited to visit another patient's room; while they talked, a room was decorated with banners and party favors made by the volunteers. When she was led into the room, her face reflected her joy as her lips moved to the words of "Happy Birthday" being sung by all.

When the volunteers met later to reflect on the celebration, they were moved by the knowledge that this might be this woman's last birthday celebration. "There was a feeling of happiness," said one volunteer, "and there was this insurmountable sadness too. She had a wonderful birthday and I'm glad we had a part in making it special."

Another patient had turned her back to her door and faced the wall. She seemed to have given up. The community volunteer noticed a sack of yarn by her bed; she had ordered it to make a sweater for her husband. "It's no use now," she said, "I know I'm going to die and it'll never be knitted." The volunteer asked if she could do it for her. The woman rolled over to face her—"You would do that for me?" Patterns appeared and the two women put their heads together to choose the right kind of sweater. Much of the work was done by the volunteer in her home, but she often brought the pieces and sat in the woman's room knitting.

When the woman was taken to the local hospital outside the prison, she was close to death. The volunteer came to her one day and roused her. She pulled from a shopping bag a sweater of earth tones. "Finished!" she exclaimed as she touched the woman's arm. With labored breath the patient smiled and said, "Beautiful! Please send it to him and tell him I love him." After she died the sweater was sent from the prison chapel with a note explaining how it was made. By return mail came thanks and a box full of yarn that might be used for others.

It's necessary for Hospice volunteers and staff alike to come to grips with their own mortality and feelings about death. They must learn to understand the stages of death and dying and develop their communication skills, both verbal and nonverbal—especially their listening skills.

A special concern is that professionalism in the

Craig Crawford/DOJ

The author (left), with Hospice volunteers—both inmates and community members. Games are important for the Hospice workers as well as the patients.

correctional setting, and the "distancing" between staff and inmates that it implies, at times makes it difficult for staff to show the compassion they feel. Without a way to express these feelings, staff who have close, prolonged contact with dying inmates risk burnout.

The duties of the Hospice volunteers are varied. They commit to visiting the patient at least twice a week—more if needed. They are on call for emergency situations. They help by writing letters, reading, playing games, and listening. One volunteer gives manicures to help the patients feel better about their appearance. One volunteer arranged to have a photograph taken so a patient could send it to her children. The volunteer was there before the photographer arrived to help the woman fix her appearance for her first picture to be sent home in years.

When a patient would not leave her room her Hospice worker was called by the nursing staff. She lay depressed and saddened that her children were far away—voicing the guilt so many mothers in prison feel: Why should she leave her room when she had been such a failure as a mother? Her Hospice companion was able to listen and respond; before the end of the visit they were walking hand in hand up and down the hospital corridor.

Sometimes, an inmate will be granted a compassionate release to spend her last days at home with her family. Maria was such a woman. The request for her

release had been submitted and she awaited a decision. As she waited, the Hospice workers stood with her; her life sustained by oxygen tubes and the will to see her sister in another country one last time. Volunteers were called repeatedly to sit by her side during the long nights; she would hallucinate and imagine herself home. The volunteers soothed her with the hope that soon she would be with her family.

The compassionate release was granted. A surge of hope caused Maria to draw inner strength. Her hair, makeup, nails, must be done; her sweatsuit must be pressed. The Hospice workers leapt into action. There was joy in the preparation, but the workers also knew they were preparing her for her final journey. When the morning arrived, Maria, a wheelchair, portable oxygen, an entourage of Hospice volunteers, and staff made their way to the sallyport door.

She made the flight to her homeland without incident. When the plane touched down she checked her appearance, then asked the nurse to remove the oxygen tubing; she walked unassisted into the arms of her family. Two months later she died peacefully at home. "When I watched her go through that sallyport door it was as if part of me went with her," said one of the inmate volunteers. "I had been given the great privilege of knowing a woman of strength and faith. Her life touched mine. The facts of compassion I shared with her are small compared to the lessons she taught me."

Death is never easy to deal with. For those in prison it is even more difficult due to their isolation. The Hospice group gives the women in prison an

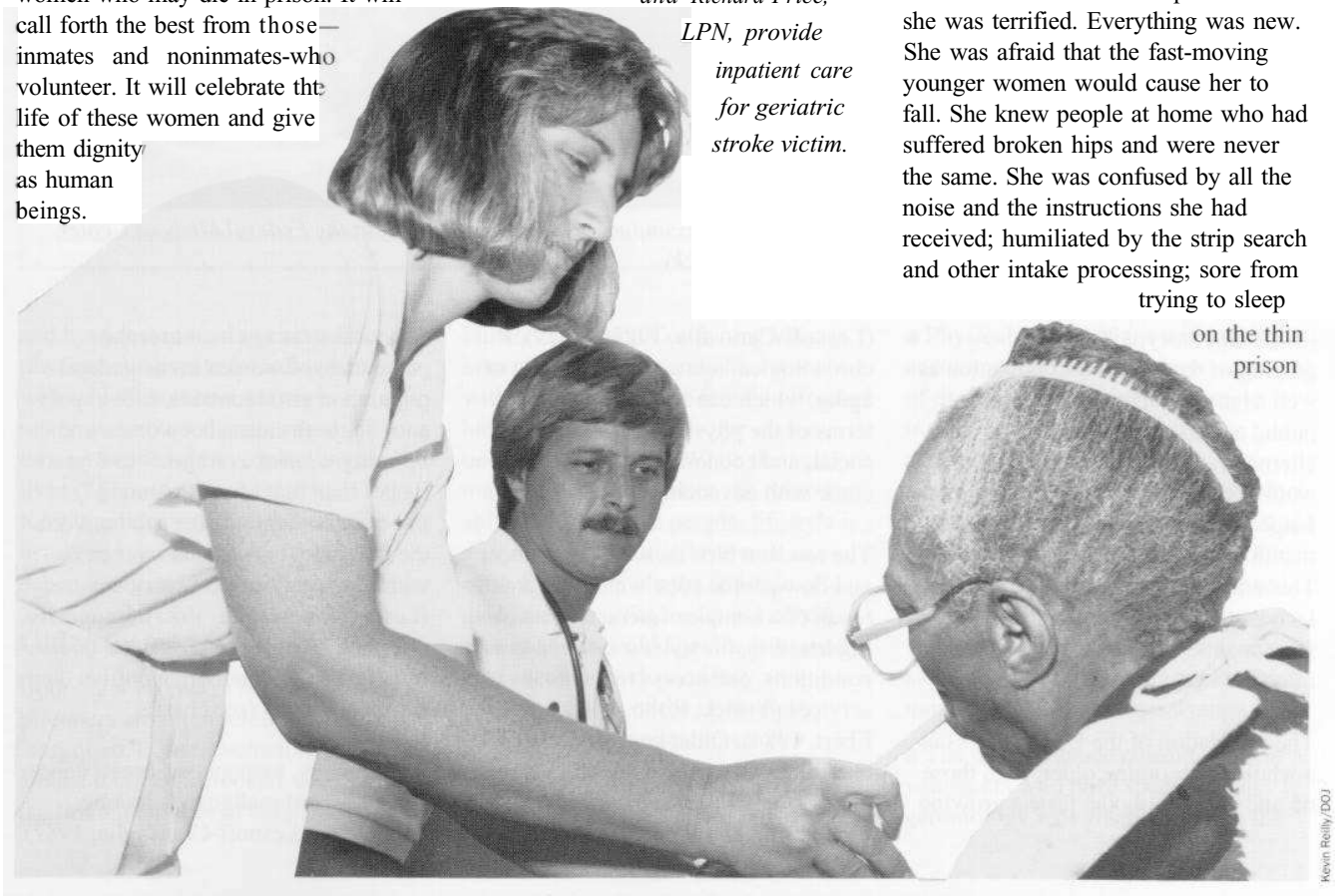
opportunity to say "goodbye" by means of a memorial service. On one occasion 20 white helium-filled balloons representing those who had died were suspended over the altar in the Chapel. At the end of the service 150 women filed into a courtyard in the pouring rain and watched as the balloons were released. The wind and rain threatened to whip them to the ground, but they began to rise, higher and higher, until one woman cried, "Look, they're over the wall! They're free."

The seed of Hospice is taking root at the Federal Correctional Institution in Lexington. As it flourishes it will ensure compassionate concern for women who may die in prison. It will call forth the best from those—inmates and noninmates-who volunteer. It will celebrate the life of these women and give them dignity as human beings. They will not die alone, but will be embraced by a group of caring individuals who bring a commitment to meeting the needs of others.

"I was scared at first," says one of the volunteers, "scared that I would say the wrong thing, do the wrong thing, act the wrong way. But now I look forward to being with these women. They teach me more about life than about death."

Angela Church is a chaplain at the Federal Correctional Institution, Lexington,

Mary Joe Powers, Registered Nurse, and Richard Price, LPN, provide inpatient care for geriatric stroke victim.



Kevin Reilly/DOJ

The Older Female Offender: Suggestions for Correctional Policymakers

Joann B. Morton

Being old, being female, or being an offender can all have negative implications in our society. Combined, they provide challenges for corrections now and in the future. Consider the following:

■ "Annie," 72, a small, frail woman with scraggly white hair, crouched against the wall as a group of boisterous young women came down the hall. This was her first week in prison and she was terrified. Everything was new. She was afraid that the fast-moving younger women would cause her to fall. She knew people at home who had suffered broken hips and were never the same. She was confused by all the noise and the instructions she had received; humiliated by the strip search and other intake processing; sore from trying to sleep on the thin prison

mattress; upset because she had trouble finding her room and had been reprimanded by an officer. Above all, she had an overwhelming dread of dying in this stark, friendless place.

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These two cases illustrate the extremes correctional personnel face in dealing with older female offenders. They do not represent isolated instances. According to a recent study, women 50 years of age and older make up some 4 percent of the female inmates in this country (American Correctional Association [ACA], 1990). In 1990, the number of women 55 and older in State and Federal prisons was less than 1,000 (ACA *Directory, 1991),* but the graying of the American population as well as mandatory sentencing, harsh public attitudes, lack of community alternatives, increasing numbers of women being incarcerated, and the longer lifespan of women will ensure that this number continues to grow. This article will review some relevant facts about aging and women as well as factors to be considered in programming for incarcerated older women.

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The rate at which these changes occur and how people cope with them are the result of a complex interaction involving heredity, lifestyle, socioeconomic conditions, and access to medical services (Yurick, Robb, Spier, and Ebert, 1984). Older people are an extremely diverse group with widely varying needs. Compare the level of functioning of your elderly relatives with other older people you know and you will have some idea of the diversity among older people.

Older women

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- Programming and supervision will have to be individualized to meet the broad range of needs of this diverse group. Individual program planning is particularly critical in prerelease preparation—women's needs vary, as do community resources. Additional lead time will be necessary in prerelease planning for older women, to help with placement in residential facilities for the elderly or in nursing homes, if needed.
- Physical plant designs will need to accommodate persons with a range of disabilities (this applies to male institutions as well). Wheelchair access, color distinctions between floors, walls, and doorframes, comfortable places to sit, and handrails will aid those who have limited mobility. Older women need privacy and quiet space as much as or more than do younger women. Vulnerable older women, such as "Annie," may need protection from more aggressive younger women.
- The use of outside consultants and volunteers who have specialties in gerontology will greatly enhance the

ability of correctional personnel to deal constructively with older women in prison, as well as assist their transition to the community. The network of service providers for the elderly, such as local Councils on Aging, can be invaluable in improving services for older women.

■ Creativity in modifying work and other activities to accommodate the interests, needs, and capabilities of older women will also be necessary. Work and other programs—which are not only critical to feelings of self-worth but also, in many systems, mean time off of one's sentence for participation—must be accessible to the elderly.

■ Internal systems of rewards and punishments must be reevaluated in light of what is effective for older female offenders and their long-term well-being. The use of traditional lockups and loss of privileges may be counterproductive. Yet the "Marys" in this group must be handled as effectively as possible under the circumstances. Flexibility and creativity are essential.

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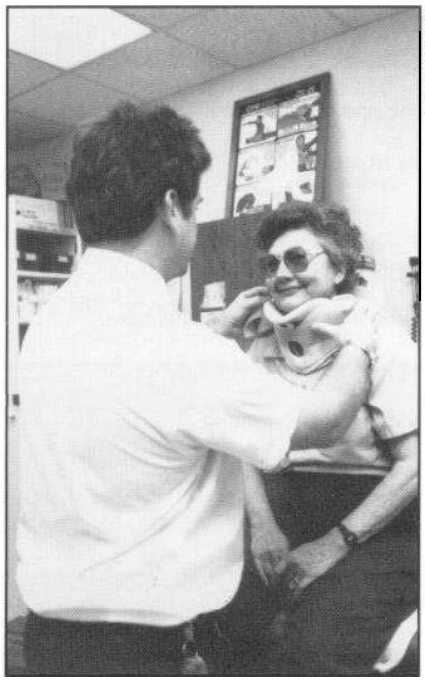
Craig Crawford/DOJ

Physician Assistant Charles Glass (left), Federal Correctional Institution, Marianna, Florida.

■ Issues of loss, including death, also must be considered when working with this age group. Women will need legal assistance with matters such as wills and living wills, as well as spiritual guidance and solace. When a death does occur, it can be traumatic for both staff and other inmates who may have worked closely with the older woman. Counseling, crisis intervention, and closure in the form of a funeral or memorial service can be helpful.

The list above is only a beginning. Older female offenders, even in small numbers, pose many challenges for correctional personnel. Now is the time to start addressing them, as well as considering alternative sanctions or timely release of those who pose no threat to themselves or the community. Acting now may avoid a costly correctional crisis in the future.

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invited. Other inmates would play guitar and sing. The nursing staff kept the secret as the young woman went from one to the other saying, "Does anyone know about a party? Did you know my birthday is coming?" Finally the hour arrived. She was invited to visit another patient's room; while they talked, a room was decorated with banners and party favors made by the volunteers. When she was led into the room, her face reflected her joy as her lips moved to the words of "Happy Birthday" being sung by all.

When the volunteers met later to reflect on the celebration, they were moved by the knowledge that this might be this woman's last birthday celebration. "There was a feeling of happiness," said one volunteer, "and there was this insurmountable sadness too. She had a wonderful birthday and I'm glad we had a part in making it special."

Another patient had turned her back to her door and faced the wall. She seemed to have given up. The community volunteer noticed a sack of yarn by her bed; she had ordered it to make a sweater for her husband. "It's no use now," she said, "I know I'm going to die and it'll never be knitted." The volunteer asked if she could do it for her. The woman rolled over to face her—"You would do that for me?" Patterns appeared and the two women put their heads together to choose the right kind of sweater. Much of the work was done by the volunteer in her home, but she often brought the pieces and sat in the woman's room knitting.

When the woman was taken to the local hospital outside the prison, she was close to death. The volunteer came to her one day and roused her. She pulled from a shopping bag a sweater of earth tones. "Finished!" she exclaimed as she touched the woman's arm. With labored breath the patient smiled and said, "Beautiful! Please send it to him and tell him I love him." After she died the sweater was sent from the prison chapel with a note explaining how it was made. By return mail came thanks and a box full of yarn that might be used for others.

It's necessary for Hospice volunteers and staff alike to come to grips with their own mortality and feelings about death. They must learn to understand the stages of death and dying and develop their communication skills, both verbal and nonverbal—especially their listening skills.

A special concern is that professionalism in the

Craig Crawford/DOJ

The author (left), with Hospice volunteers—both inmates and community members. Games are important for the Hospice workers as well as the patients.

correctional setting, and the "distancing" between staff and inmates that it implies, at times makes it difficult for staff to show the compassion they feel. Without a way to express these feelings, staff who have close, prolonged contact with dying inmates risk burnout.

The duties of the Hospice volunteers are varied. They commit to visiting the patient at least twice a week—more if needed. They are on call for emergency situations. They help by writing letters, reading, playing games, and listening. One volunteer gives manicures to help the patients feel better about their appearance. One volunteer arranged to have a photograph taken so a patient could send it to her children. The volunteer was there before the photographer arrived to help the woman fix her appearance for her first picture to be sent home in years.

When a patient would not leave her room her Hospice worker was called by the nursing staff. She lay depressed and saddened that her children were far away—voicing the guilt so many mothers in prison feel: Why should she leave her room when she had been such a failure as a mother? Her Hospice companion was able to listen and respond; before the end of the visit they were walking hand in hand up and down the hospital corridor.

Sometimes, an inmate will be granted a compassionate release to spend her last days at home with her family. Maria was such a woman. The request for her

release had been submitted and she awaited a decision. As she waited, the Hospice workers stood with her; her life sustained by oxygen tubes and the will to see her sister in another country one last time. Volunteers were called repeatedly to sit by her side during the long nights; she would hallucinate and imagine herself home. The volunteers soothed her with the hope that soon she would be with her family.

The compassionate release was granted. A surge of hope caused Maria to draw inner strength. Her hair, makeup, nails, must be done; her sweatsuit must be pressed. The Hospice workers leapt into action. There was joy in the preparation, but the workers also knew they were preparing her for her final journey. When the morning arrived, Maria, a wheelchair, portable oxygen, an entourage of Hospice volunteers, and staff made their way to the sallyport door.

She made the flight to her homeland without incident. When the plane touched down she checked her appearance, then asked the nurse to remove the oxygen tubing; she walked unassisted into the arms of her family. Two months later she died peacefully at home. "When I watched her go through that sallyport door it was as if part of me went with her," said one of the inmate volunteers. "I had been given the great privilege of knowing a woman of strength and faith. Her life touched mine. The facts of compassion I shared with her are small compared to the lessons she taught me."

Death is never easy to deal with. For those in prison it is even more difficult due to their isolation. The Hospice group gives the women in prison an

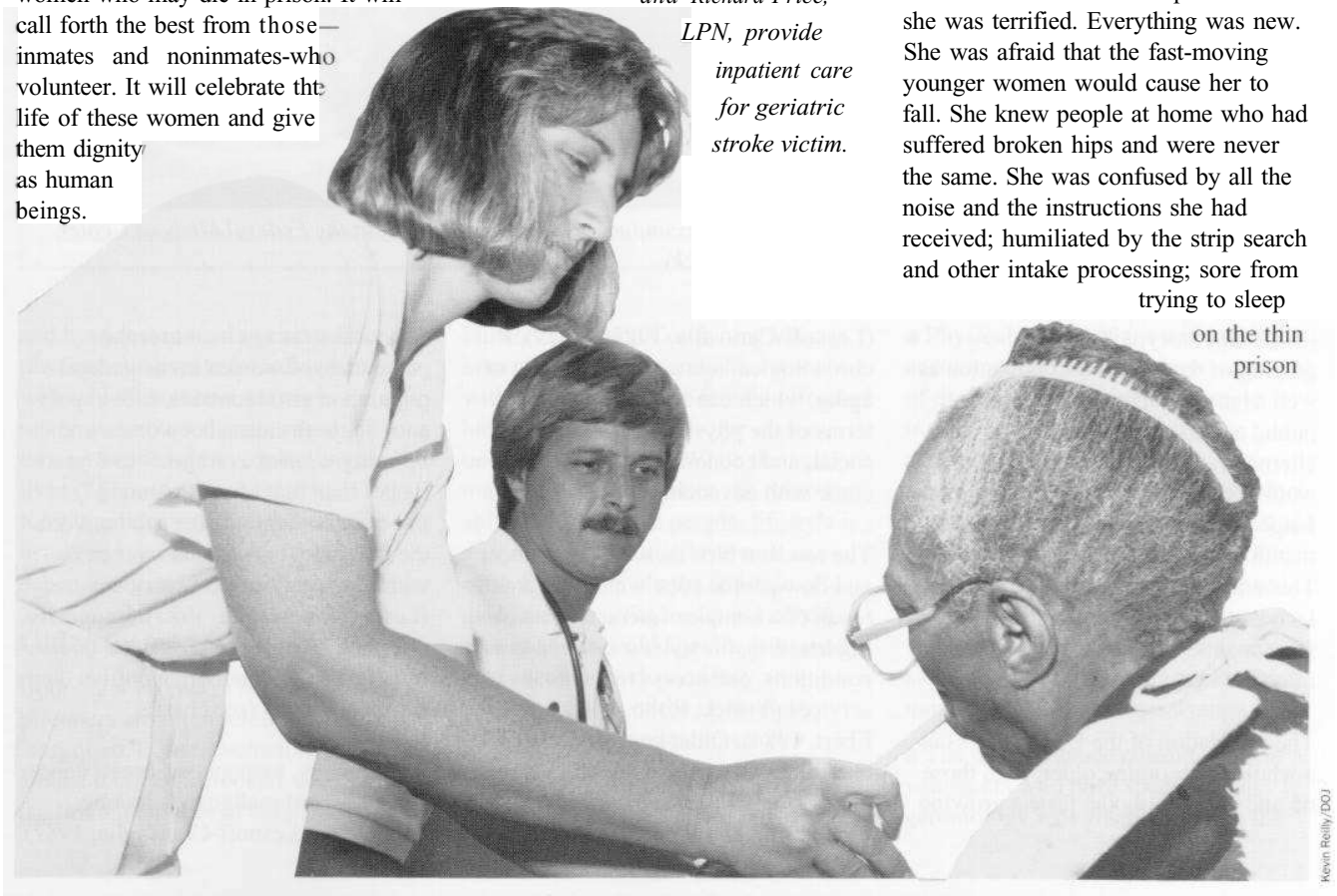
opportunity to say "goodbye" by means of a memorial service. On one occasion 20 white helium-filled balloons representing those who had died were suspended over the altar in the Chapel. At the end of the service 150 women filed into a courtyard in the pouring rain and watched as the balloons were released. The wind and rain threatened to whip them to the ground, but they began to rise, higher and higher, until one woman cried, "Look, they're over the wall! They're free."

The seed of Hospice is taking root at the Federal Correctional Institution in Lexington. As it flourishes it will ensure compassionate concern for women who may die in prison. It will call forth the best from those—inmates and noninmates-who volunteer. It will celebrate the life of these women and give them dignity as human beings. They will not die alone, but will be embraced by a group of caring individuals who bring a commitment to meeting the needs of others.

"I was scared at first," says one of the volunteers, "scared that I would say the wrong thing, do the wrong thing, act the wrong way. But now I look forward to being with these women. They teach me more about life than about death."

Angela Church is a chaplain at the Federal Correctional Institution, Lexington,

Mary Joe Powers, Registered Nurse, and Richard Price, LPN, provide inpatient care for geriatric stroke victim.



Kevin Reilly/DOJ

The Older Female Offender: Suggestions for Correctional Policymakers

Joann B. Morton

Being old, being female, or being an offender can all have negative implications in our society. Combined, they provide challenges for corrections now and in the future. Consider the following:

■ "Annie," 72, a small, frail woman with scraggly white hair, crouched against the wall as a group of boisterous young women came down the hall. This was her first week in prison and she was terrified. Everything was new. She was afraid that the fast-moving younger women would cause her to fall. She knew people at home who had suffered broken hips and were never the same. She was confused by all the noise and the instructions she had received; humiliated by the strip search and other intake processing; sore from trying to sleep on the thin prison

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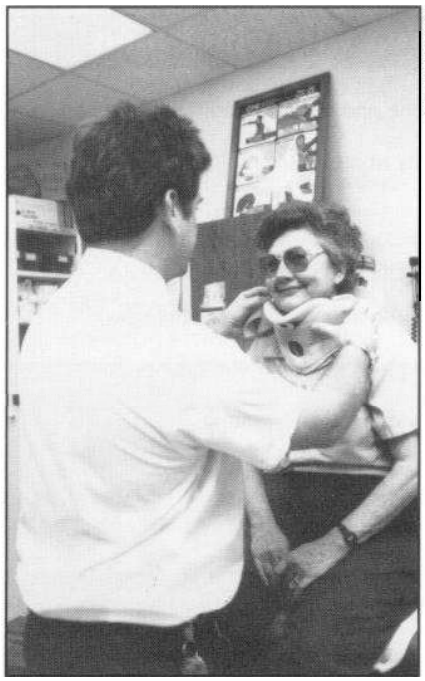
Craig Crawford/DOJ

Physician Assistant Charles Glass (left), Federal Correctional Institution, Marianna, Florida.

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A Journey to Understanding and Change

Ann d'Auteuil Bartolo

I have had a unique opportunity these last 2 years, as Chief of the Female Offender Section, to visit local, State, and Federal facilities housing females, and speak to many practitioners involved in their administration. I have listened to the concerns of dedicated and knowledgeable administrators and line staff, as well as women offenders. By making use of their shared knowledge and experiences, the Bureau has improved programs and services for the women in its custody. I would like to outline briefly some of the areas in which women offenders' needs differ from those of men.

■ One of the most significant differences in the management of male and female inmates involves medical needs. Women have different medical needs and concerns than men, the most obvious being gynecological care. Given the differences in diagnostic procedures, medical care is clearly more expensive and time-consuming for women—and there are the added issues of care for pregnant inmates and placement of newborns. We must train medical staff in female health care by providing orientation and refresher training and hiring staff who specialize in obstetrics and gynecology.

■ Women tend to react differently to their incarceration than men, and thus require different psychological services. The woman offender is more prone to depression—commonly related to separation from her children, guilt over her incarceration, poor self-esteem, and a history of abuse or neglect. A large number of women offenders have a history of alcohol and substance abuse.

It is important that we provide a female-designed therapeutic model within the prison setting that addresses these issues, as well as a community support group that assists women leaving prison.

■ Educational and vocational programs must be staffed and equipped comparably to those in male facilities. Most female offenders are high school dropouts; most have poor employment histories and lack skills that enable them to support themselves and their children. Life skills classes, parenting classes, and "reunification" programs for women prior to their return to the community need to be high priorities.

■ Recreational programs are important tension-relievers at all facilities, but female inmates have different preferences and tend to use different exercise equipment. We must provide orientation and refresher training to recreational staff and hire staff who specialize in female recreation—providing aerobics and exercise classes geared to women's interests, and walking and jogging programs that encourage them to release tension and control their weight.

■ The average female offender is more receptive than the average male offender to programs and services offered by the chaplaincy staff. We must ensure that chaplains assigned to female facilities are open to an all-inclusive spirituality and provide family-oriented services in which women can join with their children in worship.

■ More than 80 percent of women inmates are single parents. The children are ordinarily cared for by the inmate's mother. The construction of facilities reasonably close to where most inmates live will help maintain family ties.

These are a few of the issues surrounding the care and custody of women offenders—a population that is increasing at a faster rate than is the male population. The following articles, written from several different perspectives—the academic community's, corrections professionals', and the women's themselves—do not "solve" these issues, but I believe they will inspire both thought and action. ■

Ann d'Auteuil Bartolo is Chief of the Female Offender Section, Federal Bureau of Prisons, and Guest Editor of this issue of the Federal Prisons Journal.

From *The American Prison From the Beginning...A Pictorial History.*

Equality or Difference?

Nicole Hahn Rafter

Over time, women in U.S. jails and prisons have been incarcerated under enormously varied conditions. However, one question has remained constant: whether these women should be treated like male prisoners or differently.

The current situation is complicated, however, by the growing realization that outwardly "equal" treatment often means less adequate care for women. It does so because the standard is set on male terms that overlook important gender differences. Today, we are seeing a search for new policies that can achieve equality while taking gender differences into account. The chart at right shows broad historical shifts in policies.

First period

Let me clarify some of the problems inherent in the first period's straightforward equal-treatment approach. When the first State prisons were founded at the end of the 18th century, there were (as there are today) many fewer female than male convicts. With only 1, 3, or 10 female prisoners, States had no need for a separate women's institution. They began by operating just one prison or penitentiary to which all felons were sent, regardless of sex. In these early institutions, women were often celled next door to men. Outwardly, they received the same treatment. But this ostensible equality in fact meant more difficult circumstances for women, as three examples will illustrate:

Stages of care governing incarcerated women

- **The first stage** began about 1790, when the very first State prisons were founded, and continued to about 1870. During this period, women were subjected to essentially the same conditions as male inmates.
- **The second period** covered the century from 1870 to 1970, during which the emphasis fell on differential treatment—on providing care designed to meet what were thought to be the special needs of women.
- **The third period** began in 1970 and continues into the present. It has been characterized by a reaction against differential treatment and a swing back toward the idea of equal treatment.

- My first example concerns *isolation.* Alone in a sea of men, the women were surrounded by members of the opposite sex. This created privacy problems, and meant that they were more lonely than their male counterparts. It also made women more vulnerable to sexual exploitation by "guards" and male prisoners.

- A second example, concerning *prison personnel,* also shows how apparent equality created harsher conditions for the few women in these early institutions. All the staff were male—not only the guards but the physicians and chaplains. Visitors from the outside, like the guards on the inside, identified more closely with the male than the female convicts. For visiting physicians and chaplains, as for members of their broader culture, women belonged on a pedestal; thus, if a women "fell," she fell farther than any man, and must consequently be far more depraved. Physicians and chaplains therefore often steered clear of the women, giving more attention to the male convicts.

- My third example concerns *pregnancy and birthing.* If a female convict in one of these early prisons was pregnant, she had to deliver the baby alone, in her cell. Predictably, infant death rates were very high. Male convicts did not have to contend with such problems.

As the decades passed and more female prisoners accumulated, they were removed to separate quarters, perhaps a small cell block in a corner of the prison yard or—toward the middle of the 19th century—to a separate unit just outside the wall. Removal brought some advantages. The women convicts were no longer so isolated from other members of their own sex, and they were less vulnerable to sexual exploitation.

But removal also took a toll. The further the women were located from the center of the prison, the less access they had to whatever opportunities were available to the male convicts, such as medical advice and services, religious services, and opportunities to exercise in the yard. The isolated women's units had no kitchens. Food was carried to them from the men's quarters, often just once a day, usually cold. And if the warden did not hire a matron to supervise the women's quarters, female inmates had no protection from one another. There are records of some wild fights in these early women's units.

In sum, during this first stage in women's prison history, from roughly 1790 to 1870, the policy was to treat female and male convicts alike. But because the norms were set by male officers with reference to the needs of the far larger

number of male convicts, outward equality in fact produced inferior conditions for incarcerated women.

Second period

This situation began to change about 1870, as the ideal of rehabilitating prisoners took hold. Interest grew in reforming female as well as male convicts. However, due to the "separate spheres" doctrine—according to which men are best fit for public work, while women are inherently better at dealing with domestic tasks, children, and other women—the job of reforming female criminals was relegated to other women: middle—class reformers.

This task was welcomed by late 19th-century feminists, who threw themselves into the task of establishing separate women's reformatories. These middle-class feminists succeeded in the often very difficult job of persuading all-male legislatures to fund separate reformatory prisons for women. When the new reformatories opened, these reformers frequently became the administrators.

The reformers established the principle that women in prison must be treated entirely differently than male prisoners. Copying the mode1 of the juvenile reformatory, they built the new women's prisons on the cottage plan. Inmates lived in relatively small "cottages," or individual units, where they could be supervised by motherly matrons.

Programmatically, the new women's reformatories were designed to rehabilitate by inculcating domesticity. While the programs included outdoor work, inmates were mainly trained to sew, cook, and wait on tables. At parole, they

Inmates at work at Alderson in the 1940's.

were sent to positions as domestic servants, where they could be supervised by yet other middle-class women.

In short, the regimen of the first separate penal institutions for women was infantilizing: inmates were treated as wayward children rather than responsible adults who, after release, would have to live independently. The reformers did not face the fact that most of their charges would have to support themselves. Alderson—the first Federal women's prison—was built during this period. Like its State counterparts, Alderson adhered to the principle that women should be treated differently than men.

Differential treatment manifested itself in sentencing practices as well as in architecture and programs. The reformers who founded the State reformatories for women had little interest in dealing with felons—serious offenders who were also often black. The reformers preferred to direct their rehabilitative efforts toward minor offenders with whom they could identify—white women found guilty of misdemeanors or (more frequently) offenses against chastity. The new women's reformatories held these minor offenders on long sentences—terms equivalent to those imposed on felons in the State penitentiaries.

Thus, differential treatment carried its own set of liabilities:

- Women imprisoned in female reformatories were forced into a "true woman" mold of domesticity that infantilized and ill-prepared them for self-support in an industrializing society.
- Moreover, minor female offenders were now held on very long sentences—much longer than those to which male misdemeanants were subjected.
- And, of course, males were never sent to State prisons for violations of chastity. The women's prison system became a means of enforcing the double standard of sexual morality.

Third period

The ideal of differential treatment of male and female prisoners prevailed through the 1960's, a persistence illustrated by a 1960's recommendation that a certain women's prison develop a dairy industry. Milking cows, the formulator of this policy argued, is an excellent activity for women prisoners, since women have a natural affinity for udders!

The women's movement of the late 1960's brought a reaction against such talk, however, and renewed demands for equal treatment of male and female inmates. The tide began to turn against

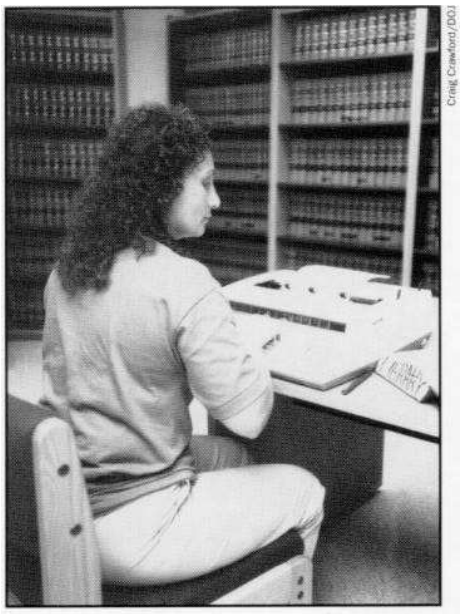
domestic training. Instead, advocates insisted on programs that would prepare released women for real-world jobs and self-support.

Another signal of the shift back to the ideal of equal treatment was a wave of litigation against differential care. For example, in the 1960's female inmates began using the courts to challenge sentencing laws that made them liable to longer terms than men who had similar records and conviction offenses.

We are all familiar with aspects of this drive toward equal treatment. But many people are unaware that it has been accompanied by a growing perception that equal treatment usually means less adequate treatment. Inferior care is the rule because today, as in the first stage, the ideal of equality does not take gender differences into account. Two examples illustrate this new awareness:

■ One concerns *law libraries.* Incarcerated women are finally being given law libraries as adequate as those available to incarcerated men. But because women have no tradition of "jailhouse lawyering," they are less skilled in using legal resources. Thus, several recent court decisions have ordered not only adequate law libraries, but legal training for female prisoners, so that their level of access to the courts will *in fact* equal that of males. These decisions recognize that equality involves parity—actual as well as apparent equivalence.

■ A second, very different, example of the need to recognize gender differences concerns *children.* Unlike incarcerated men, most women in prison leave behind children who are solely dependent on them. Every study of this matter concludes that separation from children



Law library, Federal Correctional Institution, Marianna. Florida.

constitutes the major hardship for incarcerated women. The studies show that separation is also devastating for the children, who must keep in contact with their primary parent if they are not to suffer severe psychological damage. Thus, although male and female prisoners are both separated from their children, this situation affects them differently and has different social consequences.

Beyond the models

Today, the two major historical themes of equal and differential treatment are flowing together. Those involved with planning for female prisoners are trying to deal with both considerations simultaneously.

This confluence signals an awareness that neither approach works well on its own. Outwardly even-handed treatment produces inferior treatment for incarcerated women because the norm is still set by male administrators, working with male needs uppermost in mind. Deliberately differential treatment, alone, also spells inferior treatment, for it reinforces the gender division of labor.

Today, policymakers are seeking ways to go beyond both the equality and difference models. I want to stress "beyond." The move is emphatically not toward merely combining the two approaches, for the result would be to compound their individual disadvantages. Rather, the search is for a way, or ways, to transcend the traditional approaches by developing a new model.

This new model will no doubt borrow the best elements of the two older approaches. But it will also have to find ways of avoiding their inherent drawbacks. As yet we do not know what the new model will look like. We do know that merely extending the older approaches will perpetuate a tradition that began to form on the day the first State prison received its first female convict. That tradition, whether based on the idea of similar treatment or different treatment, has been one of automatically condemning incarcerated women to inferior care. ■

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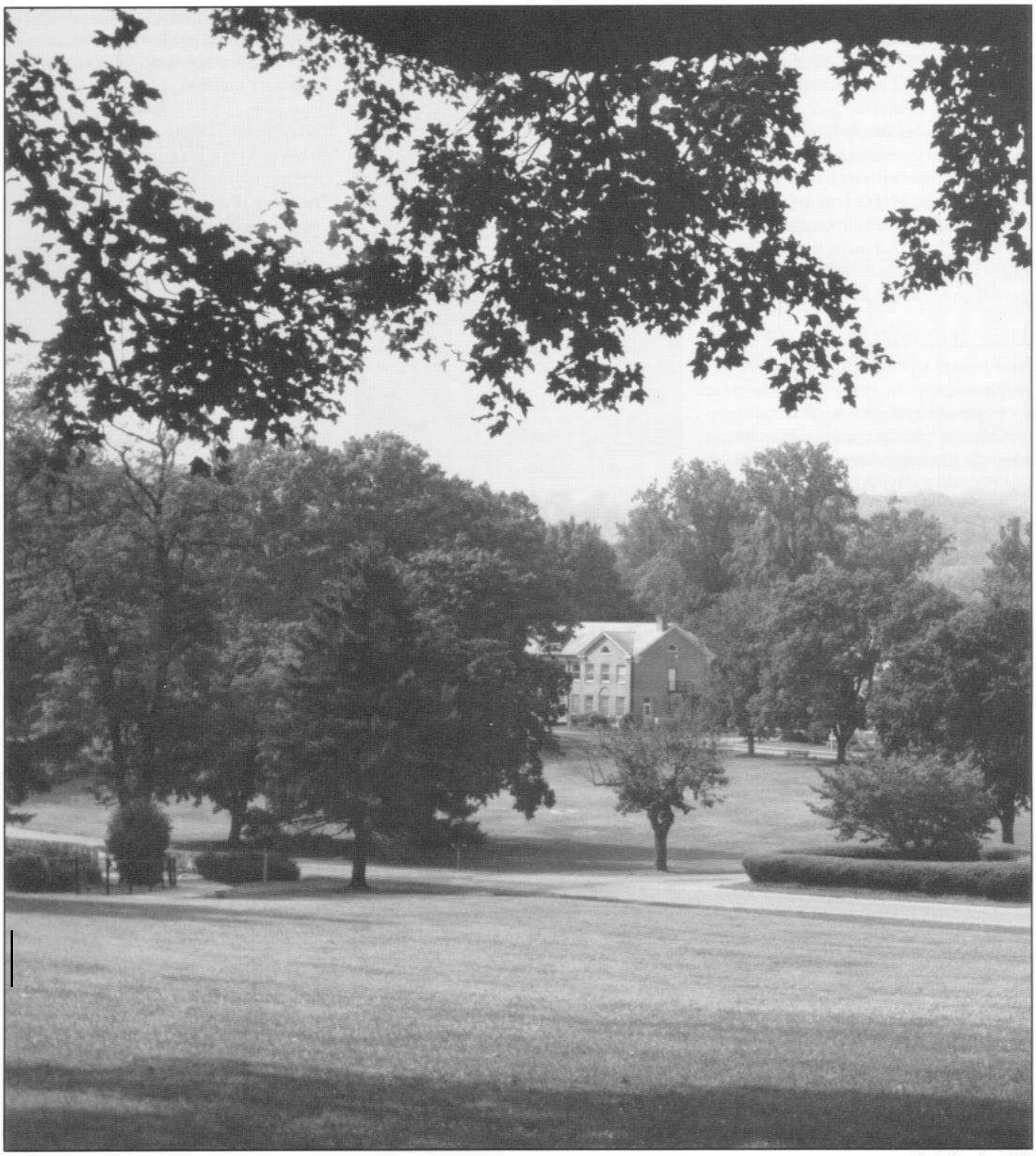


Craig Crawford/DOJ

The Alderson Years

Esther Heffernan

Editor's note: Professor Heffernan's article is an excerpt from a larger work, "Banners. Brothels, and a 'Ladies Seminary': Women and Federal Corrections." first presented at the Conference on the History of Federal Corrections in March 1991. The full paper traces the influence on corrections of the Progressive movement and the struggle for women's suffrage; this excerpt examines the early years of Alderson and the repercussions of that experience on the Bureau's institutions for women through World War II.

James V. Bennett, for 27 years director of the Federal Bureau of Prisons, in his memoirs, begins the chapter "Women Behind Bars" with the statement: "No one has really known what to do with the few women who are condemned to prison, least of all the federal government." He comments later that with the "leniency," "mercy," and "favorable treatment" that women receive in the courts and corrections, he is led "to wonder why the public paid so much attention to such a relatively insignificant sector" of crime and corrections.

The early publications of the Bureau of Prisons reflected that "insignificance." Bureau staff, inmates. and programs were exclusively identified as male, with the few exceptions in which women (3.9 percent of the prisoners in 1930) were designated a "problem." With the creation of the Bureau in 1930, women moved into a new status in Federal corrections.

Alderson, West Virginia, the first Federal institution for women, opened in 1927, predating the founding of the Federal Bureau of Prisons by 3 years. At that time, the few Federal wardens operated largely independently; it was not until several years after the founding of the new agency that directors Sanford Bates and James V. Bennett were able to exercise effective control over the wardens. One of the most independent-minded wardens was Mary Belle Harris of Alderson.

Assistant Attorney General Mabel Walker Willebrandt played an important role in laying the groundwork for the Bureau of Prisons. By the end of her tenure in the Department of Justice, denied the Federal judgeship that she had expected as a reward for her competence, commitment, and loyalty, Willebrandt watched the political influence of women wane and her contributions be attributed to others. In 1929, in response to an editorial recommending that the newly formed Bureau be taken out of her jurisdiction, she wired Attorney General William D. Mitchell:

> I think you owe it to me to make a statement of facts...that it is due solely to my labor and vision that the prison bureau is reclassified into a scientific major bureau.... As a monument to my hard work...a first offender's reform atory has been established at Chillicothe...a modern women's institution established at Alderson...and industries started at Leavenworth...1 can no longer endure the belittling of my part in every accomplishment resulting from years of devoted labor...[and it is] unjust to give you, a newcomer to the whole problem, sole credit and picture me as a danger to prisons.

In turn, in his memoirs, Bennett attributes the passage of appropriations for Alderson to President Calvin Coolidge's recommendation in his State of the Union Address, with no mention of Willebrandt's role.

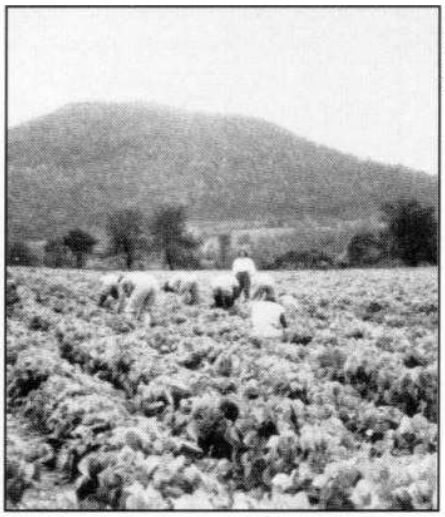
In the critical years from 1925 to 1929, while Willebrandt remained at the Department of Justice and fought for the needed appropriations, Mary Belle Harris developed her "grand experiment" at the new institution at Alderson, West Virginia. At a cost of $2.5 million (with the aid of male prisoners brought from Leavenworth and Atlanta and housed in an adjoining camp), 14 cottages (segregated by race), each containing a kitchen and rooms for about 30 women, were built in a horseshoe pattern on two tiered slopes. Administrative buildings and cottages were named in honor of Katherine B. Davis, Mabel Walker Willebrandt, Ellen Foster, and Elizabeth Fry—all important figures in the history of corrections.

According to Eugenia C. Lekkerkerker, writing in 1931, "it is undoubtedly the largest and best equipped reformatory that exists." However, she voiced some concerns that have a familiar ring to contemporary observers: the heterogeneity of the population—rural South to industrial North, "white and colored, Indian and Mexican, Chinese and Japanese women"; the nature of Federal

offenses, which brought "a large number of drug addicts into the reformatory"; and "the difficulty of contact with the communities from which the women come, with their families and other social relations." Despite the myth that Alderson opened its doors with moonshining women from the hills of West Virginia, in the first year of operation before its formal "opening" on November 14, 1928, 174 women had been sent to Alderson from State prisons and jails, 119 of whom were drug law violators, while only 1.5 had violated prohibition laws. A.H. Conner, in his testimony in 1929, commented that "70 to 80 per cent...were coming suffering from social diseases" so that "we can not use them around the dairy and the kitchens and until they are cured they can not be put at any hard physical labor." Hospitalization rather than industry appeared to be the first need at Alderson.

Mary Belle Harris, in her autobiography *I Knew Them in Prison (1936),* describes the development of an individualized classification system, the institution of inmate self-government with Co-operative Clubs, and her insistence that the "warders" in each cottage be included in decisionmaking and the classification process. Educational classes were begun (segregated by race for the 20 percent "colored"), ranging from English and arithmetic to table service, elementary agriculture, stenography, and typewriting, and capped with Bible study and elementary and advanced Americanization (developed for immigrants, the latter stressed civics and home economics).

Determined that drug addicts were not "hopeless," Harris emphasized the need for withdrawal under medical supervision



National Archives

Farm work was an integral part of life at Alderson during its early decades.

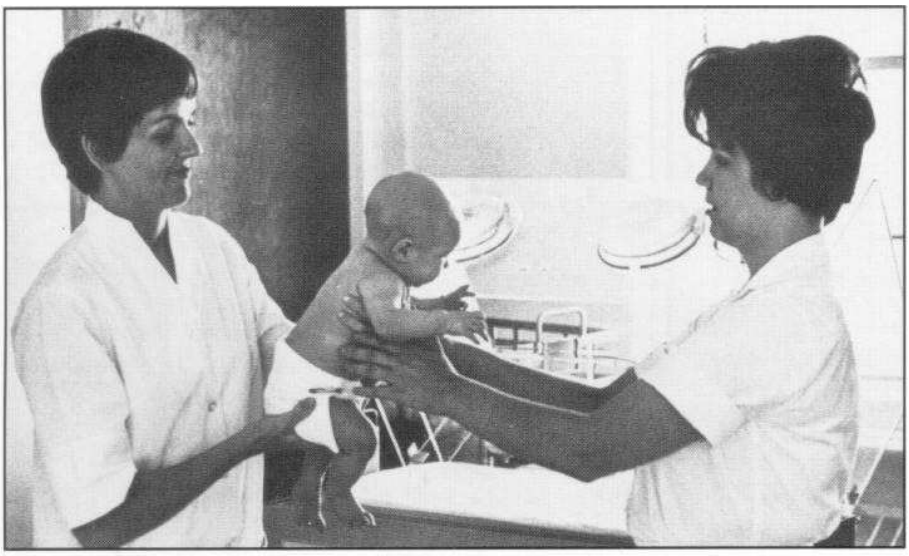
and individualized treatment under the joint watch of the staff and the inmate members of the Co-operative Clubs. Bird and Tree Clubs, pageants and plays, athletic teams, and well-censored movies enlivened leisure hours after the women's work on the farm, on the cottages and grounds, and in Alderson's garment industry. Harris quotes an inmate as saying: "This is the goin'est place I ever saw." With an annual Country Fair, which exhibited the works of the cottages and industries and the wares of the farm, Harris brought the local community, as well as the members of the Advisory Board, into her open institution.

In fact, the "excellent treatment" and the "wonderful buildings" for the women offenders led Representative William F. Kopp in the 1929 hearings (in addition to calling Alderson a "women's seminary") to wonder "whether or not it would rather unfit them for meeting the world—when you send them back to the household duties of ordinary homes...they might lose courage and want to get back to Alderson again." However, Bennett, in his famous 1928 report on "The Federal Penal and Correctional Problem" for the U.S. Bureau of Efficiency (the ancestor of the Office of Management and Budget), described Alderson as "a complete and self-sufficient institution capable of adequately caring for all Federal women prisoners for some years to come." He praised the "modem" facility as representing "the best thought in penological methods."

In Bennett's discussion of the need for specialized Federal institutions for men, he noted that Alderson's cottage plan "permits the individual treatment of women" with "their segregation into groups and cottages, by classes or types." However, he added a cautionary note that became a major point of dispute and a continuing issue in the Bureau: "Will [the Federal Industrial Institution for Women] be able to handle successfully all the women who are committed to it?"

Claudine SchWeber's excellent research on the early history of Alderson summarizes the key issues for a woman's institution after the creation of the Bureau of Prisons:

> After 1930 Alderson's relations to its superiors were characterized by continual conflict from which few areas were immune. In part, the struggle flowed from the Bureau's push to consolidate its authority and to limit institutional autonomy. In part, it flowed from the fact that "in many instances, the only point in the whole system where the [Bureau] met any resistance was at [Alderson]." Most important, the men at the Bureau disagreed with the women of Alderson's contention that as a women's institution it should be



Alderson's nursery during the 1960's, its last years of operation.

> exempt from many policies and practices that had been devised for the largely male inmate population of the system. Whereas Alderson's correctional superiors in the 1920's included a powerful woman, Willebrandt, who agreed with the women-oriented approach, leadership of the Bureau of Prisons during the 1930's was composed of men who did not. Conflict was inevitable.

Ironically, the "women-oriented" approach of Alderson in classification, specialized programs for drug addiction, forms of inmate self-government, unit management, and cottage-style open institutions became the pride of the Bureau of Prisons—but only when they became Bureau policy and were instituted in male institutions. The early introduction of Classification Boards in the Bureau provides an interesting example of the process. In *Federal Offenders 1933-34,* Warden Hill of Lewisburg Penitentiary proudly reports on the new policy that "this is possibly the only prison in the United States where every prisoner who has ever entered it has been required to appear before such a Board." Superintendent Harris (who fought the title of warden until 1937), in her section of the report, notes that at Alderson, where this had been the practice since the opening of the institution, not only does each new commitment come before the Board, but every woman in the institution is reviewed every 3 months! In *Federal Offenders 1935-36,* Harris comments that Alderson's classification process is "shaping its activities to conform with the general classification program of the department."

Interestingly, regarding those aspects of Alderson that were truly "women-oriented"-the cottage-centered kitchens and the presence of a nursery-Harris was either relatively silent or somewhat defensive. In *Federal Offenders 1930-31* she commented:

> A few years ago, there was a sentimental outcry against dooming the inmates of correctional institutions to the drudgery of the kitchen and of domestic service. My experience here and in other institutions has been that most women are greatful [sic] for the opportunity to learn how to keep house well.

She concludes by noting there is a good defense for training women "and men, too, for that matter," in basic household skills.

In her regular reports in *Federal Offenders* from 1930 to 1940 (the last issue to include Warden's Reports), there is no direct mention of the nursery at Alderson, and only an occasional reference to the number of births, three in 1940 and a "birth of triplets to a colored inmate" in May 1937. Nor do her memoirs touch this dimension of Alderson's programs. Lekkerkerker's description of Alderson in 1931 includes mention of a "fine maternity cottage." But only in later Bureau of Prisons descriptions of Alderson (1942 and 1957), where it is noted that "the presence of babies in the cottages adds to the homelike atmosphere," do babies and classes in child care become integral to the perception of Alderson as a "women's institution." However, according to Virginia McLaughlin, Alderson's fifth woman warden, in the late 1940's, Helen Hironimus, Alderson's second warden, accompanied her annual reports with pictures of babies to remind the Central Office that the babies were uncounted "inmates," lost in the cost-accounting of the Bureau. Elizabeth Gurley Flynn, in her inmate's view of Alderson in the 1950's, mentions that the

babies remained in the cottages with their mothers for a few months, a shorter time than a year or two earlier, but that "the parting of mother and child, especially if she faces a long sentence, was heartrending."

In the 1960's, Federal judges were surprised at the number of babies born at Alderson, but were concerned that a difficult pregnancy might mean a 50-mile trip on mountain highways to the nearest specialized hospital. But, according to Virginia McLaughlin, the end of the era came when "two high-powered social workers came down from [the Department of Health, Education and Welfare] and said 'prison is no place for a child'." Between the forces of centralization in the Bureau of Prisons, which had difficulty handling a "woman's institution," and a "child-saving" perspective that included "saving" a child from an inmate mother, Alderson lost its babies.

While Sanford Bates in 1936 described Harris' administration as "one of the outstanding accomplishments of the Federal penal system," Bennett, by 1970, characterized Harris' tenure as one whose aim was to make Alderson "as nearly as possible like an old-fashioned girl's school." Bennett attributed to himself the creation of women's open institutions and experimentation in self-government. Alderson's "remote location" was viewed as "a problem for Sanford Bates and the rest of us" trying "to develop a realistic rehabilitation program for women." Significantly, Harris' effort to demonstrate that women were as capable as men left her vulnerable to Bates' and Bennett's argument that women inmates should be treated "like men."

The laundry was one of the few "industrial" jobs available for Alderson inmates.

The issue was exemplified in the conflict over whether there was a need for a maximum-security Federal facility for women. Harris' description in 1936 of Alderson's "five rooms of reinforced concrete" in the Reception Center and "two small barred cottages" for a possible 48 medium-security women, with accompanying anecdotes on her handling of "resisters and smashers" and "molls," was in reaction to Bates' decision in 1933 that:

> The conviction of a number of women during the past year for serious and desperate crimes or for aiding gangsters and racketeers has made it necessary to provide a special place for their incarceration in an institution of the maximum security type. The Federal Industrial Institution for Women at Alderson was not designed and is not equipped to handle women who are desperate and incorrigible.

Harris argued that, with inmate cooperation and skillful handling by staff, with very few exceptions—when the good of the institution overruled the needs of the woman—Alderson's open institution could handle all commitments. She questioned the assumption in Alderson's enabling legislation that some women were not "reclaimable," and denied the need for a separate facility for "desperate and incorrigible" women. Nevertheless, as Bates describes in his memoirs, in the newly opened Federal Detention Farm at Milan, Michigan, "a small section of the cell block at Milan has been completely sealed off from the rest of the institution and contains twenty-two cells for women." In the *Federal Offender* for 1933-34, Bates notes that "they can be adequately guarded by armed officers and housed in the more traditional type of steel cells" with a "matron and number of warders" to "assist the Superintendent in guarding these women."

In the intervening years, as reported by the warden of Milan in *Federal Offenders 1940,* in addition to the "problem women" the Bureau used the institution for "informers...narcotic addicts, constitutional psychopaths, and homosexuals who were found troublesome elsewhere." In 1936, a transition year from the administration of Sanford Bates to James Bennett, Bennett called for a maximum-security institution for women: "We need to specialize our institutions for women just as been done for men." Citing the fact that Alderson was overcrowded, with more than 200 women boarded out at non-Federal institutions under contract, he mentioned that a new jail was planned for Terminal Island in California, which would accommodate 24 women in a wing of a facility built to house 600 men. Despite his call for specialization, the new maximum-security institution as Bennett described it would house

Left to right: Mrs. Henry Morganthau, wife of the Secretary of the Treasury, Mrs. Eleanor Roosevelt, and Alderson Warden Mary Belle Harris, about 1934.

> ...not only the approximately 250 women who come from western districts at a considerable saving in transportation costs but also accept those most difficult cases originating in other sections of the country...unregenerate keepers of houses of prostitution, gangsters' "molls," and confirmed drug users.

Harris fought back. In her "Report of the Superintendent," following Bennett's "Introduction," she responded:

> It seems that the time has come, which was anticipated when this institution was built, to plan for an institution west of the Mississippi, built like this on the cottage plan...to care for a population of 500, and with cottage facilities for 300 at the outset.

The issue was one of principle:

> I do not believe that a maximum security institution for women is necessary, and I feel that it would be a decided letting down of our standard if such an institution were proposed. I am convinced that we have made a demonstration here which has set a standard for the country, and that it would be considered a set-back if we should depart from the policy so far adopted here and in well conducted state institutions for women.

However, her argument was weakened by her request that the courts select cases for Alderson "in which there is the greatest possibility of reclamation." By implication, the other women would be contracted to the States.

In 1938 Bennett approached the House Appropriations Committee with a request for three new institutions—one a women's facility in the Southwest: "It is an extremely expensive and undesirable situation to be forced to transport these women all the way to Alderson." In 1937, more than 1,267 Federal women offenders had been committed from the courts, with 400 sent to Alderson and the rest to State institutions.

A Congressman inquired whether the new women's institution would "be along the line of the Alderson Reformatory, with cottages?" Bennett replied: "It will be more in line with a maximum-security institution." All of the 25 long-term problem women would be taken out of Milan (where they had no exercise space and little employment) and the "drug-addict population" would be divided between Alderson and the new custodial institution. Bennett admitted that "certain women's organizations feel we are discriminating against women prisoners, because there are no facilities, comparable with the facilities at Lexington and Fort Worth, for handling women addicts."

When the new Federal Reformatory for Women officially opened on October 10, 1940, in Seagoville, Texas, it was an open institution. With a capacity for 400 women, situated on farmland, it was built on a cottage plan similar to that of Alderson. It appears that Harris had won—and Bennett lost. How did it happen?

The records are scanty. A 1958 brochure on Seagoville indicated that the first warden (Helen Hironimus—Harris' long-time friend and assistant) "good-naturedly begged, cajoled, and browbeat her Washington superiors into giving her funds for the progressive development of

its plant." However, it appears that the "great coalition" of Progressive women's clubs that had helped bring Alderson into being may have been rallied again. In *Federal Offenders 1936-37* Harris described the great celebration in May 1937 of the 10th anniversary of Alderson's founding. Key participants in the earlier victory, Mabel Walker Willebrandt and Julia K. Jaffrey, as well as the chair of the Public Welfare Committee of the General Federation of Women's Clubs, gave speeches. Bennett was present. In other "Reports" Harris describes Eleanor Roosevelt's visits and interest in Alderson. There is some indication from the nature of the questions at House Appropriation Hearings that the "heavy artillery" the women's clubs were able to muster had affected members of the Appropriation Committees as well as the Director of the Bureau of Prisons.

By 1941, when 104 women were at Seagoville, the members of the House Appropriations Committee quizzed Bennett on a $5,000 item for fencing—was it to keep cattle or people in? Bennett replied that it was to keep cattle in and people out. The Congressmen appeared somewhat startled to discover that the women were doing the farming: "But they drive the tractors?...They bring home the cows and do all the regular farm work?" Bennett replied in the affirmative.

But the history of Seagoville as a woman's institution was short-lived. In 1941, with the retirement of Mary Belle Harris, Helen Hironimus returned to Alderson as warden. Amy N. Stannard, who had been a member of the Bureau's

The commissary at Alderson, 1940's.

first parole board, moved from assistant to warden. In March 1942, Seagoville became a Federal Detention Station for Japanese, German, and Italian families. Amy Stannard remained as administrator, but the women staff and inmates returned to Alderson, and the Federal Reformatory for Women ended its short career.

Terminal Island's first life as a men's facility with a "wing for women" also came to an end with World War II. In 1940 Bennett reported to the members of the House Appropriations Committee that Milan's "notorious cases" had been transferred to Terminal Island. The removal of the women from Milan brought the number of women at Terminal Island to 56. According to the warden's report in *Federal Offenders 1940,* while vocational training for the men was limited, vocational training for women was "progressing nicely," with all of the women inmates enrolled in "one or more of the following: music, sewing, knitting, dressmaking, weaving, laundry work and nursing."

The next year at the appropriation hearings, a Congressman raised the question: "What was the reason for having women at Terminal Island? Was there any effort to move them to any other place?" Bennett responded: "Yes, sir. We are moving these women to Dallas. We put them at Terminal Island simply because we had no other place to put them." With the closing of Terminal Island and Seagoville in 1942, some of the women were put in non-Federal institutions, and the others joined the women at Alderson.

Fifteen years after its founding, Alderson was once again the only Federal institution for women offenders. Ironically, during World War II, the "ladies seminary" performed the function that during World War I transformed former brothels into Federal detention centers for women. With the passage of the "May Act," patterned after the World War I antivice legislation, as a contribution to the war effort, Alderson became the temporary "home" for several hundred women arrested for prostitution in military areas. In 1945, it was reported that 52 percent of the women committed to Alderson that year suffered from venereal disease. Perhaps the situation can best be described as providing a final twist to the end of an era for women in Federal corrections. ■

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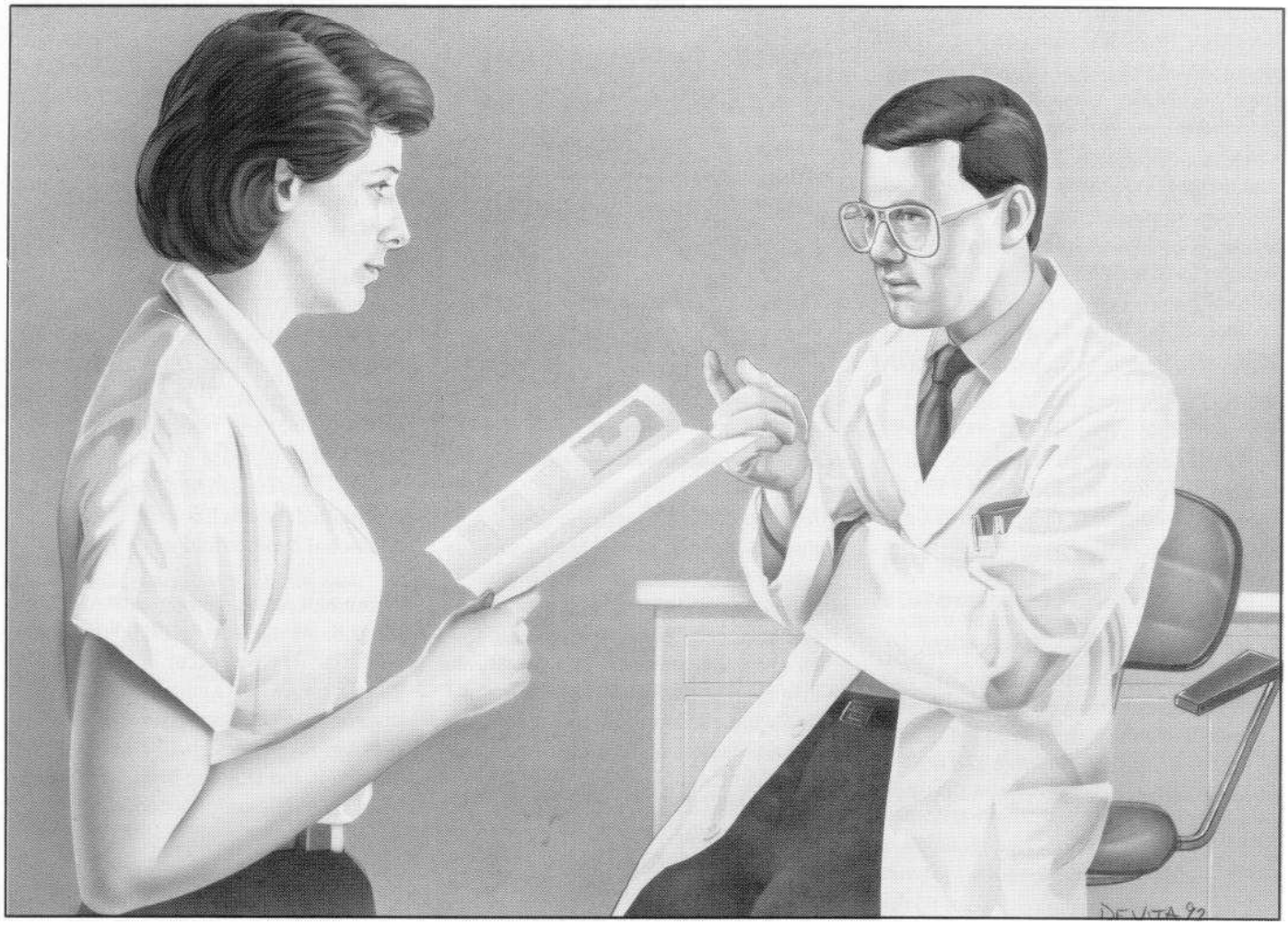
HIV, AIDS, and the Female Offender

W. Travis Lawson, Jr., and Lena Sue Fawkes

In 1990, the number of reported Acquired Immunodeficiency Syndrome (AIDS) cases among women in the U.S. exceeded 15,000, an increase of 34 percent from 1989 and approximately 9 percent of all adult AIDS cases in the U.S. As the AIDS epidemic approaches its second decade, both the number of new infections with HIV (the Human Immunodeficiency Virus that causes the disease) and the number of full-blown cases of AIDS are expected to continue rising sharply for the next few years in the U.S. and worldwide. At least one drug, AZT, may slow the progression of the HIV infection. In addition, there are medications to treat certain opportunistic diseases to which people with AIDS are susceptible.

Nevertheless, the Centers for Disease Control (CDC) estimates that a million Americans are infected with HIV, most of them with no symptoms and no knowledge that they are carriers. Another 7 to 10 million people around the world are also infected, according to estimates by the World Health Organization (WHO). At the end of 1990, more than 150,000 Americans had been diagnosed with AIDS, two-thirds of whom have since died. The CDC estimates that by the end of 1993, 390,000 to 480,000 Americans will have been diagnosed with AIDS—with between 285,000 and 340,000 deaths.

The disease is no longer primarily the affliction of well-defined risk groups, according to the National Research Council. In particular, heterosexual transmission is on the rise: though it still accounts for a relatively small percentage of U.S. cases, it is the predominant mode of spread in most countries. Among



Fred DeVita

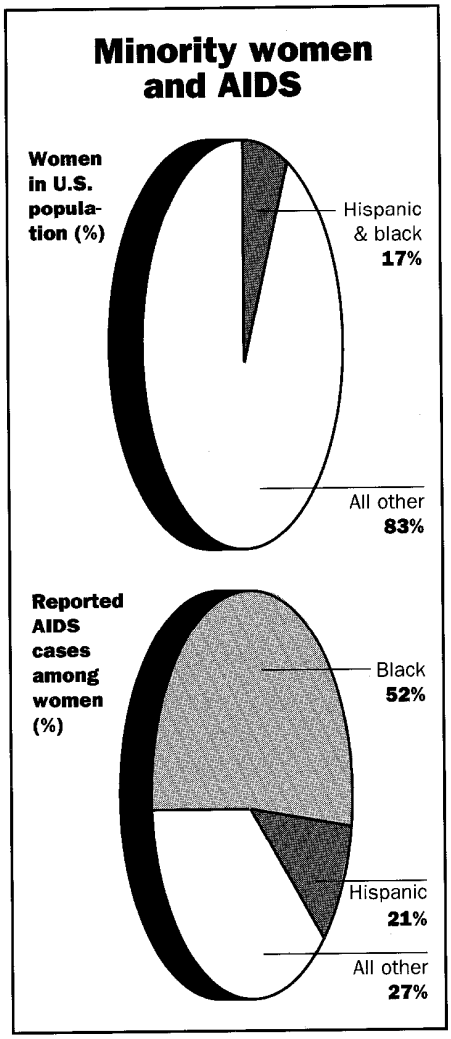
American heterosexuals, sexual partners of IV drug users and people who have multiple partners remain at greatest risk. Some additional facts:

■ By the year 2000, 25 to 40 million people will be infected with HIV internationally, according to projections by the World Health Organization.

■ AIDS is rising sharply among American women, especially poor blacks and Hispanics. The death rate from AIDS among women aged 15 to 44 quadrupled between 1985 and 1988, and undoubtedly will continue to rise. By the year 2000 the number of new cases among women worldwide will begin to equal the number of newly diagnosed men, according to WHO estimates. As of 1990 about 700,000 infected infants had been born worldwide. About 10 million infected infants will have been born by the year 2000, according to WHO data, and there will be millions of uninfected orphans whose parents have died from AIDS. About 6,000 infected American women gave birth in 1989 alone (one-third of babies born to HIV-positive mothers in the United States became infected).

■ AIDS is not just a disease of young people. Those over age 50 account for about 10 percent of all U.S. cases. AIDS-related symptoms are more likely to be misdiagnosed among these older people because doctors may assume that they are not at risk.

■ To identify risk factors for the transmission of HIV from men to women, a European study group analyzed 155 couples recruited from six European countries. Couples were included only if the men were infected first and the women had no risk factors other than an infected partner. Overall, the rate of transmission from men to women was 27 percent. Three independent factors significantly increased the risk of transmission: full-blown AIDS in the men, the practice of anal intercourse, and a history of sexually transmitted disease in the woman. Couples with none of these risk factors had a transmission rate of 7 percent; couples with two or three risk factors had a rate of 67 percent. The authors concluded that the risk of male-to-female transmission of HIV varies considerably and depends on the couple's clinical and behavioral characteristics.



■ Assays of more than 16,000 blood samples collected in health centers at 19 United States universities revealed an HIV seroprevalence rate on campus of 0.2 percent (1 in 500 students)-within the range found in other national surveys. While no HIV infection was found in more than half of the schools, one school had a rate approaching 1 in 100. Seroprevalence increased with age, reaching 1 percent in students over 40, and was 25 times higher in men. Because many students still have misconceptions about the modes of HIV transmission, and because some high-risk behaviors (such as sex with many partners) are common on campus, HIV may spread further in this population.

Epidemiology of HIV infection in women

According to data published by the CDC, as of January 1989, 52 percent of women diagnosed with AIDS in the United States are intravenous drug users: 30 percent were exposed to HIV through heterosexual contact, and 11 percent received HIV-infected blood or blood products. The transmission category for the remaining 7 percent is "undetermined." A significant trend noted between 1982 and 1986, however, is the hundredfold increase in the percentage of female cases classified as heterosexually transmitted, which has increased an additional hundredfold since 1986.

About half of the women with AIDS in the U.S. are aged 30 to 39; 90 percent of adult female cases occur in women aged 20 to 50. CDC data underscore HIV's disproportionate impact on minority populations. Although 17 percent of all women in the U.S. are black or Hispanic, blacks and Hispanics account for 73

percent (52 percent and 21 percent, respectively) of reported AIDS cases among women. This number reflects the prevalence of intravenous drug use in some black and Hispanic communities, particularly on the east coast. Although most States have reported adult female AIDS cases to the CDC, more than half of these cases have been reported from the northeastern States—half in New York alone.

Fifty-nine percent of women with AIDS reported to the CDC have subsequently died, compared to 50 percent of men. AIDS has a significant impact on mortality patterns for women in areas where HIV infection is common; it has now become the leading cause of death for women aged 30 to 34 in New York City.

The virus that causes AIDS may be more common among prison and jail inmates, especially women, than previously thought, according to a study based on testing of nearly 11,000 inmates entering 10 prisons and jails between mid-1988 and mid-1989. The study, conducted by the Johns Hopkins School of Public Health and the Centers for Disease Control, found that rates of HIV infection ranged from 2.1 to 7.6 percent for male inmates, and from 2.5 to 14.7 percent among females.*

*Earlier studies indicated HIV infection rates as high as 17.4 percent among inmates from the New York City area, but far lower rates elsewhere. The names of the prisons and jails in the more recent study were not released, but were said to represent all areas of the country. The findings were reported in the *Journal of the American Medical Association.*

At 9 of the 10 correctional facilities, women had higher rates of HIV infection than men. The difference was greatest among prisoners under age 25, with 5.2 percent of women in that age group testing positive, compared with 2.3 percent of the men. Minority groups also had higher rates of infection: 4.8 percent overall, compared to 2.5 percent of white inmates. No major difference in HIV infection rates was found between prisons and jails.

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In April 1992, 12 percent of HIV-positive inmates in the Federal Bureau of Prisons were women. However, the rate of infection among women was higher—1.52 percent, versus .9 percent for males.

Transmission during pregnancy

The vast majority of adults with HIV infection are in their reproductive years. According to CDC data, the risk factor for about 78 percent of the children who have AIDS in the U.S. is a parent with AIDS or in an AIDS risk group.

It is assumed that these children were born to infected mothers and were infected themselves during the perinatal period. (While the exact methods of perinatal transmission remain unknown, both transplacental and postpartum transmission have been suggested by case reports.) The relative risk of HIV infection to the fetus of an infected woman is not known. In an early study of infected mothers who had previously delivered infants who developed AIDS, 57 percent (6 of 14) of babies born subsequently were also infected. In contrast, no babies born to women impregnated by artificial insemination showed evidence of HIV infection after 1 year of followup. (Because these were small studies, it is important to emphasize that the risk estimates are varied and uncertain.)

At this time, outcomes for the newborn cannot be predicted by the clinical status of the mother during pregnancy. Infected babies have been born to women who are HIV-positive but have not developed symptoms, as well as to mothers with AIDS. A mother with AIDS can also deliver a baby with no evidence of disease. Transmission from an infected woman to older children or to other household members who are not her sexual partners has never been documented.

HIV infection and AIDS in correctional facilities

While the crisis atmosphere surrounding AIDS in prisons and jails seems to have dissipated, the disease remains a serious issue for correctional administrators. Concern has shifted significantly from short-term matters such as fear of casual transmission to "long-haul" issues such as housing, programming, and medical care for prisoners who have HIV infection.

As the population ages, and as determinate sentencing and strict sentencing guidelines continue, inmates will age within our facilities. We will see more and more women of childbearing age who are infected. The historic differences between the Federal offender versus offenders within State, city, or county systems have become blurred by the issue of drug trafficking. These offenders tend to be less well educated, predominantly urban, and from depressed socioeconomic backgrounds. The frequent victimization of female offenders also increases the risk for heterosexual disease transmission.

Although during its first appearance within the correctional setting, AIDS victims were predominantly white homosexual or bisexual males, heterosexuals and minorities are being infected in increasing numbers. In society, the disease currently has a greater impact on the IV drug user population than on the homosexual community. In the Bureau of Prisons, a considerable percentage of present and future inmates will come from backgrounds of IV drug use, or will have had intimate contact with IV drug users.

Although current data suggest a roughly 1-percent seropositive rate of HIV infection (a composite infection rate, slightly less for males and slightly more for females, using current Bureau monitoring standards), this still exceeds the estimated seroprevalence within the at-large population of .005 percent.

Evaluation

Intravenous drug users in treatment programs and those who have the physical signs of IV drug use are at risk for HIV infection. Other women at risk, however, are not so easily identified. A comprehensive patient history will help identify some women at risk. Appropriate questions can be inserted into the social, sexual, and medical portions of the history. These sensitive matters may then be documented in a way that maximizes confidentiality.

Some symptoms of HIV infection are similar to those commonly seen in problem pregnancies—fatigue, anorexia, weight loss, and shortness of breath. Health care workers caring for pregnant women in HIV risk groups must assess these women carefully for signs of HIV infection.

1 "Have you ever been tested for antibodies to AIDS virus? If so, what was the result of your test? When and why were you tested?"

2 "Since the late 1970's, have you ever injected drugs into your body with a needle? If yes, have you shared needles with other people?" If a woman is or has been an IV drug user, a history of the type of drugs used and the extent of drug use and needle sharing should be obtained.

3 "Since 1979, have you ever had sexual relations with a person at risk for AIDS—someone who injects drugs, a gay or bisexual man, a hemophiliac, or a person from Haiti or Central Africa?" If yes, further history should be taken on the clinical status of the person at risk, the type of sexual activity involved, the duration of the relationship, and the use and type of contraception.

4 "Have you had any anonymous sexual partners or partners that you did not know well who may possibly have been in AIDS risk groups?" Many women do not know the risk status of all their sexual partners. The question is most relevant if the patient lives where HIV infection is common.

5 "Have you tried to become pregnant through artificial insemination since the late 1970's? If yes, where?" Again, this question is most relevant if the patient lives where HIV infection is common.

6 "Have you received a transfusion of blood or blood products since 1979?" If yes, ask when, where, and how much blood. The risk is higher if a woman received transfusion before 1985 in an area where HIV was common.

7 When applicable, "are you from Haiti or Central Africa?"

8 "Is there any other reason why you think you might be at risk of exposure to HIV?" This question may lead to the patient's revealing an additional possible risk factor, such as providing health care to people with AIDS or HIV infection. The question also gives the woman a chance to express her fears about AIDS so that the health care worker can evaluate her needs for information.

Even when such histories are taken, not all women at risk will be identified. Many women are unaware of the drug use or unsafe sexual activities of their current or past sexual partners.

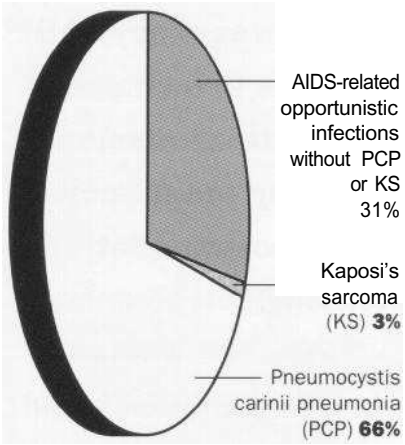
Clinical issues

The signs and symptoms of HIV infection are the same for women as for men, with one notable exception: women rarely develop Kaposi's sarcoma (KS), the most common AIDS-related malignancy. Women with AIDS most frequently develop pneumocystis carinii pneumonia (PCP), the most common AIDS-related opportunistic infection. Sixty-six percent of women diagnosed with AIDS as of October 1988 had PCP as their initial diagnosis; 3 percent had KS as their initial diagnosis. The remaining 31 percent had other AIDS-related opportunistic infections without PCP or KS.

Few studies have been published on aspects of HIV infection that may be unique to women. However, some studies have revealed a high percentage of women with gynecological disorders as well as very high maternal morbidity and mortality rates. Whether these findings were related to HIV infection or to other patient characteristics (such as IV drug abuse and poverty) has not been adequately addressed. Another study reported that women with clinical manifestations of HIV infection had a greater tendency to be inaccurately diagnosed, despite numerous medical evaluations; given the preponderance of infected males, HIV infection in females had simply not been deemed statistically relevant until recently.

HIV infections

Initial diagnoses among women, October 1988



The signs and symptoms of HIV infection are the same for women as for men, with one notable exception: Women rarely develop Kaposi's sarcoma (KS), the most common AIDS-related malignancy.

Pregnancy, which is associated with changes in cellular immunity, may affect both the natural history of HIV infection and the development of AIDS-related disease. One study followed 15 HIV-positive women, asymptomatic at childbirth, for 30 months after their deliveries. During the follow-up period, five of these women developed AIDS, seven developed related symptoms, and only three remained asymptomatic. Still, while there remains a theoretical risk that pregnancy could accelerate progression of HIV disease, controlled studies following both pregnant and non-pregnant seropositive women are needed to answer the question.

A number of case reports discuss women who develop AIDS-related opportunistic infections while pregnant. These women's diseases progressed rapidly; they died within weeks of diagnosis. Some symptoms of HIV infection are similar to those commonly seen in problem pregnancies—fatigue, anorexia, weight loss, and shortness of breath. Health care workers caring for pregnant women in HIV risk groups must assess these women carefully for signs of HIV infection.

Counseling women with HIV infection

Counseling issues differ for women depending on whether they are uninfected but at risk for HIV infection, seropositive but asymptomatic, or have symptomatic HIV infection or AIDS.

- Women at risk should be counseled on how HIV is transmitted and how to avoid or minimize their exposures. Programs designed to meet the needs of women at risk who are or may become pregnant should make the HIV antibody test understandable and readily available. The CDC recommends antibody testing for women at high risk but emphasizes that many women are unaware of their risks. The most important part of any such program is identifying women at risk and educating them to prevent exposure to (and transmission of) HIV infection. The best way to prevent transmission of HIV to infants is to prevent its transmission to women.

- The concerns expressed most frequently by seropositive women are fear of becoming ill; fear of transmitting HIV to their sexual partners and children; difficulty in communicating with potential sexual partners and in remaining sexually active; and not being able to bear children for fear they will become infected.

The CDC recommends that seropositive women avoid pregnancy until more is known about HIV transmission during pregnancy. This recommendation is often difficult to accept. Childbearing is a life goal for many women; the potential loss of that option can be devastating. Even more difficult is the situation of a woman who is already pregnant and then learns that she is infected with HIV. Although transmission to the infant is neither inevitable nor predictable, its likelihood is high. Infected women in late pregnancy and those in early pregnancy who do not elect to have an abortion will need extensive counseling and support.

■ The issues that women who have symptomatic HIV infection and AIDS must deal with overlap those of asymptomatic seropositives and women at risk. Fear of transmitting HIV to others is a major concern. Unlike women in the other groups, those who have symptomatic HIV infection and AIDS must deal with grief over the loss of their previous body image, sexual freedom, and potential for childbearing. They must also come to grips with the imminent loss of their own lives. Grief and other emotions triggered by an ARC or AIDS diagnosis can be profound.

Women who have symptomatic HIV infection and AIDS experience a unique social isolation. Although women were among the first persons diagnosed with AIDS, they are still not widely perceived as at risk for AIDS, which is seen as a "man's disease." Moreover, women with AIDS are a diverse group with no parallel community to look to for support, as gay men can. Very few programs have services designed for women with AIDS.

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For some women, being diagnosed with symptomatic HIV disease or AIDS is the first indication that their sexual partners are infected and that these partners are therefore probably IV drug users or bisexuals. The anger and sense of betrayal add to the emotional crisis provoked by the diagnosis.

Because most women with severe HIV disease are in their childbearing years, many already have children. A major concern of such women is care for their children if they become disabled or die. Many infected women are also poor and have had to deal with the problems associated with poverty—inadequate housing, poor nutrition, lack of health care and child care—long before their diagnosis. All of these problems are exacerbated by the diagnosis.

Women who have symptomatic HIV disease and AIDS are often part of households already dealing with the disease: their children and sexual partners may be infected. When AIDS affects an entire family, the psychosocial needs are extensive.

AIDS is a complex, challenging, and tragic issue. It is even more challenging for incarcerated women. The HIV epidemic will continue to influence the custodial and medical missions in correctional facilities for the foreseeable future. This mandates that the correctional system stay abreast of developments in this area. National population projections over the next 10 years notwithstanding, correctional populations will continue to rise. The demographics of those at risk tell us that AIDS will be a significant part of correctional medicine through the coming decade. ■

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A Profile of Female Offenders in the Federal Bureau of Prisons

Sue Kline

In the decade 1981-91, the number of females in Bureau of Prisons custody steadily increased. In 1981, slightly more than 1,400 women were held in Bureau facilities. By 1991, women inmates numbered more than 5,000, representing a 254-percent increase during the 10-year period. The rate of growth for males during the same period was 147 percent, from 24,780 in 1981 to 61,208 in 1991. In June 1992, the Bureau held 5,103 females in its facilities—7.4 percent of the 68,779 inmates then being housed.

The female prison population grew at a faster rate than the male population in 7 of the 10 years between 1981 and 1991. While the number of female inmates has been increasing, the proportion of the population they represent has also been on the rise. In 1981, females made up 5.4 percent of the Bureau's inmate population. By 1991, they represented 7.6 percent of the inmates. By comparison, in State prison populations, the proportion of women in 1991 was 5.6 percent.[1]

The 5,103 women in Bureau custody in June 1992 were housed in 13 facilities—6 of which were all-female facilities, while the other 7 included both male and female units, primarily in detention facilities. The largest all-female facility is the Federal Medical Center, Lexington, Kentucky, the primary medical center for female inmates, where more than 1,800 women (36 percent of all females) are held. The next largest all-female facility is the Federal Prison Camp, Alderson, West Virginia, cur-

Recreation area, Metropolitan Detention Center, Los Angeles, California.

Kevin Reilly/DOJ

rently housing 809 females, or 15.2 percent of the female population. Alderson was the first institution for Federal female offenders; it opened in 1927 as the Federal Reformatory for Women.

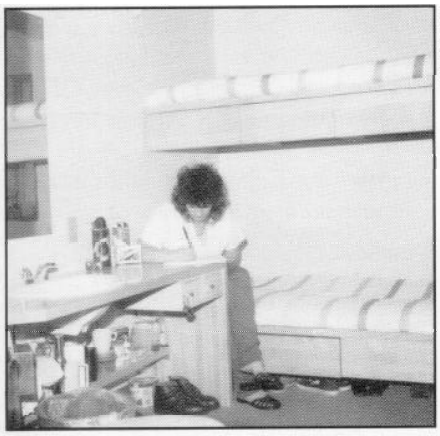
In 1991, almost 64 percent of females were serving time on a drug-related offense—most commonly for the manufacture or distribution of illegal drugs. The next most common identifiable offenses were property offenses such as larceny or theft (6.3 percent), and extortion, bribery, or fraud offenses (6.2 percent). The offense type of today's female offender differs from that of the female offender of 10 years ago. In 1981, the largest number of women were being held for property offenses (28.2 percent).

The next most common identifiable offenses in 1981 were drug offenses (26.0 percent), robbery (11.8 percent), and white-collar offenses (7.6 percent).

The offense profile of males in 1991 shows that the majority of them (55.8 percent) were also being held for drug offenses. The next most common identifiable offense for men was robbery (12.2 percent). The male population also saw a decrease in the proportion of robbery, property, white-collar, and immigration offenders between 1981 and 1991. Both males and females showed increases in the proportion of drug offenders, and a small increase in the proportion of arms, explosives, courts and corrections, and national security offenses.

The latest offense-specific information for females housed in State institutions shows them most likely to be housed for a property or violent offense (81.9 percent). These 1986 figures from the Bureau of Justice Statistics (BJS) show that only 12 percent of women housed in State facilities were there for a drug-related offense.[2]

The female population housed in BOP facilities as of June 1992 had characteristics similar to the male. The majority of inmates were white and not of Hispanic origin. The distribution of ages was similar for males and females, the average age for males (37.3) being slightly higher than that for females (36). The latest figures from BJS show that State inmates are noticeably younger



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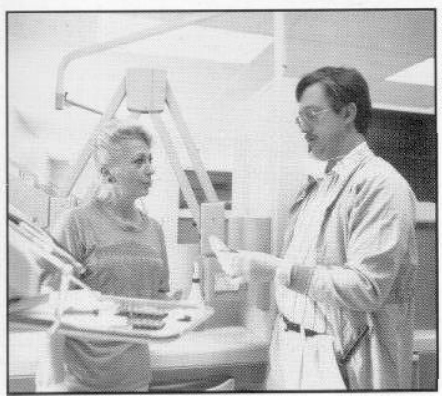

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Federal prison population

	Female	Male	% Female
1981	1,415	24,780	5.4
1982	1,519	26,614	5.4
1983	1,722	28,492	5.7
1984	1,842	30,475	5.7
1985	2,183	33,859	6.1
1986	2,741	38,771	6.6
1987	3,058	41,911	6.8
1988	2,949	41,730	6.6
1989	3,635	48,213	7.0
1990	4,263	55,025	7.2
1991	5,006	61,208	7.6
June '92	5,103	63,676	7.4

Data for 1981-1991 are for September of each year.

Offense of inmates by sex (%)

	1981		1991	
	Female	Male	Female	Male
Drug offenses	26.0	26.3	63.9	55.8
Robbery	11.8	24.2	4.4	12.2
Property offenses	28.2	14.9	6.3	4.5
Extortion, bribery, fraud	5.1	5.2	6.2	4.9
Violent offenses	7.1	8.2	2.0	3.8
D.C. offenses	N.R.	N.R.	3.4	2.2
Arms, explosives, arson	1.0	4.2	2.1	5.0
White-collar offenses	7.6	3.4	2.6	1.3
Immigration	3.6	5.0	0.6	0.9
Courts or corrections	1.2	0.7	1.3	0.8
Sex offenses	0.1	0.5	0.1	0.5
National security	0.0	0.0	0.1	0.1
Miscellaneous	8.5	7.3	7.0	7.9

N.R.: Not reported separately.
Percentages may not add to 100 due to rounding. Data are for September of each year. 1981 data includes 16 unsentenced female Inmates and 101 unsentenced male inmates. The offense listed is the one with the longest sentence length.

than those in Federal prisons. In State prisons in 1986, 72.0 percent of males and 73.0 percent of females were under the age of 35.[3] Males and females in Federal prisons did differ in their security level assignments. Most females (75.1 percent) were classified as either minimum- or low-security, but only 49.8 percent of males were. Males were more than four times as likely to be classified as high-security.

In June 1992, every State in the union was represented by females incarcerated in Bureau facilities. More than 91 percent of females had as their place of residence a U.S. State, territory, or the District of Columbia, leaving 8.8 percent as non-U.S. citizens. More than 11 percent of the female inmates had California as their State of residence. The other top States were California (11.1 percent), Texas (9.8 percent), New York (9.2 percent), and Illinois (3.5 percent). The top five States of residence for males are California (12.3 percent), Florida (11.3 percent), Texas (8.9 percent), New York (8.4 percent), and Illinois (3.7 percent).

Results from an in-depth survey of Federal inmates, conducted in conjunction with a BJS survey of State inmates in 1991, will soon provide us with more detailed comparisons for males and females across systems. ■

Sue Kline is a research analyst in the Federal Bureau of Prisons' Office of Research and Evaluation.

Notes

1. "Prisoners in 1991," BJS *Bulletin,* NCJ-134729, May 1992.

2. "Women in Prison," BJS *Special Report,* NCJ-127991, March 1990.

3. *Ibid.*

Top left: An inmate in her room, Metropolitan Detention Center, Los Angeles. Bottom left: Dental clinic, Alderson, West Virginia. Top right: A staff member assists with a computer class, Federal Medical Center, Lexington, Kentucky. Bottom right: Parenting class, Lexington.

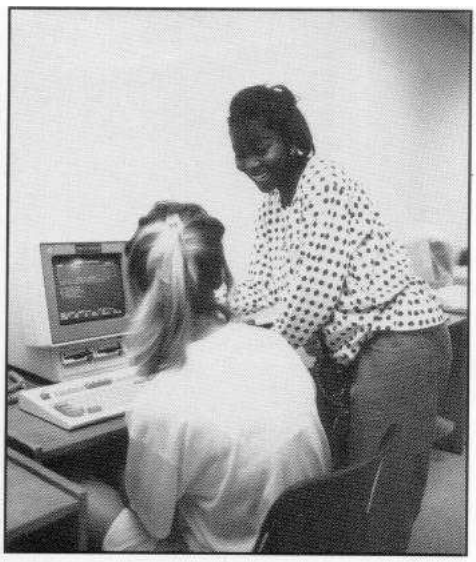
Inmate characteristics
June 1992

Age (%)	Female	Male
18-25	13.2	12.2
26-30	19.2	16.8
31-35	20.9	19.2
36-40	18.9	17.8
41-45	12.2	14.3
46-50	8.0	8.7
51-55	4.0	5.2
56-60	1.9	3.1
61-65	1.0	1.7
Older than 65	0.6	1.1
Average age	36.0	37.3

Inmate characteristics
June 1992

Race (%)	Female	Male
White	58.7	64.9
Black	39.1	32.5
Native American	1.0	1.6
Asian	1.2	1.1
Ethnicity (%)		
Hispanic	24.9	26.2
Non-Hispanic	75.1	73.8
Inmates by security level (%)		
Minimum	44.7	24.1
Low	30.4	25.7
Medium	15.4	27.2
High	3.1	14.0
Unassigned or old security level	6.4	9.0

Percentages may not add to 100 due to rounding.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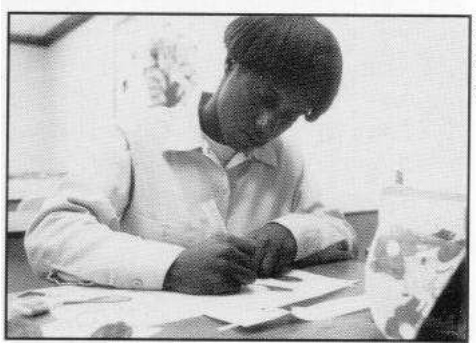
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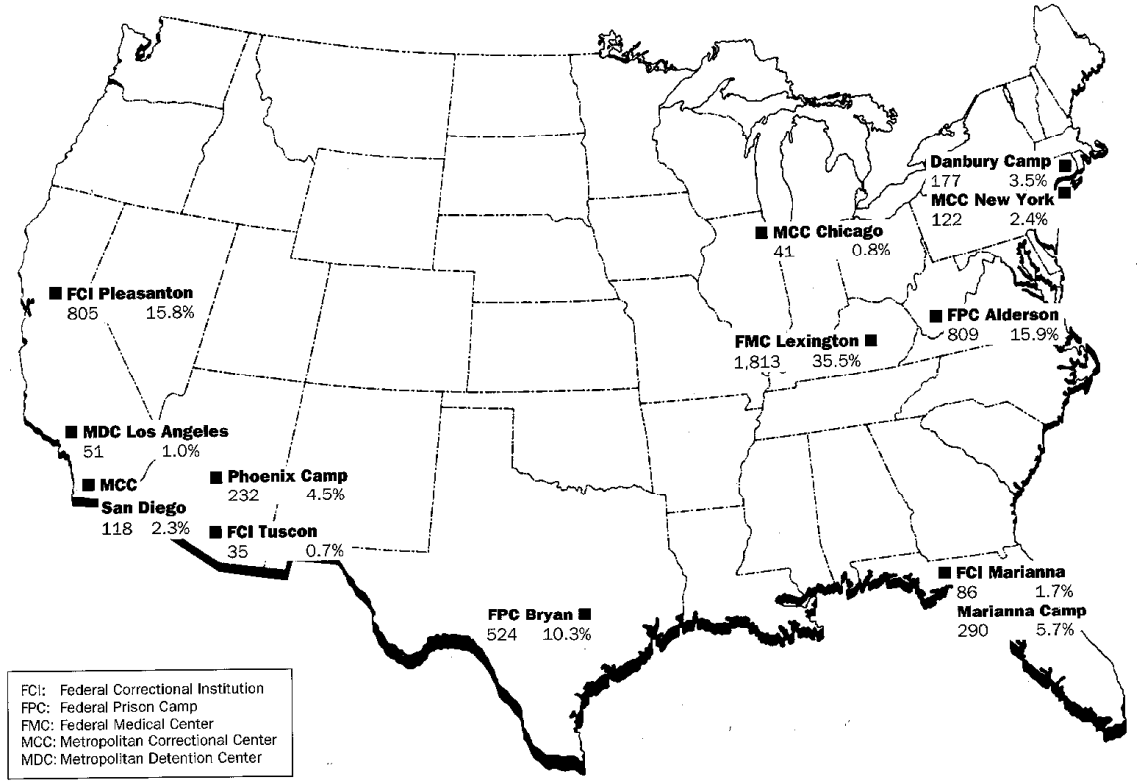
Female institutions: location, population, and percentage of total Federal inmates

Total 5,103 June 1992



Residences of women in Bureau custody

Alabama 100	Hawaii 18	Michigan 112	North Carolina 148	Utah 9
Alaska 11	Idaho 6	Minnesota 39	North Dakota 1	Vermont 8
Arizona 93	Illinois 181	Mississippi 39	Ohio 127	Virginia 137
Arkansas 28	Indiana 35	Missouri 100	Oklahoma 71	Washington 43
California 560	Iowa 32	Montana 9	Oregon 35	West Virginia 74
Colorado 26	Kansas 17	Nebraska 23	Pennsylvania 102	Wisconsin 37
Connecticut 18	Kentucky 37	Nevada 27	Rhode Island 16	Wyoming 10
Delaware 4	Louisiana 67	New Hampshire 9	South Carolina 36	Guam 4
Dist. of Columbia 117	Maine 13	New Jersey 63	South Dakota 7	Puerto Rico 21
Florida 592	Maryland 99	New Mexico 23	Tennessee 105	Virgin Islands 12
Georgia 154	Massachusetts 21	New York 473	Texas 504	Non-U.S. citizens 450

Linking Inmate Families Together

The L.I.F.T. program at FPC Alderson

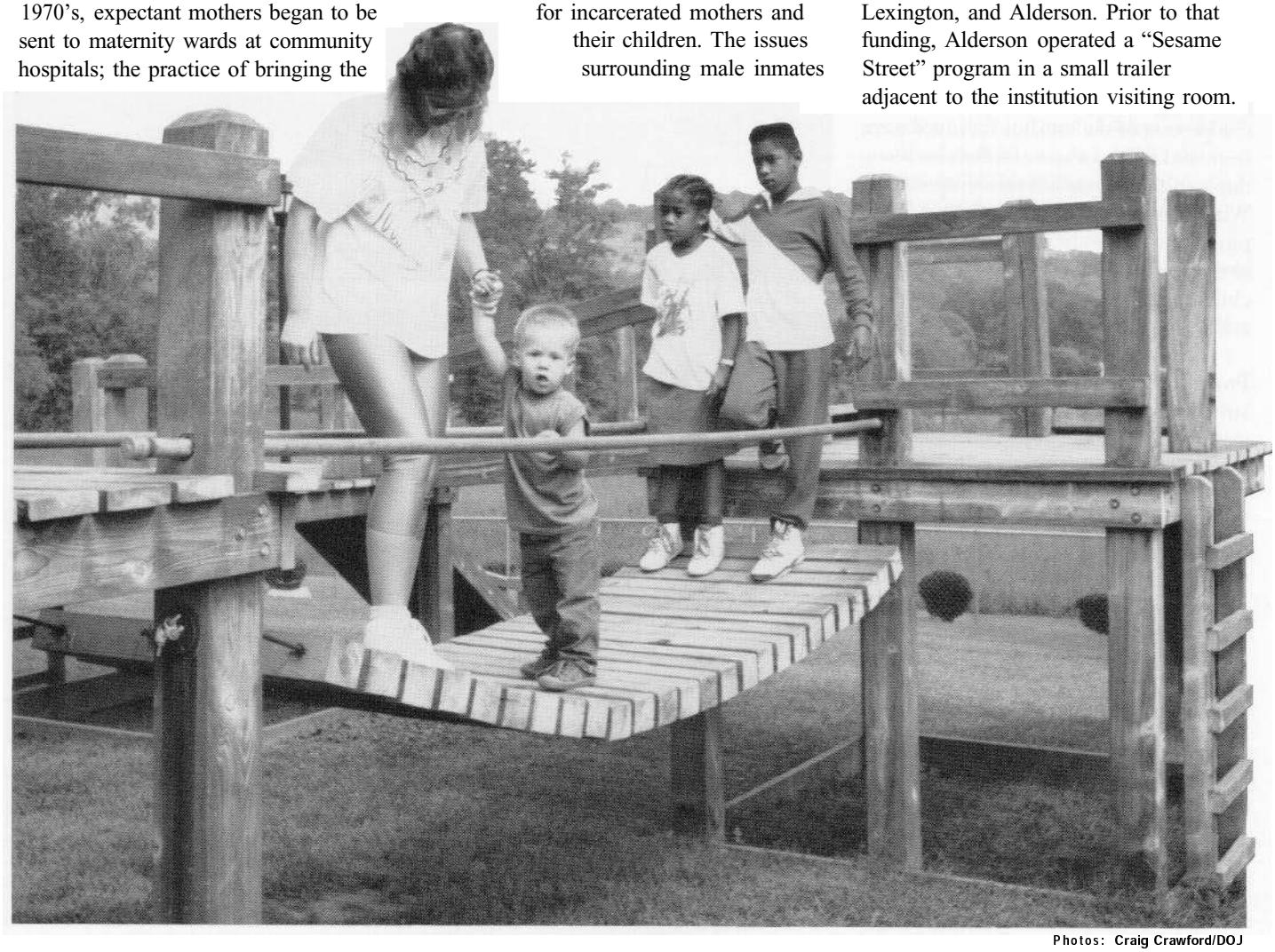
Bobbie Gwinn

The parenting program at Alderson has deep historical roots. The facility was dedicated in 1927 as the first Federal institution for female offenders. Throughout Alderson's history, management has attempted in various ways to strengthen family ties and promote parenting skills, and the children of inmates are central to that concern.

Earlier in the prison's history, babies were delivered in the institution hospital and remained in a nursery on the institution grounds until age 2. During the early 1970's, expectant mothers began to be sent to maternity wards at community hospitals; the practice of bringing the infant back into the institution was discontinued at the behest of social service agencies, which regarded the presence of children in a prison as unhealthy. Today, concerns for bonding, parenting, and related matters are ever-present for incarcerated mothers. The attempt to resolve these concerns has been evident in Alderson's past programs and policies, which have evolved into our present program—Linking Inmate Families Together (L.I.F.T.).

One concern regarding inmate management has been how to determine what services and facilities are appropriate for incarcerated mothers and their children. The issues surrounding male inmates as parents are not unimportant, but major traumas involving bonding, parenting, and separation are much more common among incarcerated mothers. Some correctional practitioners support the theory that the resolution of issues surrounding parenting is important to rehabilitation and may promote a decline in recidivism.

In 1986, the U.S. Congress appropriated funds for the continuation and development of parenting programs at four Federal Correctional Institutions housing female offenders—Pleasanton, Fort Worth (the only such program for males), Lexington, and Alderson. Prior to that funding, Alderson operated a "Sesame Street" program in a small trailer adjacent to the institution visiting room.



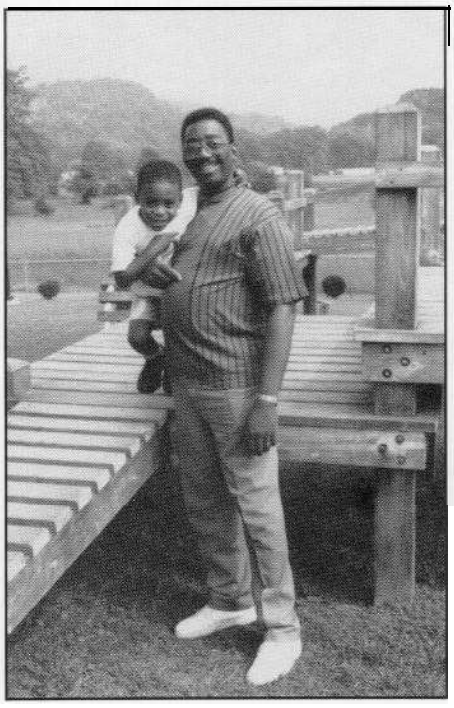
Photos: Craig Crawford/DOJ

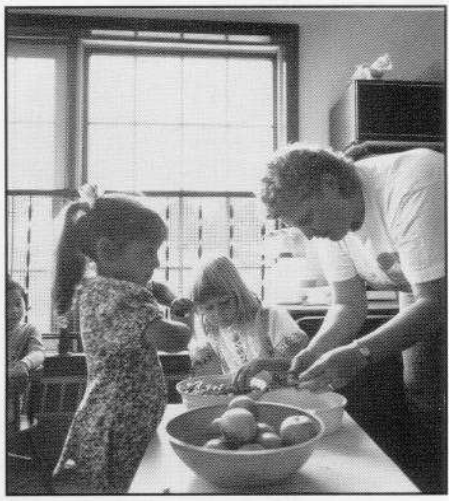
Although small, the program was popular with the inmates and their family members. Upon receiving the parenting funds appropriated by Congress, Alderson constructed a Children's Center.

In January 1987, prior to program startup, the Federal Bureau of Prisons' Office of Research and Evaluation conducted a survey to determine the likely usage of the Children's Center. The survey was voluntary; 256 inmates (30.5 percent of the population) were selected at random. Analysis revealed that 75 percent of the inmates using the visiting room felt that their children were not comfortable and that the visiting room was too crowded, restricting privacy and activities for children. Sixty-one percent of the inmates surveyed were from 400 miles away or further; two-thirds of these were not receiving visits. With the survey completed, the parenting program was developed to be sensitive to the needs of both inmates and their children, as well as correctional services staff.

From the beginning, the organizational structure has centered on an advisory staff committee and an inmate steering committee. The inmate committee represents the various ethnic groups at the institution, and remains active with 10 members. Trained inmate volunteers, from a list of 25, work in the Children's Center during Center hours. In addition to the Center itself, a playground area was constructed; its design included areas for imaginative play and fitness.

The parenting program includes not only Children's Center activities, but social service and educational courses. The education component has always been





Top: Michael Vincent, Project Director, Catholic Community Services, with the author. Left: The outside visiting area has play equipment for the children. Right: An inmate volunteer, one of 35 to donate time during weekends.

Top: Sherry Dasher, staff member of Catholic Relief Services, counsels an inmate. Bottom: Three generations unite on a visitation day.

popular and well attended, with many classes offered on a regular basis. Exploring Parenting and Parenting From a Distance are the two core courses; other workshops include prenatal care information, diet, nutrition, family nutrition, parenting skills, and community resources for family life. Also included are skills for family support—budgeting, setting priorities, coping with change, and other life skills. The social services component deals with crisis intervention and helps address such concerns as facilitating visitation, child placement, legal issues, and support services.

L.I.F.T. has successfully operated since September 1987. Alderson's Education Department coordinates the program and contracts with a local social services agency to staff it. Careful selection of qualified staff has made L.I.F.T. activities almost problem-free. An early-childhood educator is responsible for classes and training, while a licensed social worker handles crisis intervention.

The program has benefited hundreds of short- and long-term inmate mothers and their children. Visits occur in less crowded surroundings, and the area allows parents to participate in more constructive activities with their children. While incarceration is a fact of these women's lives, communication skills and projects help reduce their isolation and separation. The Alderson program has proven to be a very positive link in getting inmate families together. ■

Bobbie Gwinn is Supervisor of Education at the Federal Prison Camp, Alderson, West Virginia.

My experience with the L.I.F.T. program

Norma Zambrana

I am a native of Bolivia. I arrived at FPC Alderson in March 1989. For the first year, all I could do was cry over the 8-year sentence I had received for distribution of drugs. I am a naturalized citizen of this country with three children—two sons and a daughter. My youngest son was just 8, and the family had suffered financially throughout the conviction process. Thankfully, he was living with relatives in Alabama. The possibility of visiting with my little boy wasn't even a consideration due to the distressed financial circumstances of the family.

I was so devastated by my incarceration and the concerns over my family that I was placed under a "suicide watch" in the county facility. That was a difficult year in which self-pity ravaged my waking hours. After absorbing my grief for those many months, I had no more tears—only a new determination to *do* something positive with my situation at Alderson. I marched to the Education Building and signed up for every available course. "Growing Up Again," offered by the L.I.F.T. (Linking Inmate Families Together) program, was the first course I was able to attend.

I entered the class skeptical of learning much, viewing the opportunity as more entertaining than productive. Much to my amazement, I realized that some things about the way I had raised my two older children were wrong. I came from the old school, the Spanish heritage providing strict guidelines for my children's upbringing. I didn't even allow my daughter to date!

Now I was learning about situations of abuse and ways to guide children, offered in a positive light. Intrigued, I began to put into practice the principles being taught and found that my small son responded beautifully to the creative offerings his mom was producing as a result of her classes.

Armed with renewed spirit, I attacked several projects. But what was the most rewarding was the blessing I received as a volunteer in the Children's Center. On weekends, I was able to work with other incarcerated mothers' children, using the skills I learned in the parenting classes. The L.I.F.T. program sponsors and staffs this center to accommodate the many children of inmates and offers an opportunity for the visits to be great fun for both children and moms.

Birthday cakes are prepared in the small microwave oven—made especially for and by the child. Creative juices flow while painting, working with modeling clay, playing with building blocks, listening to music, and watching carefully selected videos. Sometimes, there are small animals or items of similar interest, such as turtles, to amuse the children.

It is not unusual to see the little families grouped around tables working with beads or string art. One mother of a very small son enjoyed giving the 6-month-old a bath in the sink in the bathroom and then reading to the sleepy, powdered, and sweet-smelling baby in the Center's version of "Granny's rocking chair." There is a changing table, a fresh supply of diapers, and paraphernalia that would normally be found in the nursery at home. The Center provides high chairs, cribs, playpens, and a multitude of toys to appeal to all age groups.

I realized that this opportunity was helping me blossom in my trials, and I began telling others. I became a leader to the women at Alderson, encouraging them to "get involved" and do something constructive with their time. I began working at the Federal Prison Industries garment factory, where I started out sewing, but graduated to repairing the sewing machines. It is a skill that I plan to take with me back into the community.

My work at the Children's Center helped my emotional attitudes immensely, but in the background there was always the longing to be with my small son. Finances would not permit the expense of a trip to Alderson, West Virginia, from Alabama. Last summer, my son was picked as one of 10 children to participate in the L.I.F.T. Summer Camp Program. My joy knew no bounds as my son was transported to the camp with all the costs fully underwritten by Catholic Charities. The week-long camp gave both of us the opportunity to renew our bonds and share in many delightful activities. Laughing, hugging, sharing special treats: the experience has carried me through many, many days with wonderful memories. I am a new person, a better mother, and a more worthwhile human being. I attribute these qualities to the work done for me, personally, by the training and caring I have received from the L.I.F.T. program. My life will never be the same. ■

Women's Spirituality in Prison

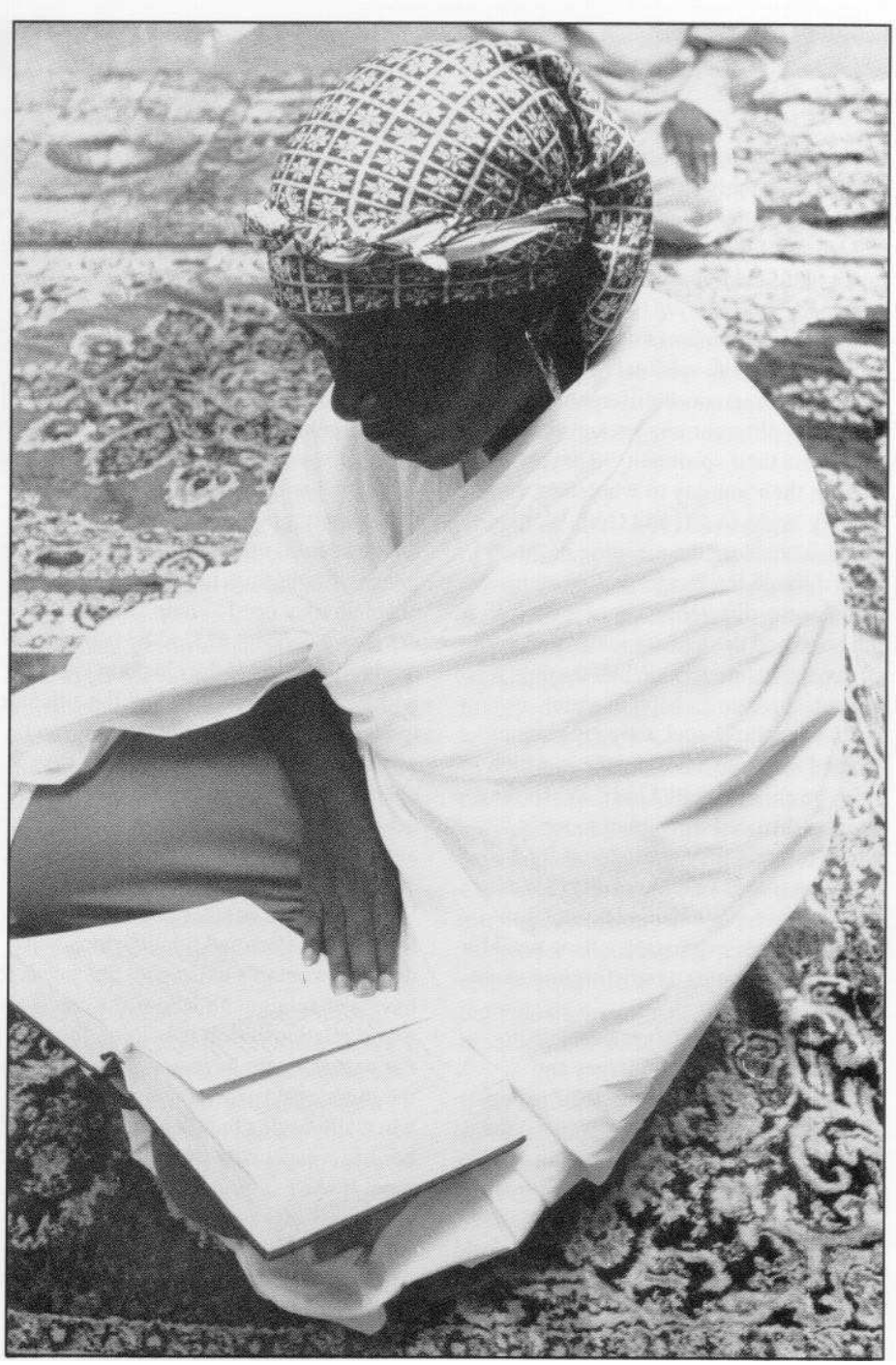
Guylan Gail Paul

It is important for the reader to understand "spirituality" in its broadest sense. Spirituality is not simply a person's relationship with God, but also to others and to him- or herself. It encompasses *all* of our relationships. Too often, women come into the prison system broken, betrayed by men, grieving over the loss of their role as caregiver to their children, estranged from parents, less educated than they want to be, traumatized by incest or sexual abuse, not knowing how to put themselves back together, not knowing God or having any idea that a journey to God is a journey to wholeness.

Maria Harris, in her book *Dance of the Spirit,* speaks of seven steps of women's spirituality:

- *Awakening* to the God spirit within and without.
- *Discovering,* or achieving self-knowledge.
- *Creating*—shaping our own image of God, our own spirituality.
- *Dwelling*—"Be still and know that I am God"—until we discover that God dwells within.
- *Nourishing*—practicing spiritual disciplines that nourish ourselves.
- *Traditioning*—passing on the faith through ritual, song, community, and person.
- *Transforming*—facing brokenness through stories from scripture and being reborn into a wholeness that incorporates all of life's experiences.

Harris' seven steps are one way of expressing a woman's spiritual journey from isolation and brokenness to relationship and wholeness. These steps are not discrete but overlapping and inter-



Kevin Reily/DOJ

twined. They give us a good model from which to understand the spiritual journeys of women.

If chaplains want to help incarcerated women make this journey, they must understand other psychological aspects and needs of women and integrate these factors into the journey.

Language is an important clue to ministering to the spiritual needs of women. Women need different language as well as different images and symbols to express their spirituality. They may express their journey to wholeness as a journey home to self and God. Women may best explore the meaning of their lives through the imagery of weaving together the different parts of their lives; the good and the bad are integrated into an acceptable pattern. When these women speak to a chaplain about decorating the chapel, they are saying, "I need to create a holy space in which I can be at home with God." When they express the need for a quiet room in which to pray, they are longing for a dwelling place. When they say, "We need to have a Woman's Day celebration," they are expressing a deep need for ritual that becomes a transforming event.

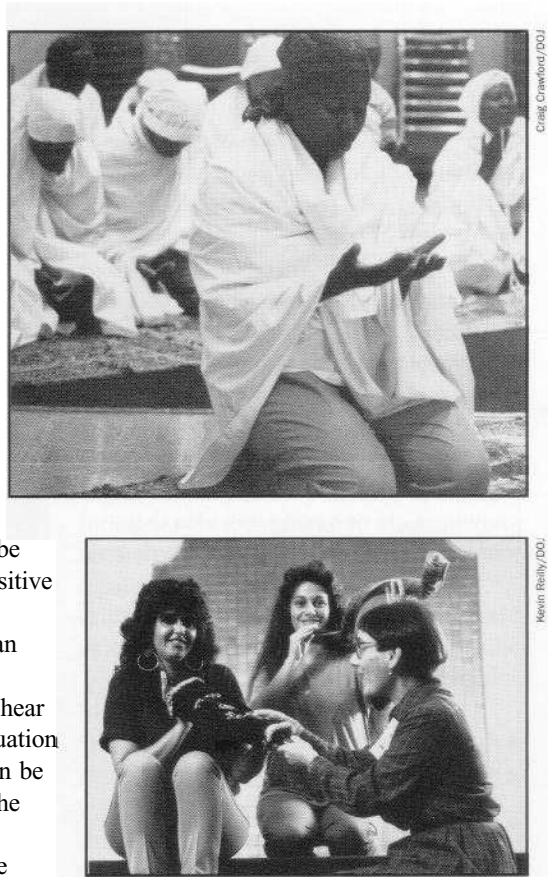
It's important, as often as possible, to speak to women using images and symbols that resonate with their experience. One of my best sermons used the unlikely imagery of toilet training—something most women take responsibility for—to express how basic the Ten Commandments are to living in the world without "creating a mess" in our personal relationships. I was able to separate the Ten Commandments into groups that reflected our different relationships to God, to others, and to self. This sermon was successful because it began by using woman's language, moved to the idea of relationship as seen in the Old Testament, and finally incorporated Jesus' commandment—to love your neighbor as yourself—as a new dimension of relationships.

A woman's life experiences will affect her idea of what God is like. For example, if her God concept is perceived through the memory of a father who was often drunk, a wife-beater, and abused the woman physically or sexually, her understanding of the imagery of God the Father may be different from others who have a positive image of fathering. In that case, the chaplain may need to help the woman develop a concept of God by using mother imagery. If the chaplain can hear with sensitive ears and adapt the situation to the inmate's needs, the woman can be awakened to the God spirit—and the chaplain and the inmate will have achieved a new relationship with one another.

Relationship is another critical concept for women. Personal relationships help define a woman's existence. She needs to have a chaplain with whom she can form a safe relationship. It is helpful, though not necessary, to have a woman chaplain; the inmate may trust a woman more when she begins to talk about the hurts in her life—especially those hurts related to men. If she can find a safe place in the chaplain's office to share her broken feelings and lack of self-esteem, she can begin to believe that it is safe to share her pain with a psychiatrist or a trusted friend—or even risk sharing in a group.

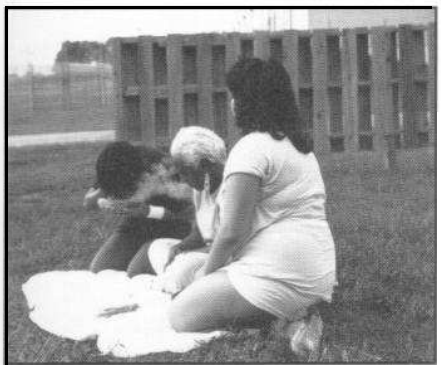
According to Irvin Yalom, in his book *The Theory and Practice of Group Psychotherapy,* 11 factors in group therapy foster healing: instillation of hope, universality, imparting of information, altruism, "corrective recapitulation" of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors. These therapeutic factors are found not only in secular therapy groups, but in scripture study and prayer groups.

Group relationships are important in a woman's journey to wholeness. Prayer and scripture study groups may be the first support groups that she begins to attend, as she examines her life story in


Craig Crawford/DOJ

Kevin Reilly/DOJ

The spectrum of religious observances at the Federal Medical Center, Lexington, Kentucky. Top: Daily Islamic prayer. Bottom: Jewish inmates and a volunteer perform a ceremony using a shofar, *or ram's horn.*



Top: Lexington's New Life Gospel Choir. Bottom: During a sweat ceremony, Native Americans purify themselves with smoke from wild sage.

relation to the stories in her Bible, Koran, or Torah. These stories bring hope of forgiveness, second chances, renewal of relationships; here she begins to hear the stories of other women and realize she is not alone.

Women often can relinquish control to another person more easily than can men. Guided meditations based on scriptural passages can be introduced in study groups as a new form of prayer that women easily relate to. The chaplain can interpret these dream-like experiences much as Freud did: to further psychological understanding of relationships and the spiritual issues that emerge.

I used a meditation, from Carolyn Stal's book *Opening to God,* based on the story of Jacob and Esau. The meditation was designed to help women identify people in their lives toward whom they need to make a conscious effort toward reconciliation. The Jacob-Esau story also pointed out such concerns as the fears we face before attempting reconciliation, the length of time it will take, and the need for the cooperation of the person with whom we want to be reconciled.

One inmate identified an estrangement she had all but forgotten about, a cousin who used to be one of her major supporters. Another was able to talk about her struggle with a father who was not ready to forgive her. As we discussed each woman's experience of the meditation, I could clearly see Yalom's therapeutic factors come into play; the other women would console her and help her understand her experience.*

In these spiritually oriented groups, a woman can be accepted for *who she is right now,* with a vision of who she can be in relation to God, self, and others. She begins to talk and learn group skills. From there, she may move with more confidence to other groups—Alcoholics Anonymous, parenting, and so on. If these groups are not available in a particular prison, the chaplain may need to introduce them or become an advocate for them.

If a woman does not move out into these other groups, spiritually oriented groups become the only place where she can talk as a member of a community and attempt to integrate all the aspects of her life. And talk she does! Women talk to make sense of what has happened to them, to exchange ideas, to deal with the pain and guilt they feel being separated from their children. The telling of their life stories brings healing.

Then they need to get busy again, to give of themselves to causes beyond themselves. Chaplains can channel such activities into church-related events that help build self-esteem: helping plan worship services, introducing a dance liturgy, decorating the sacred space with homemade banners, singing in the choir. In so doing, inmates discover that they have skills and leadership abilities that are appreciated. As Howard Clinebell says in his book, *Basic Types of Pastoral Care and Counseling,* the church's mission is to be an *"abundant life center,* a place for liberating, nurturing, and empowering life in all of its fullness, in individuals, in intimate relationships, and in society and its institutions."

If the church is successful in its mission, women can begin to feel a sense of freedom while incarcerated that changes their orientation toward all their life experiences. This relates to Clinebell's definition of liberation: "...the freedom to become all that one has the possibilities of becoming."

Understanding the uniqueness of women in their spiritual journeys to wholeness—their needs for a *woman language,*

Continued on page 48

*I see another interesting phenomenon operating in guided meditations—a movement toward "androgynous wholeness." This can be defined as a balance between one's vulnerable, nurturing, feeling, "feminine" side and the rational, assertive, analytical, "masculine" side. Letting the holy spirit bring images to mind constitutes the "feminine" side and the cooperative analysis of the images as symbols constitutes the "masculine."

Women's Prisons

Their social and cultural environment

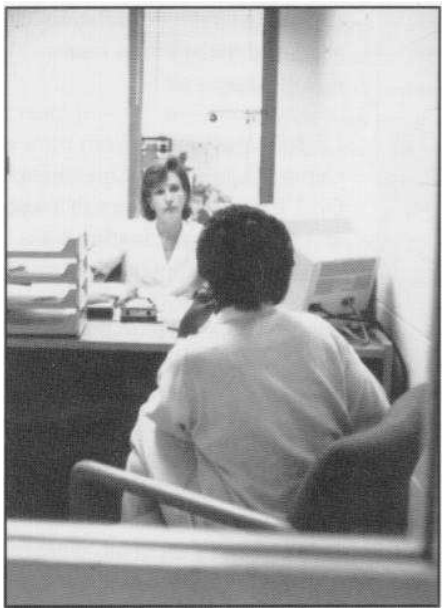
Anne Sims

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

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

Physical environment

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



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

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

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

Staff/inmate relations and psychological characteristics

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

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

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

Photos: Craig Crawford/DOJ

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

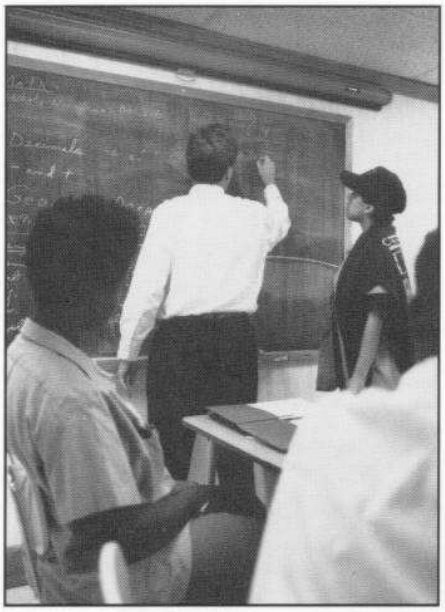
These women tend to suffer from anxiety and depressive disorders as a result of their situation. They are more likely than men to participate over the long term in group discussions led by a staff member, involving topics such as stress management, assertiveness, and family relationships. Most women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

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

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

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

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



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

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

Visits and family contact

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

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

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

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

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

Educational/vocational participation

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

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

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

Release planning

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

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

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

Conclusion

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

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

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

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

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

Spirituality *from page 43*

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

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

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

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Care of the Pregnant Offender

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

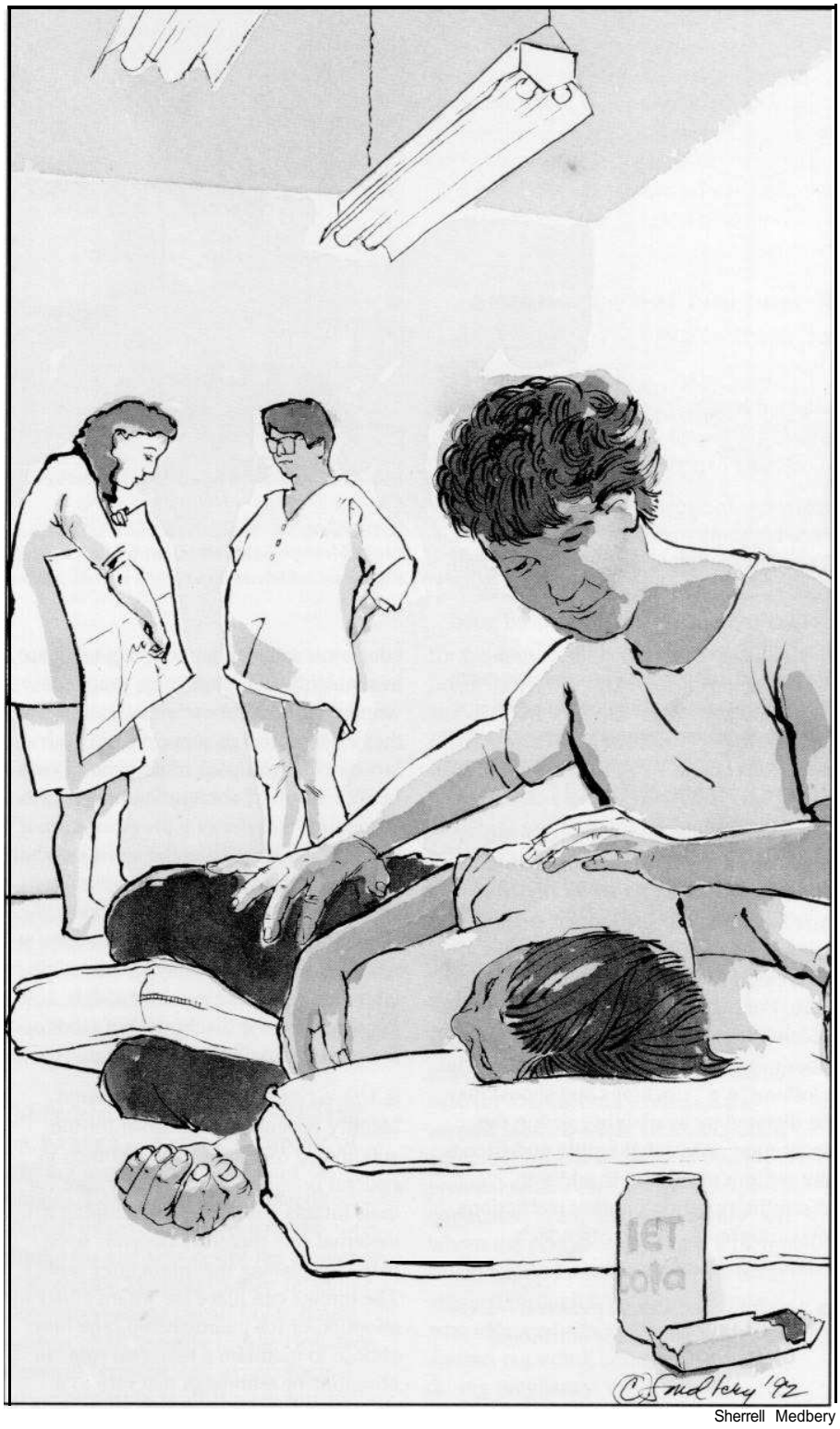
Women face many choices once they are pregnant. Even deciding to find out if she is pregnant can be an overwhelming experience for some women. Whether to continue the pregnancy, how to manage it, and how to select a particular childbirth method largely depend on the knowledge, attitudes, and disposition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

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

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

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

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



Sherrell Medbery

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

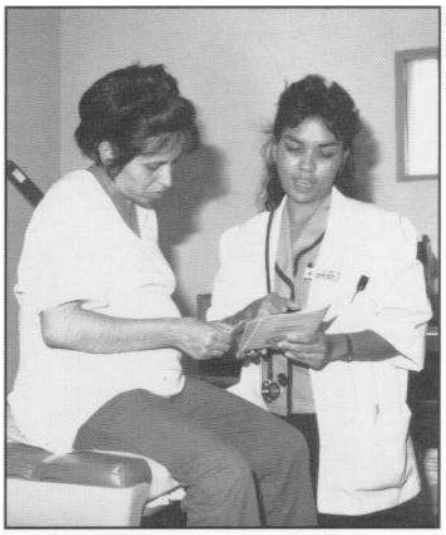
Prison and the experience of mothering

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

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

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

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



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

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

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

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

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

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

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

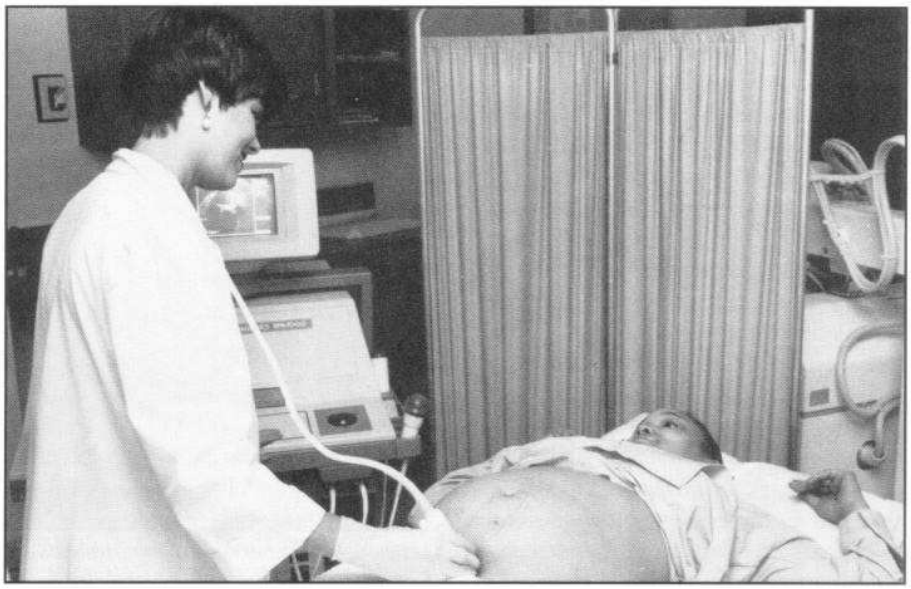
If the inmate is successful in coping with pregnancy and childbirth, she may have learned the skills necessary to successfully cope with her remaining period of imprisonment. Comprehensive maternity care for the pregnant inmate is one component of a supportive prison environment for the female offender.

The clinical dilemma

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

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

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



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

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

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

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

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

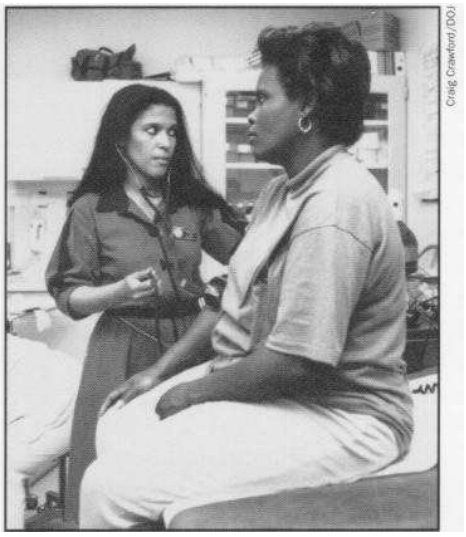
The social network during pregnancy

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

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

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

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



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

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

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

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

Satisfaction with maternity care

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

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

Conditions for positive pregnancies and childbirths include:

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

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

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

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

Team delivery of services

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

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

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

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Pregnant in prison: An inmate's experience

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

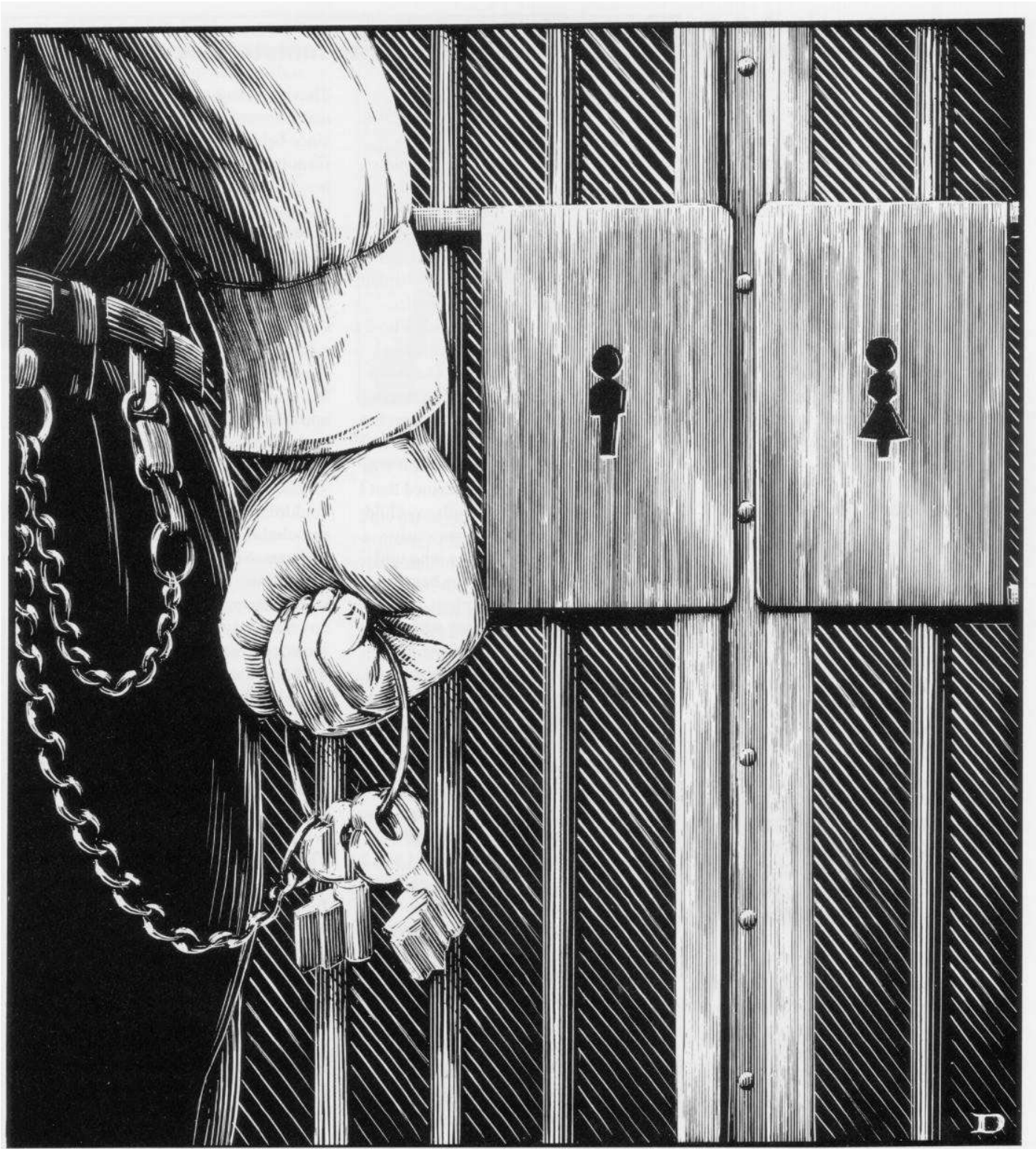
I came to prison pregnant. I thought that it was the end of the world, but it wasn't. The psychologist and chaplain counseled me and gave me advice. They told me about a program where I could spend time with my child and form a mother/child bond. The name of the program is MINT, which stands for Mothers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

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

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

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

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



Bob Dahm

"Constants" and "Contrasts"

Managing female inmates

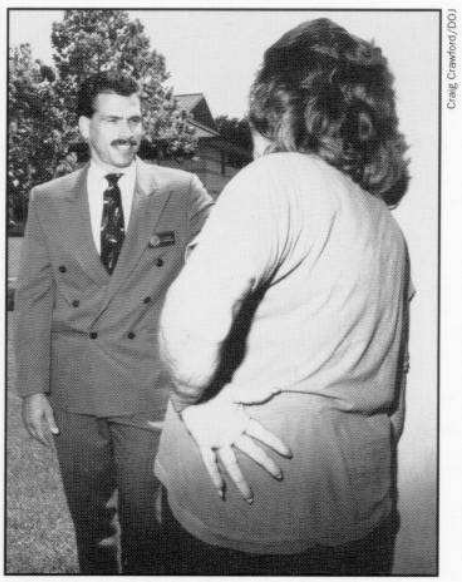
David W. Helman

The reader of this article must surely agree that, on this topic, there is potential for the author to get himself into trouble. Addressing distinctions between the sexes on any issue is usually fraught with controversy, and the management of female versus male inmates is no exception.

I risk antagonizing traditionalists in the corrections business, who argue that "inmate management is inmate management" and that the same administrative principles and practices are required regardless of the population. We all agree that fundamental principles of management guide modem corrections. Nonetheless, others maintain that rigid adherence to standard tenets of management in administering today's diverse inmate populations can inhibit flexibility and innovation. Proponents of this perspective believe that there must indeed be distinct considerations in managing different segments of our inmate populations-particularly when administering male and female institutions.

We all know prison administrators who hold these divergent views. While maintaining clear distinctions in philosophy and practice, they generally share one set of characteristics-they are experienced, opinionated, and outspoken. Thus, the author's dilemma.

I weighed both perspectives before committing thoughts to paper. As it turns out, I think both viewpoints are right. Each has merit; combined, they shape much of today's thinking in correctional management.



Basic principles of managementensure that there will be "constants" in how inmates are treated. Here, Randy Ream, Camp Superintendent, Marianna, Florida, makes his daily rounds.

This may strike the reader as a "safe harbor." Before being critical, however, I ask the reader to glance again at the title of the article. In what follows I trust there will be due consideration for both "constants and contrasts" in managing men and women committed to our care.

Principles past and present

Correctional practice has gradually evolved through this century to its current state in which fundamental principles guide practices in managing inmates. Such was not always the case. In the past, practices in dealing with inmates were glaringly disparate among individual prisons, correctional systems, and governing jurisdictions. Wardens could often act with autonomy—in some cases impunity—in day-to-day inmate management. The lore of correctional history is laden with tales of autocratic rule—accounts that have often been embellished to attract the moviegoing public. Nonetheless, the record shows that prison officials of the past had substantial latitude to make up the rules as they went along.

This situation surely dismayed the benevolent civil servant, who felt that doing a good job meant treating inmates decently and with impartiality. The absence of some basic principles of management usually left him or her to the changing political and philosophic whims of a superior, the legacy of a predecessor—or to simply do whatever he or she wanted.

The big loser was, of course, the inmate. Violations of what we now consider basic civil and human rights were so numerous that many civil servants turned activist reformers and were joined by concerned citizens from various walks of life to help bring about change in the corrections system.

Central to the evolution of this system was the gradual implementation of a feature critical to the success of all modem organizations—basic principles of management to which organizational policy and culture required administrators to adhere. This ensured that there would be guiding principles to help prison administrators manage—and "constants" in how inmates were treated.

The constants

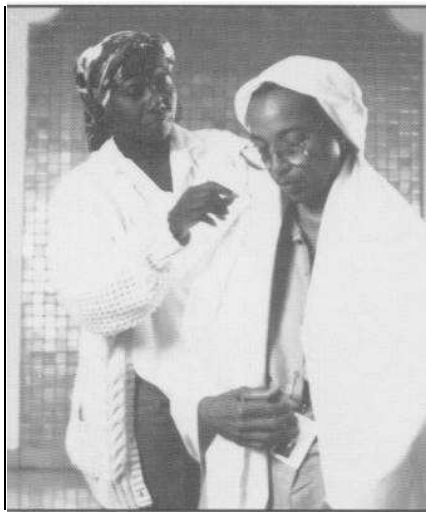
At no time has the diversity of our nationwide prison population been as great as today. This diversity takes the form of increasingly varied cultural, racial, and ethnic demographics, changing offense behaviors and security requirements, expanding health care needs, and a rate of incarceration of women greater than that of men.

Despite these factors, prison administrators are today attempting to apply constant principles to daily management, regardless of the populations they serve. Many such principles are common to all successful organizations, public or private, human services or industry. All such principles, albeit broad in scope, have direct impact on inmate management practices.

Foremost among modem organizational principles is the need for a continuity of mission that is understood by all employees. A healthy system of communication both up and down the hierarchy is critical in support of the mission. It is essential that a sense of pride and professionalism combine with a qualified workforce that is well trained. Employees must have opportunities for career advancement and their leaders must have integrity.

Additional management principles are emerging as constants to join those already mentioned. These include the importance of long-term planning and the use of up-to-date information systems in evaluating programs and developing planning strategies. Participatory management continues to gain favor with employees, and broader contacts with community officials, media representatives, and the general public are considered to be of great benefit. Not surprisingly, promoting an understanding of the agency mission is being linked to its past; accordingly, we are seeing increased attention to the history and culture of corrections.

Finally, there are constants that most directly affect our management of inmates and form the core of training programs: sound institution security; individualized classification; adequate staffing; an inmate discipline program based on due process, fairness, and impartiality; and high standards of sanitation and safety. Equally high standards must be maintained in such critical care areas as food services, health care, and chaplaincy programs. The constant that demands increased attention in times of continuing crowding is the constructive involvement of inmates in institution programs. Skill development through meaningful work activities, education, recreation, and counseling programs are central.



Culture, race, ethnicity, and religious belief must all be taken into account when making management decisions. Here, Islamic inmates prepare for prayer at the Federal Medical Center, Lexington, Kentucky.

Affirmation of these constants of correctional management occurs on several fronts. Legislative initiatives, judicial review, and sound written policies help establish these basics, while the increased prominence of professional organizations such as the American Correctional Association helps ensure ongoing attention to and focus on issues in corrections. The successful efforts of the Commission on Accreditation for Corrections to establish nationwide management standards are a hallmark in the profession's history. With the Bureau of Prisons, as in many State and local agencies, strategic planning centers on the constants of sound management.

The contrasts

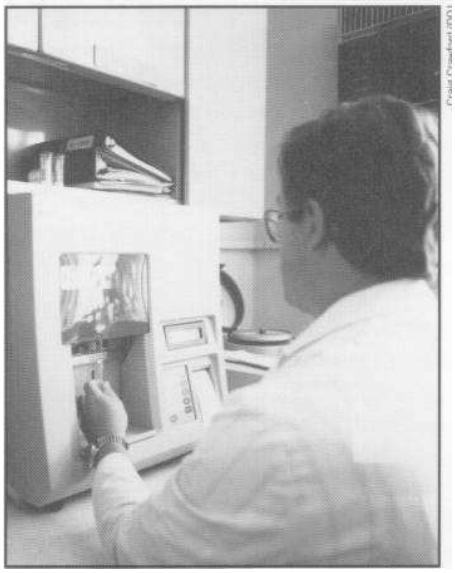
To explore the contrasting management variables in administering female as opposed to male inmates, we must return to the issue of population diversity. With the constants as our baseline, there must be appreciation of the diverse character of our populations when making management decisions. Culture, race, ethnicity, religious belief, social history, and gender must all be taken into account. At times, these variables can affect how we employ the constants. The ability to understand and adapt to this distinction is arguably critical to the effectiveness of the administrator who moves from one setting to another.

To address what I consider to be several notable contrasts, I draw primarily on my work at the Federal Prison Camp in Alderson, West Virginia. During my tenure there the institution was known as the Federal Reformatory for Women and later as a Federal Correctional Institution; in its early years the facility was named the Federal Industrial Institution for Women. From the opening in 1927 through today, Alderson has had as its mission the care and custody of female offenders. Alderson's history is rich and its contributions to corrections and Bureau of Prisons culture are many. Several Alderson administrators have been among the most principled and dedicated professionals that corrections has known.

Foremost among the contrasts is the role Alderson and institutions like it have played in managing inmates through custody and security. As a general principle, the least amount of "hardware" deemed necessary is used in managing inmates. Rather, the first line of defense has been emphasis on a safe, productive "prison community" environment, with reliance on healthy staff-inmate relationships as a primary means of supervision.

Remote location is a factor in security (although in its early years, when rail operations were more efficient, Alderson was not considered as remote as it is today). It can be argued that female inmates respond to the remoteness differently than males. With regard to propensity for escape, there appears to be greater intimidation due to the foreign surroundings, a tendency to form ties—not always healthy—within the prison community that deter interest in escape, and less external support for escape attempts.

These factors are certainly of less relevance with male inmates. Yet we have all too often seen efforts to apply traditional male inmate security standards to female populations. Rarely does the newly assigned Alderson captain, usually male and with limited experience with female inmates, not experience considerable discomfort in viewing the security features—or lack of them, before Alderson became a minimum-security camp in 1990—at such an institution. It would be difficult to tabulate how often proposals have been advanced for double fences, secured cottages, high mast lighting, and pass systems—usually not based on need but on what the proposing official has become accustomed to in male institutions.



Physican Assistant Jim Harvey checks blood counts on a DT60 analyzer at the Federal Prison Camp, Alderson, West Virginia.

This perspective does not alter the importance of security and control as a correctional "constant"; Alderson's history of managing some of the Bureau's most difficult offenders bears this out. It does affirm that application of the constant should require thoughtful consideration of the distinctions between the male and female response to incarceration.

A second distinction rests in the varying "dependency response" of the sexes when incarcerated. As we know, the male response is *generally*—I emphasize "generally"—guided by the "do your own time" adage, making an effort to manage one's own affairs and keeping a distance from staff. Such is *generally* not the case with the female population. Myriad relationships with fellow inmates and relentless, often pillar-to-post demands on staff can be commonplace. The open physical environment promotes this sort of interaction.

The experienced case manager, having examined hundreds of presentence investigation reports, might suggest a rationale for this condition. Females who make their way to prison have been socialized more toward dependent relationships, as opposed to life activities that promote independence. One is likely to find limited work histories and early school dropouts. Meaningful job training is unlikely, health care neglected, and the self-discipline that derives from military experience much less common. Histories of abuse of various forms at all ages are not exaggerated; high levels of dependence on prostitution and drugs are common. The result is that dependencies of varying forms are actually sought out in the prison community to "replace" those the inmate has experienced prior to incarceration.

This has clear implications for the administrator's application of the constants. In disciplines such as health care, case management, counseling, and psychology services, staffing levels guided by male institution standards may well prove inadequate. In turn, decisions regarding inmate programs and resources can be greatly affected by the female dependency response—which brings us to the next contrast.

The importance of aggressively developing programs that promote community and family ties—particularly with children—cannot be underestimated. One merely has to examine the visiting room rolls to understand who suffers the greater abandonment when incarcerated. Also, single parenting occurs nationwide to a greater extent among women, particularly in the increasing populations of minorities and the disadvantaged.

Without doubt, many women in prison have been ill-suited to parenting. Nonetheless, the nurturing bonds between mother and child more often than not remain strong during incarceration. I am not suggesting that male inmates do not experience a similar response. My point is simply that the sheer numbers of female inmates who have young children awaiting their return, combined with the "dependency response" and abandonment that comes with incarceration, can prove a substantial management concern in the female setting.

The potential impact is clear. Innovation is required to establish programs that promote successful adjustment on release by strengthening family relationships. With visitors often traveling great distances to the few women's prisons, expanded visiting room hours, child care programs, and innovative procedures are called for. Telephone programs take on added importance, as do parenting classes, counseling services, and chaplaincy programs.

Furlough programs have proven critical to fostering family ties and release planning for appropriate inmates nearing release. However, furloughs are less used today, even in cases where they may well be indicated—again, probably a management response transferred from male inmates to the female population.

Two additional institution operations in which contrasts exist are medical and mental health care programs and commissary operations. With regard to these key correctional functions, the incoming administrator's motto must be, "Be Flexible!" While the constants of providing high-quality medical and mental health care remain the same, their day-to-day application can differ in female institutions as the administrator faces several realities. Sick calls will be longer, physical and mental health concerns more frequent, the need for specialized medical care in the community more common, and histories of medical and dental neglect more chronic.

Likewise, commissary operations will baffle the newcomer to women's prisons. In light of constants developed to control male inmates' personal property, the volume and nature of items stocked in the women's commissary can indeed be troubling. Cosmetic and personal hygiene items usually provoke the greatest anxiety for the security-minded traditionalist. While strict oversight is needed to limit the proliferation of items on the shelves, the male guidelines are not likely to prove suitable for control in the female setting.

Applying the "constants"

I have presented several correctional management issues involving contrasts between female and male institutions, in the context of the clear "constants"—proven principles and practices—of managing all correctional institutions. For the administrator, it is important to acknowledge that distinctions between female and male populations do exist. Appreciation of these distinctions can have a significant effect on the manner in which these constants are applied in the correctional environment. ■

David W. Helman is warden of the Federal Prison Camp, Duluth, Minnesota. He served at Alderson from 1972 to 1987 as case manager, drug abuse program director, case management coordinator, executive assistant to the warden, and associate warden.

Pregnant *from page 53*

by the team leader) through interdisciplinary contributions to the treatment plan. While this model is common, it depends upon the availability of staff and the patient's needs. The use of other health care professionals to manage treatment planning and intervention may represent a better use of resources.

A holistic, health-oriented model is the framework that guides the delivery of health services to pregnant inmates in Federal correctional facilities. The coordinator for maternity health services supervises the activities of staff physicians, consulting physicians, physician assistants, social workers, and nurses. Referral to specialized services is performed as required by the patient's needs and institutional policy.

The patient is an integral part of the treatment team's setting of health care goals and determination of treatment plans. When a patient is allowed to work with the medical team in setting goals, compliance with treatment is likely to be greater. ■

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The Cycle

From victim to victimizer

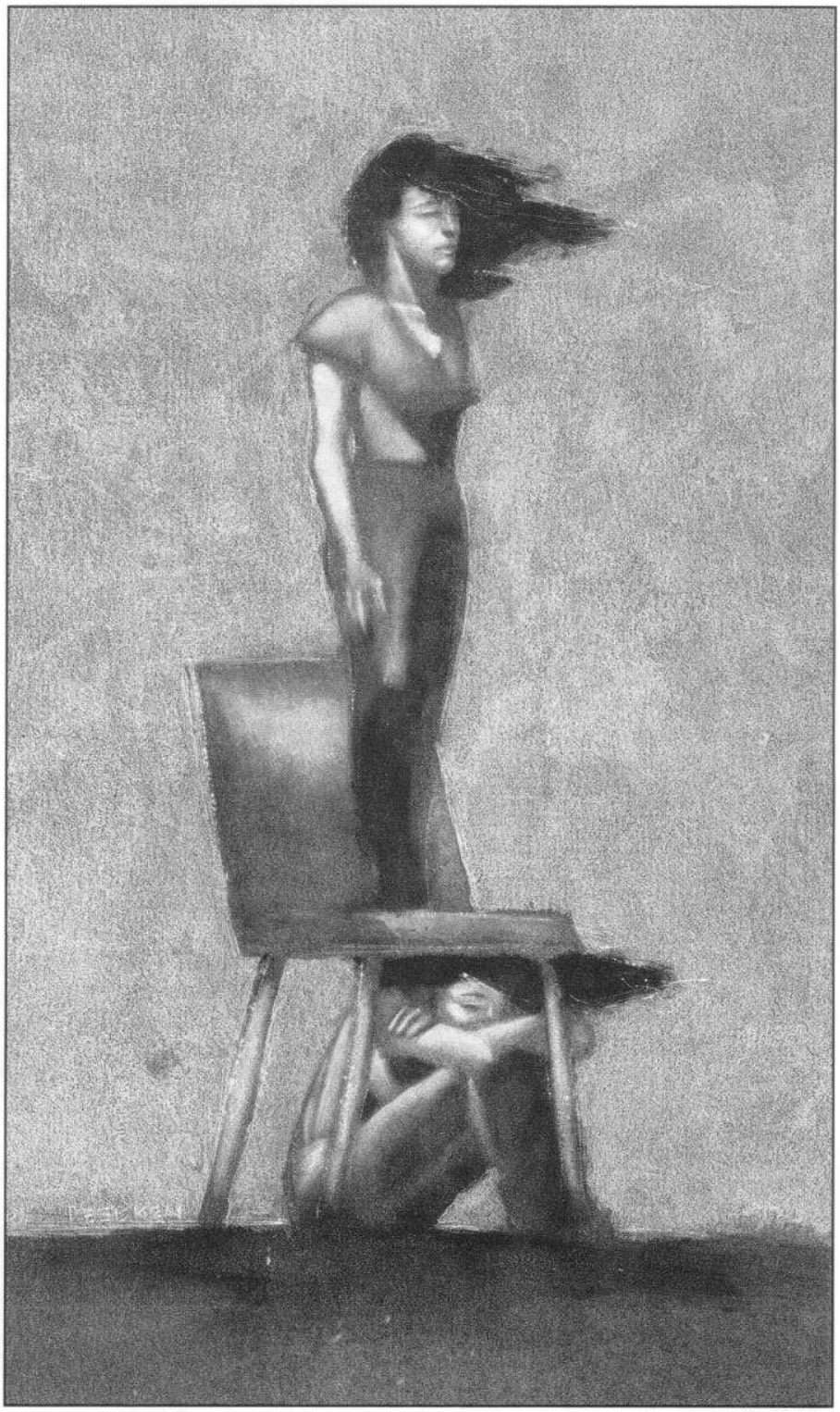
Crista Brett

While journalists chronicle acts of violence on an unprecedented scale—in our homes and on our city streets—the criminal justice system struggles with an ever-increasing number of inmates, raising concern about the increasing potential for violence in law enforcement and correctional settings.

Many inmates have been victims of violence, before and during their victimizations of others. Understanding the violence cycle in families helps us deal more effectively with the mental health and socialization needs of inmates. Addressing the cycle of victimization is especially important when it comes to women.

In early 1991, a number of Federal Bureau of Prisons officials who work with women came together to discuss issues affecting the female offender. One important issue was the effect of victimization on women. It has been suggested that, worldwide, more women and children are killed or injured each year as a result of domestic violence than any other cause (such as disease, accident, or war). Recent statistics demonstrate that reported cases of serious child abuse have increased by 35 percent, and death from child abuse has increased in many States (Hackett et al., 1988). It is estimated that America's police spend almost a third of their time responding to domestic violence calls (Freeman, 1979).

Every 18 seconds a woman is beaten in the U.S. It is estimated that 6 out of every 10 women have been abused at some point in their lives. Each year, about



Tim Teebken

4,000 women are killed due to domestic violence. One-third of all women who leave an abusive relationship will be assaulted again by their abusive partner (Kaufman and Zigler, 1987). Many female inmates have been victims of domestic abuse as adults, and have witnessed spousal abuse as children. In one study of children who murder, more than 75 percent had been exposed to violence and abuse, especially sexual abuse during childhood (Lewis et al., 1985). Child abuse and neglect are thought to be on the increase due to drug abuse (Hackett et al., 1988). Drug abuse by parental figures is likewise thought to be a factor in the disinhibition of violence in the family and neglectful behavior (Gropper, 1984). For every reported case of child abuse, it is estimated that as many as 10 go unreported (Wolock and Horowitz, 1984).

Many inmates have abuse in their backgrounds. In a study of women inmates who were given prison terms for killing their children, each had a history of severe rejection, neglect, or abuse. Many inmates with a history of severe alcohol abuse reported receiving little parental affection and remember being seriously punished. They also reported severe parental conflict in their families of origin (Gayford, 1975).

Some of the psychological effects of long-term spousal and child abuse are similar to the effects of being taken hostage. A very strong bond is created between victim and victimizer-so strong that hostages have tried to stay with their hostagetakers after the terms of release have been negotiated, and abused children and wives have lied about their injuries to protect their abusers (Dutton and Painter, 1981). Researchers have suggested that memories of a traumatic situation are "burned in" more deeply and affect behavior more directly than memories developed under normal circumstances. This may help explain the strength of a victim's emotional response—even though it seemingly defies logic. This bond has been labeled the "Stockholm syndrome" in hostage events, and "traumatic bonding" when discussing spousal or child abuse (Van der Kolk, 1989).

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The cycle of violence

Lenore Walker (1980) has described a cycle of violence in families—a tension-building phase, an explosive battering phase, and a calm and loving phase that some call the "honeymoon phase." Any abuser tends to give intermittent reinforcement to the victim. Sometimes the abuser may be kind and rewarding to the victim, and other times may attack. (A positive reward may be something as simple as allowing the victim to live.)

This system of reward and punishment is similar to the experience of gambling. Slot machines use the principle of intermittent reinforcement, where a person pulls the arm and is either rewarded with money or punished with no money. A person can develop all kinds of ideas about this process. They can believe that a certain slot machine is lucky or "hot." They can believe that a reward will surely come on a specific time or day, or that God will grant them the money for good behavior. These belief systems help people convince themselves that they are in control of a chance phenomenon, even though they aren't. Once the behavior is learned, it is difficult to extinguish—the chance of winning is always there. If they don't win on the first or second pull, maybe they will on the 15th.

Women in a battering relationship attempt to keep it in the honeymoon phase—behaving in ways that will be rewarded and avoiding behavior that will be punished. Many times, however, the punishments and rewards are not linked to behavior, even though the victim may choose to believe they are. Victims may develop inferences about the victimizer's behavior in an attempt to feel in control. These inferences can have "magical" or superstitious qualities, and have little to do with the victimizer's actual behavior. Many victims work to read every mood of the victimizer in an attempt to avert punishment. Women and children who have been abused tend to be acutely aware of other people's thoughts and feelings and unaware of their own thoughts and feelings. They have learned over time that survival depends on pleasing others.

When an individual is victimized, she begins to lose any sense of self-efficacy in the abusive situation. This loss carries over to other situations. Many abused women believe they are helpless to escape or unworthy of escaping, and think they have no value to other people (Dutton and Painter, 1981). Some believe that their faults cause the abuse, not the abuser's faults.

Reliving victimization

Traumatic events can be reenacted in many ways. Individuals may experience nightmares and intrusive memories of the traumatic event. They may avoid places, events, or people who remind them of a traumatic occurrence. People may also deliberately reenact traumas in an attempt to master them; such reenactments can take the form of harm to others, harm to self, or revictimization. For example, if a man was sexually molested as a young boy, he may sexually molest other young boys when he reaches maturity. In this way, he gains control over a frightening event by being the perpetrator instead of the victim (Van der Kolk, 1989).

Rape victims have been known to walk in dangerous parts of town in an attempt to provoke another attack. They unconsciously hope to prevail in this attack so they won't continue to feel victimized. Women who have been victims of violence tend to reenact their abuse as victims; men who were victims tend to reenact their abuse as victimizers. Many prostitutes have histories of sexual molestation as children, and prostitution appears to be a behavioral reenactment of that molestation. Unfortunately, the woman is never able to master the trauma and it repeats itself over and over.

Craig Crawford/DOJ

Education and therapy are proven tools in the care of traumatic stress reactions. Here, volunteer Gloria Martin conducts a domestic violence workshop at the Federal Prison Camp, Alderson, West Virginia.

Bessel van der Kolk (1989) described some physiological changes that can occur in victims of trauma. When an individual has been traumatized, she tends to experience chronic physiological hyperarousal. Behaviorally, victims demonstrate deficits in learning novel behavior, may experience chronic subjective stress, and may have increased tumor genesis and immunosuppression. Chemicals in the brain, such as serotonin, norepinephrine, and endorphins, may be unbalanced as a result of hyperarousal.

Research with animals and humans has shown that when an organism is overly aroused it will persevere in familiar behavior even when the familiar is self-destructive. If you put an animal in a cage with no means of escape and shock it, it will probably cower in a comer. If you repeat this procedure numerous times, then open the cage door, chances are the animal will remain in the comer. This unwillingness to attempt new behavior has been labeled "learned helplessness." It is easy to see how, when a person has lived in a situation of chronic abuse, the motivation to avoid rearousing conflict may become so great that she will choose a course of action without thinking through the consequences.

Hyperarousal can also have a paradoxical effect. Occasionally people (and animals too) will become "addicted" to stress and seek greater and greater levels of stress to obtain release. High levels of stress tend to activate natural opoids called endorphins—probably most familiar as the substance causing the so-called "runners' high." Once a person has adapted to one level of stress, she or he must seek a greater level of stress to get the same endorphin high. This theory has been applied to people who self-mutilate, using the reasoning that mutilating one's

body increases the level of stress, and endorphins would thus be released. To test this theory, researchers blocked the opoid receptors in the brains of subjects. The result was a reduction in mutilation attempts (van der Kolk, 1989).

The challenge for correctional workers

People who have been victimized tend to view the world more pessimistically. Traumatic bonding is an extremely powerful bond—and highly resistant to change. Abused women often do not have the same freedom or capacity for problemsolving and decisionmaking as women who have never been abused.

Education and therapy are proven tools in the care of traumatic stress reactions. It is important to help abused women inmates work through the traumatic content of their lives, and explore the ways in which they have constricted their thinking and behavior. Staff will need to address issues of suicidal ideation and behavior, revictimization, and intentional harm to others. Many victims believe that the type of attachment behavior they have experienced—the only type of bonding to which they have been exposed—is love. They need to be given the tools to form less violent, more stable relationships in the future.

Working with inmates who have family histories of abuse is paramount—they will be the caretakers of the next generation. Victims need to be educated about the effects of violence on their offspring; they cannot be expected to be good parents without the proper tools. Many of these women have never had proper child care models; the type of parenting they have seen and experienced is often extremely destructive.

The choices we make now in corrections will affect the coming generations....We who work with female inmates may have contributed to a few more children and a few more women achieving stable, loving relationships.

Many victims have learned that violent confrontation is the way to win an argument. They need to be given skills to solve confrontation without violence. It would also be helpful to educate women about chronic hyperarousal and give them tools such as biofeedback to monitor their progress. Ultimately, they must come to understand what constitutes a healthy relationship, rather than simply moving from one battering relationship to another.

The choices we make now in corrections will affect the coming generations. It would be good to know that knowledge about the effects of domestic violence was put to work, and that we who work with female inmates may have contributed to a few more children and a few more women achieving stable, loving relationships. ■

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Canada's Female Offenders

New options in the Federal system

Jane Miller-Ashton

In March 1989, the Commisioner of the Correctional Service of Canada (CSC), Ole Ingstrup, established a Task Force on Federally Sentenced Women, in collaboration with the Canadian Association of Elizabeth Fry Societies (a nonprofit, private-sector organization which works with, and on behalf of, women in conflict with the law). The Task Force included women inmates, as well as members from a broad range of relevant community agencies, women's groups, Aboriginal [native] organizations, and Government departments. A large number of women participated in the Task Force and decisionmaking was conducted by consensus.

The Task Force was one of five set up by the CSC to review such fundamental correctional issues as substance abuse, mental health, and community and institutional programs. The results of these task forces are being used by CSC to more effectively address the needs of offenders in their efforts to become law-abiding citizens.

In April 1990, the Task Force on Federally Sentenced Women submitted its final report, which called for a new approach to meeting the unique needs of Federally sentenced women.

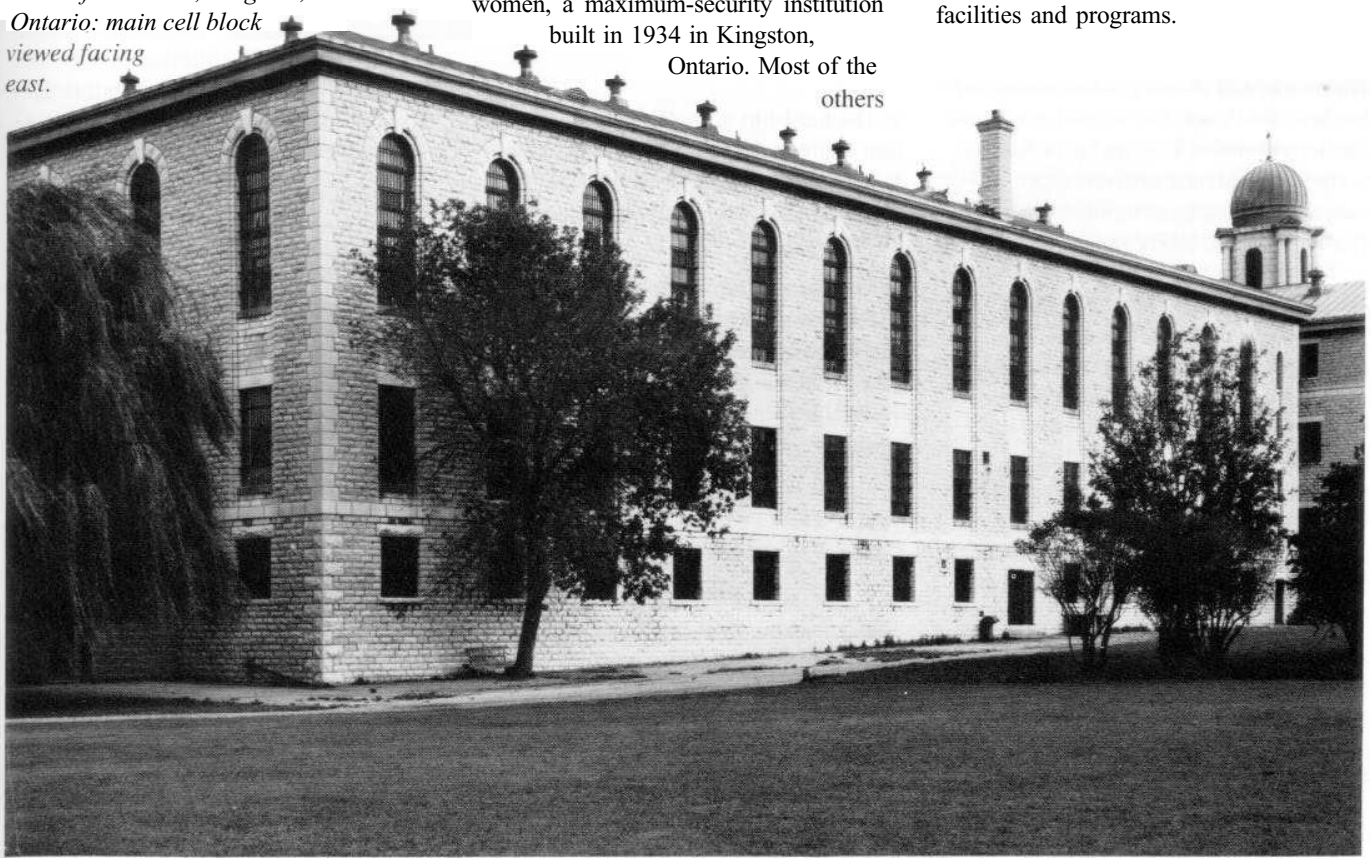
At the time of the completion of the report, about 260 Federally sentenced women were incarcerated in Canada, about 50 percent of whom were accommodated at the only Federal prison for women, a maximum-security institution built in 1934 in Kingston, Ontario. Most of the others were serving their sentences in provincial institutions. There were, as well, about 200 women under community release supervision. The number of women offenders is generally stable, and represents 2 percent of the total Federal offender population in Canada.

Issues and concerns

Several long-standing and unresolved issues have placed women, due in part to their small numbers, at a disadvantage in the correctional system:

- The geographic dislocation of many women from their families, cultures, and communities.
- The "overclassification" of many women, and the lack of significant opportunity for movement within a range of both institutional and community facilities and programs.

Prison for Women, Kingston, Ontario: main cell block viewed facing east.



Photos courtesy Correctional Service of Canada

■ The lack of sufficient programs and services that respond to the unique needs of women.

■ Program inequities that result from placement of women in provincial institutions, which are often not geared to the needs of longer-term offenders.

■ The difficulty of effective prerelease planning.

■ The uniquely disadvantageous situation experienced by Aboriginal women who, at about 16 percent, are overrepresented in the Federal prison population, and are particularly isolated from their cultures and communities.

Over the years, these problems have been examined by a variety of task forces and commissions, and considerable effort has been made to improve the situation for Federally sentenced women. Nonetheless, major problems have persisted. Numerous and recent recommendations to close the Prison for Women emerged, challenges under the Charter of Rights were launched, and pressures for substantive change continued to mount from concerned lobby groups.

Given this background, the mandate of the Task Force was to examine the correctional management of Federally sentenced women from the commencement of sentence to warrant expiration, and to develop a plan to guide this process in a manner responsive to the unique needs of this group.

Findings

The Report of the Task Force on Federally Sentenced Women was based on insights gained from extensive consultations and from several research projects. Pertinent findings included:

Above and left: Inmates can earn permission to spend up to 72 hours once every 2 months at a private family visiting house on the grounds of their institution.

■ The hardship of mother-child separation expressed by incarcerated women, two-thirds of whom are mothers, and many of whom are single parents of children under 5 years of age.

■ The extensive histories of physical or sexual abuse experienced by 80 percent of Federally sentenced women, and 90 percent of Aboriginal women under Federal sentence.

■ The high incidence of self-injurious behavior among women at the Prison for Women, and its relationship to past histories of abuse.

■ The relatively high incidence of substance abuse as part of the offense or offense history of the women and their expressed need for more comprehensive substance abuse programs.

■ The high need for educational and vocational training geared to the development of marketable skills.

■ The paucity of community-based services for Federally sentenced women.

■ The high need for culturally sensitive programs and services.

■ The high priority placed by Federally sentenced women on their desire to be closer to home.

■ The evidence that successful program directions for women offenders include those that focus on self-awareness and self-esteem, promote community involvement and adherence to community norms, use tools validated for women and Aboriginal peoples, and provide in supportive environments programs responsive to the needs of women, with less emphasis on static security measures.

Recommendations

The Task Force made eight short-term recommendations geared to improving the immediate situation at the Prison for Women. In large measure these recommendations have been fully implemented. In addition, an 11-bed minimum-security institution for Federally sentenced women was opened during the course of deliberations.

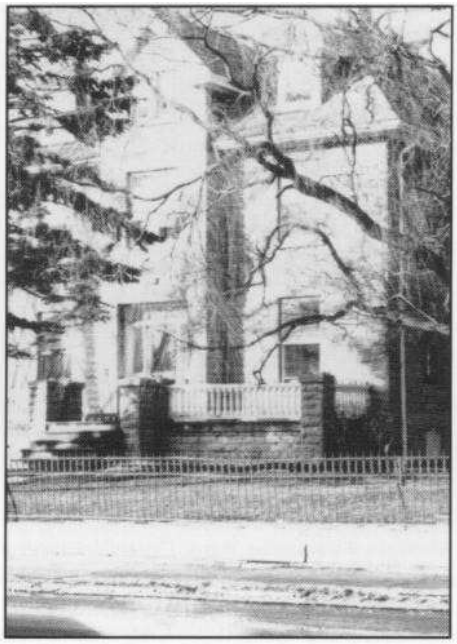
The Task Force's longer-term plan incorporated a societal understanding of women's and Aboriginal people's experience of disadvantage. It was based on the belief that a holistic women-centered approach to the treatment of Federally sentenced women is required to address the historical problems, and is predicated on principles of empowerment, meaningful choices, respect and dignity, supportive environments, and shared responsibility. The plan placed high emphasis on the need for Federally sentenced women to recover from past trauma, and to develop self-esteem and self-sufficiency through programs and services designed to respond to their needs. It stressed the need for physical environments that are conducive to reintegration, are highly interactive with the community, and reflect the generally low security risk of these women.

The plan included the following recommendations:

1. Close the Prison For Women.

2. Establish four Federally operated regional facilities for Federally incarcerated women.

3. Establish a Healing Lodge, which would serve as an incarceration option for Federally sentenced Aboriginal women.



The Elizabeth McNeil House, an 11-bed minimum-security facility for women in Kingston, Ontario, opened in March 1990.

4. Develop a community release strategy that would expand and strengthen residential and nonresidential programs and services for women on release.

5. Respond to the needs of the few women from remote or northern parts of Canada by negotiating agreements for them to remain in their home areas under Territorial/Provincial jurisdiction.

The Task Force plan was situated within the Canadian Federal Government's ongoing efforts to achieve equality for women and Aboriginal people, and was fundamentally rooted in the mission of CSC, which respects the dignity of individuals, the rights of all members of society, and the potential for human growth and development. It was consistent with CSC's strategic objectives to provide a safe, humane environment that promotes health and well-being and encourages positive interaction between staff and offender. Further, it honored CSC policy respecting the social, cultural, and religious differences of individual offenders and addressed the special needs of female and native offenders. Finally, the plan brought a disadvantaged group within a long-standing CSC policy of regionalization, enhancing program opportunities for women and bringing them closer to their families, communities, and cultures.

The locations recommended by the Task Force report for the regional facilities were based on proximity to the home communities of the majority of women from a given region, and on the availability of community resources generally found in larger urban centers.

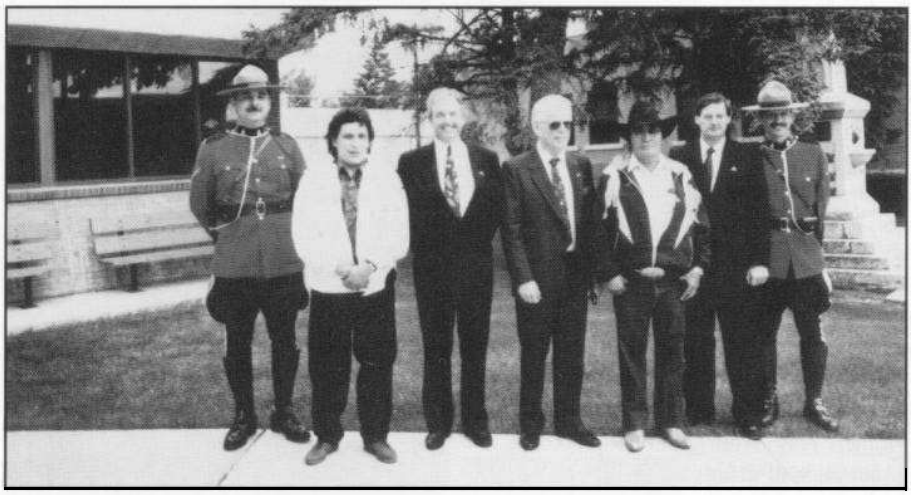
Facility description

The Task Force recommended that regional facilities be developed and operated premised on a program philosophy that approximates community norms, focuses on extensive use of community expertise, and is geared to the safe release of Federally sentenced women at the earliest possible point in their sentences. Program delivery would be based on gender-sensitive assessments and individualized plans developed by each woman in conjunction with a staff person (primary support worker) and a community worker assigned from a private-sector agency.

Programs should be holistic, culturally sensitive, and responsive to the needs of women. Primary programming would focus on counseling and treatment—including sexual, physical, and substance abuse recovery; educational, vocational, and skills development; leisure activities; family visitation; onsite residence of children; and spiritual services. Self-sufficiency and community responsibility

would be fostered through daily opportunities for living skills acquisition, and through the positive support of staff who are skilled in counseling, communications, and negotiations, and are sensitive to women's and cross-cultural issues.

It was recommended that the regional facilities be situated on several acres of land and be built to modem environmental standards that foster wellness, including considerations of natural light, fresh air, color, space, and privacy. Living areas would be cottage-style, with 6 to 10 women per cottage. A central core area for administration would contain flexible program space for recreational, social, spiritual, and counseling activities. The facilities would be designed to maximize mother-child interaction and family visits.



May 1992: Official announcement of the location of the new Healing Lodge facility for Aboriginal women at Maple Creek/Nekaneet, Saskatchewan. Left to right: Royal Canadian Mounted Police officer; John Oakes, Nekaneet Band Councillor; the Honourable Doug Lewis, Solicitor General of Canada; Doug McAlister, Mayor of Maple Creek; Chief Gordon Oakes, Nekaneet Band; Geoff Wilson, Member of Parliament; RCMP officer.

The Task Force report suggested using dynamic rather than static security measures wherever possible, to reflect the supportive orientation of the facilities. An unobtrusive perimeter security measure, for detection purposes only, may be added to what would otherwise be a boundary fence surrounding each facility, built to community standards. One cottage (or part of a cottage) in each facility would require enhanced static security features, but staff support to higher risk women would be the preferred approach.

The Task Force recommended that the Healing Lodge be developed and operated according to native traditions and staffed by Aboriginal men and women. The Lodge would be designed in consultation with Aboriginal people, and would require, in addition to standard CSC administrative requirements, a connection to a nearby native community and the support of an elders' council.

The physical space and programs for the Healing Lodge would reflect Aboriginal culture. The needs of Aboriginal women under Federal sentence would be addressed through native teachings, ceremonies, contact with elders and children, and interaction with nature. Program delivery, as in the other facilities, would be premised on individualized plans, a holistic approach, an interactive relationship with the community, and a focus on release preparation. The Healing Lodge, however, would at all times operate from a unique cultural perspective, placing a high value on spiritual leadership, as well as on role modeling and the life experiences of staff, with more traditional professional expertise providing an important but largely supportive role.

Regional Advisory Councils

The Task Force report recommended that Regional Advisory Councils be established in association with each regional facility to advise the CSC on the development and operation of programs and services in both the facility and the community.

Membership for the Regional Advisory Councils would be drawn from local private-sector groups and individuals who have expertise and interest in women's issues and criminal justice. With respect to the Healing Lodge, the Regional Advisory Council would take the form of both an elders' council and a connection to a local native community.

Councils would evaluate existing programs, identify gaps in services, and recommend additional programs and services. They would also monitor the continuity of programs between the facility and community and make recommendations on how continuity could be improved. Finally, councils would play an educational role in their local communities so that the facility and

the women released from it are seen as an integral part, and a responsibility, of the community.

Community release strategy

As envisioned by the Task Force report, the community orientation of the regional facilities would facilitate the development of individualized release plans, assisted by a community support team. The team, composed of CSC staff and community workers, would work closely with each woman to ensure that needed services would be available on release.

This effort would be supported by new, enhanced residential and nonresidential opportunities for women. There would be an increased need for specialized services, including Aboriginal halfway houses and community-based treatment residences, as well as alternate accommodations such as satellite apartment beds and private home placements. Services purchased from community residential facilities would include employment counseling, substance abuse treatment, and living skills programs.

Implementation

In September 1990 the Government announced its acceptance of the major recommendations of the Task Force. Included in the announcement were plans to close the Prison for Women by fall 1994, to establish the five new facilities, and to expand and enhance community services and programs for Federally sentenced women. The cost is estimated to be about CAN$50 million.

In October 1990, the Commissioner of Corrections announced the creation of a National Implementation Committee to oversee the initiative—including all operational input to the planning and development of the regional facilities, the Healing Lodge, and the community strategy.

The Healing Lodge Planning Committee, a unique partnership composed of Aboriginal women, native elders, and Correctional Service of Canada staff.

In December 1990, an External Advisory Committee was established to provide advice on the overall initiative. The committee includes members from Status of Women Canada, the Canadian Association of Elizabeth Fry Societies, and the Native Women's Association of Canada.

Location selection

During the months following the Government's announcement, an unprecedented number of communities expressed an interest in having the facilities located in their areas. In July 1991, the Solicitor General, the Honourable Doug Lewis, announced that the new facilities would be located within 100 kilometers of the major centers of Halifax, Montreal, Toronto. and Edmonton or Calgary.

The Government had made significant progress toward achieving the closure of the Prison for Women and establishing the five new facilities. A three-step selection process was implemented, the first of which was the minister's July 1991 announcement.

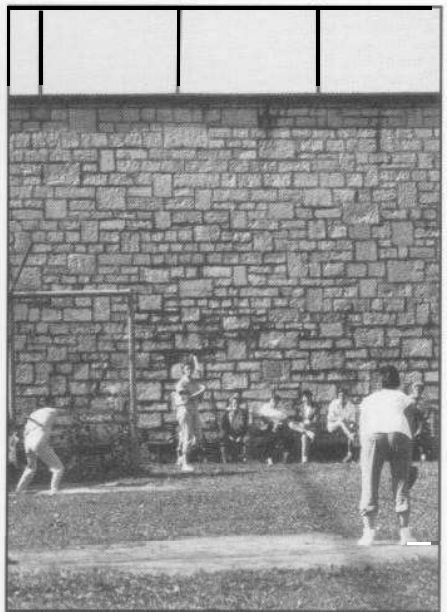
The Correctional Service of Canada subsequently developed selection criteria; communities were given an opportunity to submit proposals based on those criteria. Forty-four communities were assessed by members of the National Implementation Committee, which also included a staff member from Status of Women Canada. A report was submitted to the Solicitor General in early December 1991; later that month he announced plans to locate the Atlantic facility in Truro, Nova Scotia, and the

Ontario location in Kitchener, Ontario. Announcements for the Quebec and Alberta facilities are expected in the near future.

There is no requirement for a regional facility in British Columbia because Federal women are now accommodated in a new Provincial facility for women in that province. This agreement was negotiated prior to the Task Force report.

With respect to the Healing Lodge, the Solicitor General announced that this facility would be established in the Province of Saskatchewan. This centrally located prairie Province is home to many Native women. The Healing Lodge Committee subsequently developed culturally sensitive selection criteria to help determine the location for the Healing Lodge.

In March 1992, 23 Saskatchewan communities (many of them joint partnership proposals from urban centers and nearby Aboriginal communities) were evaluated. The first-place submission from Maple Creek/Nekaneet in Saskatchewan was endorsed by the Solicitor General and made public on May 22, 1992. This community was selected because of its strong Aboriginal qualifications: sacred land, pure spring water, and the support of a traditional Aboriginal community, including elders and medicine people. In addition, this community was favored because of the harmonious relationship that seemed to exist between the native and non-native citizens.



Left: Vocational trades training. Right: Playing ball at the Prison for Women, Kingston, Ontario.

Operational plan

In addition to determining geographic locations, the National Implementation Committee has developed an operational plan for the new facilities. Because the new approach to Federally sentenced women will, in some cases, mark a significant departure from existing policy and practice, it was deemed important to develop a plan that would provide a framework to ensure some commonality and consistency among the new women's facilities. The operational plan was developed in consultation with private-sector partners and other CSC staff, and with input from women offenders themselves. The plan reflects the principles of the Task Force report, as well as the knowledge about women in prison gained through consultation and research. Similarly, the warden's job description for the new facilities has been written to capture the unique aspects of managing in this type of setting. Other aspects of the facility development will receive similar attention to ensure sensitivity to women's issues.

Conclusion

The undertaking in Canada is in keeping with many parallel initiatives taking place in other jurisdictions and countries to effect change for the generally small numbers of women in prison worldwide. The unique aspects of the Canadian experience, which appear to have worked to positive advantage, relate to the significant involvement and consultation with women offenders, the partnership developed with private-sector groups, including Aboriginal peoples, and the commitment of the Correctional Service of Canada and the Canadian Federal Government to make needed changes for women in prison. ■

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