SPECIFIC NEEDS OF WOMEN DIAGNOSED WITH MENTAL ILLNESSES IN U.S. JAILS

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Women's Mental Health Services: A Public Health Perspective

Edited by BRUCE LUBOTSKY LEVIN, Dr.P.H., ANDREA K. BLANCH, Ph.D., and ANN JENNINGS, Ph.D.

Women's Mental Health Services: A Public Health Perspective examines, within a public health framework, the major issues in the organization, financing and delivery of women's mental health services.

This multi-disciplinary work discusses the major mental health and substance abuse services delivery issues of particular concern to women, identifying and highlighting ways in which women are making important contributions to the administration and delivery of mental health services. This book also examines special issues in women's mental health services, including empowerment, individuals with severe mental illness, survivors, and at-risk populations. The foreword is written by Elaine Carmen, M.D., and Patricia Perri Rieker, M.D.

This timely work, which includes studies based on empirical research as well as personal and first-hand experiences, will provide policymakers, administrators, graduate students, service providers and consumers with the knowledge for improving mental health services. **Available 1998.**

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INTRODUCTION

The number of detainees in U.S. jails is exploding. From 1985 to 1995, this population increased from 265,010 to 509,828, an increase of 192%.[1] Women represent an increasing proportion of these populations. In 1985, women represented 8.0 percent of adult jail inmates; a total of 19,077 women. In 1990, this percentage had increased to 9.2 percent and in 1995, 10.2 percent of jail detainees were female; a total of 52,136 women and a 273% increase since 1985.[1] Increasingly, jail administrators are challenged to find appropriate ways to provide safe pre-trial and post-adjudication detention that is on a par with male detainees' correctional, treatment and service opportunities to meet both Constitutional and humane standards.

In a previous study of mental health services in U.S. jails, many jails were found that provided state-of-the-art and creative programming - - for men.[2] However, even in these exceptional jails, rarely were comparable services provided for the female detainees. Women are typically underserved in correctional settings in all types of jail programming.[3] When women do receive services, such as mental health or substance abuse, the services tend to be based upon models designed for the male population and simply applied to women. To achieve parity, jail programming must: (1) provide women with access to the *same* medical, mental health, substance abuse and other services that are available to men, and (2) where significant gender differences exist or when providing services to meet needs that are unique to women, these services should be modified or expanded to address the specific needs of women.

CHARACTERISTICS OF WOMEN IN U.S. JAILS

The increase in the number of women in U.S. jails is due in large part to changes in criminal justice policy, particularly the "war on drugs" and "getting tough on crime" policies. These policies mean that more women are being incarcerated for all crimes, especially crimes involving drugs.[4,5] Due to mandatory sentencing laws, the courts have less discretion in incarceration and term length decisions. Because of these facts, a study of women in California prisons concluded that "the 'war on drugs' has become a war on women."[6]

While both the popular and news media have attempted to link the growing female offender population with the emergence of a new, more violent female criminal, current evidence does not support this conclusion. Female arrestees are being booked into U.S. jails predominantly for drug charges or non-violent crimes that are often economic crimes committed to support drug habits. This fact alone accounts for most of the increase in the size of the population and does not represent a fundamental shift toward a new population of violent female offenders.[5,7]

Table 1 displays some key characteristics of male and female jail detainees. As can be seen, men and women in U.S. jails are similar in terms of age and race/ethnicity. The median age of both men and women in jail is 28 years old. Slightly less than 40 percent of male and

-- INSERT TABLE 1 ABOUT HERE --

female detainees are white, non-Hispanic, a little over 40 percent are Black-non-Hispanic, about 16 percent were Hispanic, and less than three percent belonged to other racial and ethnic groups, such as Native Americans, Pacific Islanders and Asian Americans. In comparison to men, however, a greater proportion of women have been married at some time (51.1% vs.

42.3%) and have completed high school or more (50.6% vs. 45.8%). In comparison to men, a smaller percentage of women were charged with violent crimes and a greater proportion with property and drug offenses.[8] Only 13 percent of women, compared to 24 percent of men, were arrested for violent crimes. Conversely, 34 percent of women were arrested for drug charges while only 22 percent of men were arrested for the same kinds of crimes. This information continues to support the fact that women are increasingly being arrested and prosecuted for drug-related crimes. This also means that women are increasingly entering the criminal justice system with serious medical and mental health problems that are associated with drug use.

The association between the growth of the number of women in the criminal justice system, poverty and drug use is disturbing, particulary in an era of decreasing resources. Today women have less access to public subsidies, including housing, health care and financial entitlements. The change in national policies toward welfare and health care is anticipated to have a negative impact on this very group of people. In addition, these women face increasing discrimination due to their multiple statuses as offenders, as mental health service users, as substance abusers, and being predominantly people of color in poverty.

MENTAL HEALTH STATUS OF FEMALE JAIL DETAINEES

Many women are entering the criminal justice system diagnosed with serious mental illnesses. In addition to presenting symptoms related to serious mental illnesses, many women also enter jails with issues that complicate mental health problems and produce additional stress that affect a woman's mental health. A majority of women booked into jails have one or

more of the following: substance abuse/dependence, serious physical illness, pregnancy and/or primary responsibility for minor children, history of adult or childhood physical or sexual abuse, self-esteem issues, and vocational and educational needs. These factors are not unknown among male populations, but they are much more prevalent among women. In addition, jails are typically designed and administered for a male population without regard to differences between the genders,[5] particularly differences in dangerousness and interpersonal interactional styles. This rigidly structured and controlled environment can create unnecessary stress for women, many of whom do not require high security precautions.

Prevalence Estimates of Serious Mental Illnesses

Although women represent only a small percentage of jail inmates, studies show that they are more likely than incarcerated men to be diagnosed with serious mental illnesses.[9,10] In a prevalence study of mental illnesses among male and female admissions to a large urban jail, Teplin [9,11] found that 8.9 percent of males and 18.5 percent of females had diagnosable serious mental illnesses (see Table 2). Acute conditions of serious mental illnesses were found in 6.1 percent of men and 15.0 percent of women being booked into the jail. Compared to male detainees, women had fairly comparable rates of acute schizophrenia and bipolar disorder (1.8% females vs. 3.0% males diagnosed with schizophrenia, 2.2% vs. 1.1% bipolar-manic episode). However, 13.7 percent of female admissions to jail were diagnosed with a current episode of major depression, while only 3.4 percent of men were diagnosed with this disorder. In addition, a notable 22.3 percent of women in jail were diagnosed with Post-traumatic Stress Disorder (PTSD) and an additional 6.5 percent with dysthymia and approximately 3.5 percent with anxiety and panic disorders.

The diagnosis of Post-traumatic Stress Disorder is noteworthy in the context of women in correctional settings, because it both reflects a common experience of many women — namely repeated, severe and/or long term physical and sexual abuse — and because it has implications for service providers, corrections staff, and administrators. Women diagnosed with PTSD may exhibit a number of symptoms, including hypervigilance, startle reflex, phobias, auditory and visual flashbacks to incidents of abuse, and uncontrollable anger or rage. They may have problems that are directly associated with incidents of abuse, specifically interacting with authority figures or men in general (i.e., persons who remind them of the perpetrator of violence), being physically restrained or locked up, and being unclothed. Clearly, women with histories of physical or sexual abuse may experience extreme difficulties in jail settings.

-- INSERT TABLE 2 ABOUT HERE --

Corrections and health care staff are often trained to recognize the symptoms of psychotic disorders and suicide risk. However, many of the psychiatric and emotional problems that women have are not so easily identified. Because corrections staff act as the gatekeepers to psychiatric evaluations, there is a significant risk that women who have significant mental health problems may not be identified and, therefore, not have access to mental health treatment during their confinement in jail. More importantly, some psychiatric disorders such as PTSD and anxiety disorders, if not specifically acknowledged and attended to within the jail, are likely to increase the risk that women will become management problems for security staff and may inappropriately use expensive medical and psychiatric services they would otherwise not require.

Because women represent a small proportion of jail populations, many facilities do not provide a full range of mental health services or appropriate housing options for female detainees. Further, the mental health services that are offered are often based on the needs of men, including the criteria used in screening and psychiatric evaluations, the use of psychotropic medications, and specialized housing.

In addition to symptoms related to serious mental illnesses, many female detainees have substantial emotional difficulties related to separation from children, guilt and shame, conditions of confinement and self-esteem. If these issues are addressed, women are more likely to be willing to engage in treatment services, cooperate in their adjudication process, and be less difficult to supervise.

Prevalence of Co-occurring Substance Abuse

A majority of women diagnosed with mental illnesses in jails have current substance abuse problems. The National Institute of Justice's Drug Use Forecasting program indicates that 67 percent of female arrestees test positive for drugs, depending on the city.[12] Table 3 indicates that, compared to men, women arrestees are much more likely to abuse cocaine and opiates, while male arrestees are more likely to test positive for marijuana use. Lifetime prevalence rates of alcohol abuse/dependence and drug abuse/dependence disorders also reveal that female detainees are more likely than male detainees to be diagnosed with drug disorders. As indicated in Table 3, 70.2 percent of female admissions had diagnosable substance use disorders, 63.5 percent with drug abuse.[9] Among males, 61.3 percent were diagnosed with substance abuse disorders, 32.4 percent with drug abuse.[11] The rates of substance abuse are even higher for persons diagnosed with mental illnesses. Among jail detainees with serious

mental illnesses, 74.9 percent of women and 72.0 percent of men have co-occurring substance abuse disorders.

-- INSERT TABLE 3 ABOUT HERE --

Substance abuse treatment services have traditionally been designed by and for men.[4,13] However, men and women who abuse substances differ in important ways. When compared to men, women are more likely to be poor,[4,13,14,15,16] are more likely to be involved with a partner who also abuses drugs,[13,14] have lower self-esteem,[13] differ and exhibit more severe physiological effects,[4] and are more likely to be victims/survivors of violence as adults and as children.[14]

Histories of Childhood and Adult Physical and Sexual Abuse

Histories of physical and sexual abuse are common among incarcerated women. The Michigan Women's Commission[13] found that 50 percent of female Michigan jail detainees had been victims of physical or sexual abuse at some point in their lives. An American Correctional Association study[17] revealed that over half of adult female offenders had been victims of physical abuse and 36 percent had been sexually abused.

A review of histories of violence among female recipients of psychiatric inpatient and outpatient services revealed that 35 to 51 percent of women had histories of childhood physical abuse, 20 to 54 percent with childhood sexual abuse, 42 to 64 percent with adult physical abuse and 21 to 38 percent with adult sexual assault.[18] More than 70 percent of women with drug or alcohol abuse problems were victims of violence, including domestic assault by adult partners, rape and incest.[19]

Women with histories of abuse may be diagnosed with a serious mental illness. The high prevalence rate of childhood abuse among female psychiatric inpatients (51%) seems to indicate that childhood trauma is a contributing, if not causal, factor to the diagnosis of a serious mental illness later in life. The factors associated with childhood sexual abuse among women diagnosed with mental illnesses are: early age of onset, more sexual delusions, symptoms of depression and suicidality, and psychotic symptoms. They are also more likely to be diagnosed with borderline personality disorder and have higher rates of substance abuse and serious medical problems.[20,21]

Clearly, behavioral reactions to childhood physical and sexual abuse, including self-injury, flashbacks, instability in relationships, phobias, anger and rage may be misunderstood as symptoms of mental illnesses, such as schizophrenia or depression. Proper diagnosis of these symptoms has practical implications for medication and treatment. The treatment for Multiple Personality Disorder or PTSD is significantly different than the treatment for schizophrenia, for example. While medication and treatment strategies differ depending on the diagnosis, it is important that jails do not create a two-tiered system of mental health care. Services must be available to all who need and want them, provided with equal care, concern and attention to the recipient.

During incarceration, women diagnosed with mental illnesses who have histories of violence are a particularly vulnerable group. Jails are designed to control to potential for violence. The jail is a highly coercive environment that is based on strict adherence to authority. It is also predominantly male, both detainees and staff. This kind of environment is extremely threatening to women with histories of abuse. The response to this perceived threat

may be withdrawal, fighting back or extreme outbursts, and/or worsening of symptoms or physical health problems.

Health Care Needs

The most pressing health problems among incarcerated women are HIV/AIDS, tuberculosis, hepatitis, and sexually transmitted diseases. According to the Center for Disease Control (CDC), HIV infection is increasingly disproportionately among women. In the general population, HIV infection has a higher prevalence among males, African-Americans and Hispanics, and persons of low socio-economic status, with IV drug use being the predominant exposure source.[3] Among correctional populations, female admissions to U.S. prison and jail systems are significantly more likely to be HIV-seropositive than male admissions. Women are typically underserved in correctional settings. In the case of the HIV epidemic, this is alarming. Female jail detainees are more likely than men to be IV drug users and have greater family responsibilities.[3] In addition, many women enter the system pregnant or post-partum. This means that the health crisis extends beyond the woman to include her family.

Tuberculosis and other infectious diseases are a growing problem for correctional facilities. Not only do the populations in U.S. jails have a higher prevalence of these diseases, but the crowded conditions and poor ventilation of many facilities increase the risk of transmission.

Due to the high prevalence of STDs, pregnancy and post-partum conditions, good OB/GYN care is critical. While jails are first and foremost detention facilities, the medical needs of these detainees incur a Constitutional mandate to provide health care. In addition, it

is good public health policy to intervene in public health crises in jails, where medical treatment can be carefully monitored during custody.

Pregnancy and Childcare

In 1991, 67 percent of women in prisons had one or more children under 18[22] and approximately one-quarter of all women who enter prison are pregnant or post-partum.[23] Estimates for jail populations are likely to be even higher, since most individuals spend a considerable amount of time in jail prior to sentencing and transfer to a prison facility. As noted above, women in jails bring with them serious mental health, substance abuse and medical problems. Infants born to addicted mothers have a higher mortality rate than infants born to non-addicted mothers.[23] In addition, medical and mental health conditions may present complicating factors in pregnancy that require careful pre-natal care. Medications prescribed for psychiatric conditions must be carefully reviewed to insure the health of both the mother and the developing fetus, particularly during the first trimester.

The responsibility for minor children creates additional stress for women in jail. Approximately 70 percent of incarcerated women lived with their minor children prior to being incarcerated and most expressed an intent to parent after release.[22] Women have a great concern about where and with whom their children are living. In about one-third of the cases of incarcerated women with children, child protective services and other social service agencies are involved in the out-of home placement of their children.[24] In addition, many women are in the formal process of losing custody of their children. These stresses, plus the limited access to children during visiting hours, makes incarceration an extremely difficult time for parents.

SERVICES PARITY

The 14th Amendment of the U.S. Constitution, the 'due process' clause, assures "nor shall any State deprive any person of life, liberty or property, without due process of law, nor deny to any person within its jurisdiction the equal protection of the laws." This is the clause that is typically used in case law decisions regarding conditions of pre-trial detention. Case law decisions, such as Estelle v. Gamble, established the right to minimal medical care and subsequently to other essential treatment. Similar arguments have been made for sentenced jail and prison inmates under the 8th Amendment 'cruel and unusual punishment' clause. To the extent that these Constitutional mandates exist for male detainees, they also exist for female detainees.

Parity in correctional programming for female detainees means that services and programming available to male detainees are available to women in the facility, except when those services and programs can be shown to be male-specific. For example, arguments have been made that shock incarceration or 'boot camps' are not appropriate for women. A sentence to a boot camp is typically made in lieu of a jail or prison term and is designed to reduce the amount of time an offender spends incarcerated. If this program is only available to men, and women have no equivalent, female offenders will serve longer terms in jail or prison. In this instance, female offenders are not accorded equal protection under the law. In order for parity to exist under these circumstances, equivalent programming should be made available.

Equivalent mental health and other correctional services for female detainees means that women should have the same range of services and opportunity to use those services with

the same criteria and conditions for participation applied to their use. For true parity to exist in jail mental health programming, women must (1) have access to the same mental health services as men and (2) the services must be tailored to women's unique needs. Many jails provide specialized mental health housing and services for male detainees, but not for their female population. In this case, administrators believe that it is not cost-effective to provide separate housing for women diagnosed with mental illnesses and, therefore, have adapted other procedures to accomplish the same ends, including transferring women who exhibit less severe symptoms to inpatient settings and over-medicating women to reduce behavioral symptoms so that they can remain in general population. These adaptations to procedure do not provide equal treatment.

In addition, some consideration must be given to where services are physically located, when the services may be used, and who they are designed to serve. Typically, female housing units are physically separated from the male units. Commonly, jail programming and services are located within the male housing area. This means that women must pass through or close to the male housing. When this happens, the women are often harassed by the male detainees. Administrators attempt to reduce contact to protect female detainees from harassment and assault and to reduce the risk of illicit activities, both of which compromise security. Many jails have solved this problem by bringing all services to the female housing units. The unintended consequence is that services are truncated, both in the breadth of services and the time available for specific activities.

Of critical importance in jail mental health and other programming is the question, "for whom are the services designed?" Most clinical interventions are based on the assumption that

men and women will respond similarly to treatment given similar clinical characteristics. However, there is a growing acknowledgment within the medical, psychiatric and substance abuse treatment communities that women's psychosocial development, experiential characteristics and physiology are sufficiently different from men to require that treatment interventions be designed specifically for them. This is especially true of psychiatric medications. Many medications have been tested only on men. Even in drug trials where women have participated as subjects, women of child-bearing years are excluded. Careful consideration should be given to what medications are selected and how they affect the women for whom they are prescribed.

Given the growing population of female jail detainees and their unique characteristics, it has become increasingly necessary for jail administrators to begin developing appropriate, gender-specific services for women. This is not an option. It is a constitutional duty. In addition, providing appropriate services and programming to female detainees makes sense from a management perspective. Without these services, women can be disruptive and may, in fact, be more likely to use expensive medical and mental health services.

WOMEN-SPECIFIC JAIL MENTAL HEALTH SERVICES

Jails are first and foremost correctional institutions and should remain as such.[25] Jails that provide comprehensive mental health treatment services are at risk of becoming the treatment facility of choice in communities with dwindling community-based mental health resources. At the same time, jails incur a substantial Constitutional mandate to provide minimum medical and psychiatric services to all detainees who need such services. Two basic

principles guide the minimum requirements: (1) persons in detention should not leave the facility in worse condition than when they arrived, and (2) persons should not be punished for being identified as having a need (i.e., the identification of a mental illness should not impact on access to other services or length of time spent in jail). Jail mental health services are typically focussed on identification, crisis management and short-term treatment. Adaptations to typical services and resources to improve service delivery to female detainees are discussed below.

Screening, Assessment and Evaluation

Screening, assessment and evaluation is a three stage process by which jails identify persons in need of psychiatric care. The *initial screen* is conducted by a corrections officer at booking. The purpose of this screen is to flag persons in need of a more detailed mental health evaluation and to identify persons at risk for suicide. Officers are not trained clinicians and are not expected to make decisions regarding treatment. The booking officer's job is to refer all individuals who, because of their responses to specific questions or by their appearance or behavior, appear to be at risk.

A *mental health assessment* is often a second step toward providing treatment. This can be done by a mental health worker or by medical staff within the context of a medical history. Both the booking screen and the medical exam are done on all individuals who are booked into the jail and assigned housing. The mental health assessment is conducted only on persons flagged by the booking screen or by the medical department. At the final stage, persons assessed as needing psychiatric services are referred for a full *psychiatric evaluation*. Psychiatric evaluations are conducted by a psychiatrist and often result in the prescription of

medication.

Screening, assessment, and evaluation are critical points in the service delivery system for the provision of appropriate services to female offenders because information uncovered at these points affect classification decisions and whether women will receive mental health and other treatment services. Screening instruments used by booking officers should include a minimum set of questions related to symptoms of affective and psychotic disorders, history of mental health treatment, current use of prescribed psychotropic medication, and risk of suicide. For these screens to encompass the characteristics of women diagnosed with mental illnesses, questions should also ask about: (1) symptoms of depression, (2) whether the woman was recently injured, and (3) whether she has minor children and are they currently being cared for.

In addition to more detailed information regarding the areas noted above, the medical and mental health assessments, and the psychiatric evaluation are points where information about physical and sexual abuse should be gathered. This requires that medical and mental health staff receive training in assessing women with histories of abuse. This information is critical for the identification of the correct diagnosis and the development of appropriate mental health, health care, and substance abuse treatment plans.

Classification and Housing

Structurally, jails are designed to control the potential for violence. Their primary mandate to is to hold individuals in a secure environment and prevent physical injury to either staff or detainees. Single cell tiers and pods, highly regimented schedules, lack of privacy, and an expectation of an unquestioning response to authority are characteristics of correctional

facilities designed to maximize control and reduce opportunities for breaches in security (e.g., escapes, riots and violent incidents, use of contraband). This structure, in fact, functions well for men who tend to be socialized to hierarchical authority. However, women tend to rely more heavily on flat structures of interpersonal relationships and desire more privacy. In addition, women do not pose the same threats to jail security as men. Jail facilities may, in fact, create an additional unintended burden on female detainees.

Classification refers to the process by which individuals booked into the jail are assigned housing. Appropriate classification takes into account seriousness of offense and risk of violence, special needs, such as medical or mental health problems, gender and age, and adjudication status. Most jails assign different security levels within their facility and have different kinds of housing, including general population, medical (where persons diagnosed with acute mental illnesses or suicide risk may be placed), and administrative segregation. Some jails also provide specialized housing, such as mental health units for persons with stable conditions, substance abuse therapeutic communities, trustee housing, and juvenile units.

In many jails, there is only one classification status for women - - female. Because women comprise such a small proportion of the jail population, many facilities tend group all women together, regardless of security risk or needs. However, women diagnosed with mental illnesses in jail have the right to the same protections as their male counterparts. Because many jails do not provide special housing for women diagnosed with mental illnesses, many facilities transfer female detainees with moderate symptoms to psychiatric facilities, where a male detainee with similar characteristics would remain in the jail. While this appears to be more humane, it has serious consequences. First, a transfer out of the jail for

evaluation or inpatient treatment interrupts, and may significantly delay, the adjudication process, thus extending the period of confinement. Second, the inpatient facility may not be within the locality. This means that the woman may not be able to see family and other support persons easily, if at all. Also, some persons diagnosed with chronic mental health conditions resist transfers to inpatient settings, preferring the jail to a psychiatric facility. Jails must provide the same kinds of housing options to both men and women. They must also apply the same standards and procedures to both men and women when transferring detainees to psychiatric facilities.

As noted earlier, 87 percent of female offenders are arrested for non-violent crimes. For the most part, women do not require high security supervision. Given this fact and the widespread prevalence of histories of abuse, several adaptions to housing and staffing may be suggested: (1) staff must be trained in managing women in a non-aggressive and non-threatening manner, realizing that women have been victimized predominantly by men and abandoned by their female protectors, (2) housing units, particularly in jails with podular designs and direct supervision, should consider cell doors that are not locked, and (3) jails should consider ways to normalize the jail environment, including more time out of the cells for the detainees to interact socially and more protections for personal privacy, such as shower curtains and doors on bathroom stalls.

Medication and Psychiatric Follow-up Services

Medication and medication monitoring of women are major issues for jail psychiatry. Women are diagnosed at a much higher rate with unipolar depression. However, some jails do not allow the prescription of certain anti-depressants, because of their potential for abuse.

Despite indications or previous treatment, some women cannot receive the medication of choice due to standing policies. On the other hand, these policies exist for good reason. Women and men with significant addictive disorders may request anti-depressants as a substitute for their drug of choice. Each individual case must be reviewed carefully prior to the prescription of medication, and at regular intervals thereafter, to assure that the medications are appropriate to the need.

Over-prescription of medication is as problematic as under-prescription. Because women's housing is limited and because women are not as easily managed as men in general, there is a tendency to over-prescribe medications for the sole purpose of tranquilizing the detainee. From the jail's perspective, this is a reasonable policy, because it enhances the jail's security. From a human rights perspective, it is an unjustified use of chemical restraints and violates Constitutional rights. In addition, the medication may interfere with the detainee's ability to participate in her adjudication process.

Crisis Intervention and Suicide Precautions

Women diagnosed with mental illnesses in jail do not typically exhibit the same symptoms as men. Nor should the crisis intervention responses be the same. Clinicians must be trained to identify suicide risk in women and how to appropriately intervene in mental health crises without re-traumatizing a woman who typically has been repeatedly traumatized.

The policies and procedures governing the use of physical and chemical restraints should be carefully reviewed for their application on *all* female detainees, both those with diagnoses of mental illness and those without. Because histories of abuse are so prevalent among women in jail, these procedures should be developed for all women. Some mental

health systems are beginning to review these issues in response to a growing awareness of the damage that these procedures have on individuals' physical and emotional well-being. This is critically important, when managing women with significant histories of physical and sexual abuse.

If staff of jail psychiatric services expect to have a continuing relationship with a female detainee, it may be helpful to understand what actions or events cause distress and what interventions staff can use that will help to calm the detainee. It is also helpful to tell women diagnosed with mental illnesses who might require restraint what procedures are used in the facility early on in their confinement.

Other Mental Health Treatment

In jails where other kinds of mental health treatment are available, several considerations for women should be addressed. Single gender groups are critically important. Women who have been victims of abuse do not function well in mixed gender treatment groups. In addition, women who have experience physical or sexual abuse as well as women diagnosed with mental illnesses appear to benefit from peer-support groups. Given the prohibitive costs of professional services and the benefit of peer-support, jails may want to consider using community resources to supplement core psychiatric services.

Case Management and Discharge Planning

Most jails do not provide case management or discharge planning services. Arguably, release planning can be the most important service a jail can provide to reduce the probability of return. For all persons with special needs, both male and female, linkages to community services, particularly if the linkage is more than a telephone appointment, can make a

significant difference in engagement in community-based services.

While most jails acknowledge this important service, the manner by which individuals are processed limits a jail's ability to develop effective linkages. Most importantly, it is critical to understand that release decisions are made from the court. Except when inmates serve specific sentences, jails do not typically know when someone will be released; whether it is pre-trial or upon sentencing.

Beginning discharge planning early in confinement is important. Upon release, women in general, and women diagnosed with mental illnesses, will require more community services, including housing for the women and their children, mental health and substance abuse services, social services and entitlements, health care and vocational services. In the case of female detainees, discharge planning involves not only services for the individual released from jail, but a web of services for single-parent families.

Because release from jail is complicated by the re-integration of a woman into multiple contexts -- her family, significant relationships and community -- and requires a life-style change in all domains of her life if she is to remain free, lead time is important. Women recently released often express being overwhelmed by all the demands. To whatever extent possible, issues around release should be addressed early and often in mental health and substance abuse counseling. In addition, slow re-integration through halfway houses or other residential facilities is helpful.

IMPLICATIONS FOR MENTAL HEALTH SERVICES DELIVERY: APPROPRIATELY RESPONDING TO WOMEN'S SPECIAL NEEDS

To address the special needs of women diagnosed with mental illnesses in correctional settings, comprehensive and integrated strategies are necessary. To provide leadership in this area, specific attention should be given to the following areas.

Parity of mental health services. One of the major issues regarding women's mental health in correctional settings is the lack of services. The state of mental health services in U.S. jails is poor, but, for women, it is worse. Because women represent such a low percentage of correctional populations, they often do not have access to the same mental health or other services that are available to men. In addition, when they do exist, rarely do mental health services give attention to the special needs of women. But before specialized programs can be developed, basic services must be available to all women who need them. This requires a commitment on the part of the jail administration. More importantly, this requires the allocation of resources, including staffing, space and money.

Targeted screening/evaluation procedures and instruments. Currently, no screening and assessment tools exist that are designed specifically for women. A critical first step in the process of treatment is proper diagnosis and treatment planning. In corrections, woman-specific tools must be developed that support appropriate classification of women and can identify issues that complicate treatment and supervision, including histories of abuse, medical problems, and childcare issues.

Further, because major mental illnesses, such as major affective disorders, schizophrenia and dissociative disorders precipitated by childhood trauma, and symptoms associated with Post-Traumatic Stress Disorder have different courses and may involve different treatment interventions, screening and evaluation tools for women who have been

diagnosed with a mental illness must be highly specific and sensitive. However, if the facility has no flexibility in treatment provision, jail staff must carefully consider the risks associated with identifying a woman as "mentally ill" with the benefits of more complete information.

Special crisis intervention procedures. Because so many women in jail, with and without diagnoses of mental illnesses, have experienced physical and/or sexual abuse, protocols for crisis intervention should be developed for use with all women in crisis. Jails may want to consider the use of advance directives and investigate non-invasive, non-threatening de-escalation techniques for general use.

Peer support and counseling programs. Because some psychiatric interventions are coercive (e.g., seclusion/restraint, involuntary medication, locked rooms, paternalistic treatment/infantilization of patients), the more so when delivered in jails, they may be resisted or rejected. Peer counseling programs show great promise in helping women to address both mental health problems and the violent events in their lives. These programs are not designed to replace standard mental health treatment, and may, in fact, function best when coordinated with existing services. Peer support programs also offer an opportunity to connect the woman with her community prior to release. Transition from jail to the community is often one of the most difficult steps for women to take. Continuity is critical. Many peer support programs (i.e., 12-step substance abuse programs, AIDS awareness, Double Trouble) have community groups.

Parenting programs. Research indicates that adult survivors of child abuse often repeat the behaviors of their parents with their own children. Further, substance abuse is strongly associated with child abuse. To the degree that women in correctional settings are both

victims of violence and perpetrators of violence, they are also at a higher risk of abusing their own children. Parenting programs directed at education, empowerment and practical skills hold promise to break the cycle of violence in the lives of families.

Integrated services. Clearly, women in correctional settings are likely to face multiple issues, including substance abuse, mental illnesses or emotional difficulties, parenting, and dangerous or violent home environments. Integrating services, whether it is in the jail or transition to the community, holds the most promise in assisting women to remain safely in the community.

Training programs for security, mental health and substance abuse professionals. Issues specific to women are not well known. Even when the administration supports woman-specific programming, direct line staff do not always understand the need and therefore do not act in accordance with the program procedures. Training is necessary, not only for criminal justice personnel, but also for mental health, medical and substance abuse workers. Misdiagnosis, the medicalization of social problems, and sexist attitudes contribute to the continuing abuse of women in jail.

Outcome measures. How do we know when we are making progress? In regard to woman-specific services this is an especially cogent question. Attention must be given to the development of appropriate outcome measures for treatment interventions designed to affect women diagnosed with mental illnesses in jails. Where most programs are designed for men, so too are most outcome measures; not that these indicators are not applicable, rather they are insufficient. Attention must be given to outcomes that acknowledge the wide variation in women's life experiences, adaptive styles, and modes of recovery. Measures should be

developed through a joint effort by mental health professionals, researchers and the women using services. While this is a generic issue, it is equally valid in the assessment and evaluation of mental health programs in correctional settings.

CONCLUSION

U.S. jails vary enormously in size and resources. Not all facilities are large enough to provide a full array of mental health services and housing options on-site. However, all jails are required to provide *access* to necessary services. Small jails access psychiatric care typically by contracting with community providers. To ensure that the rights of women held in jails are protected, administrators and service providers should carefully review the service options and protocols applied to women to guarantee that: (1) they have access to basic psychiatric care, (2) have the same access as men in the same facility to other housing and support services, and (3) that the services provided are modified to address woman-specific treatment issues and needs, where necessary.

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Table 1

Characteristics of Jail Detainees by Gender

VARIABLE	FEMALE	MALE
Median Age	28	28
Race/Ethnicity		
% White	37.8	38.7
% Black	43.4	41.5
% Hispanic	16.3	17.5
% Other	2.5	2.3
% Never Married	48.9	57.5
% HS or More	50.6	45.8
Arrest Charge		
% Violent	13.2	23.5
% Property	31.9	29.9
% Drug Offense	33.6	21.9
% Other	21.2	24.7

Source:

Maguire K, Pastore AL: *Sourcebook of Criminal Justice Statistics - 1993.* NCJ-148211. Washington, DC: U.S. Department of Justice, 1994.

Table 2

Lifetime Prevalence and Current Incidence of Mental Illnesses

Among Jail Detainees by Gender

DIAGNOSIS	CURRENT		LIFETIME	
	FEMALE	MALE	FEMALE	MALE
Any Severe Disorder	15.0	6.1	18.5	8.9
Schizophrenia	1.8	3.0	2.5	3.8
Bipolar-Manic	2.2	1.2	2.6	2.2
Major Depression	13.7	3.4	16.9	5.1
Post-traumatic Stress D/O	22.3	na	33.5	na
Dysthymia	6.5	na	9.6	8.5
Anxiety D/O/Other	3.5	11.6	4.0	21.0

Source:

Teplin LA: Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health* 1994;84:290-93.

Teplin LA, Abram KM, McClelland GM: Prevalence of psychiatric disorders among incarcerated women. *Archives of General Psychiatry* 1996;*53*:505-512.

Table 3

Substance Abuse Among Arrestees and Jail Detainees by Gender

SUBSTANCE ABUSE	FEMALE	MALE
Arrestees:		
Any Drug	67%	66%
Marijuana	17%	30%
Cocaine	50%	41%
Opioids	8%	6%
Jail Detainees:		
Substance abuse/dependence	70.2%	61.3%
Drug abuse/dependence	63.5%	32.4%
Alcohol abuse/dependence	32.3%	51.1%

Source:

National Institute of Justice: *Drug Use Forecasting: 1994 Annual Report on Adult and Juvenile Arrestees*. Washington, D.C.: U.S. Department of Justice, 1995.

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WOMEN'S MENTAL HEALTH SERVICES

A Public Health Perspective

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17

Specific Needs of Women Diagnosed With Mental Illnesses in U.S. Jails

Bonita M. Veysey, Ph.D.

The number of detainees in U.S. jails is exploding. From 1985 to 1995, this population rose from 265,010 to 509,828, an increase of 192 percent.[1] Women represent a growing proportion of these populations. In 1985, women represented 8.0 percent of adult jail inmates, a total of 19,077 women. In 1990, this percentage had increased to 9.2 percent and in 1995, 10.2 percent of jail detainees were female, a total of 52,136 women and a 273 percent increase since 1985.[1] Jail administrators are being more often challenged to find appropriate ways to provide safe pretrial and post-adjudication detention that is on a par with male detainees' correctional, treatment, and services opportunities to meet both constitutional and humane standards.

In a previous study of mental health services in U.S. jails, many jails were found that provided state-of-the-art and creative programming—for men.[2] However, even in these exceptional jails, rarely were comparable services provided for the female detainees. Women are typically underserved in correctional settings in all types of jail programming.[3] When women do receive services, such as mental health or substance abuse, the services tend to be based on models designed for the male population and simply applied to women. To achieve parity, jail programming must (1) provide women with access to the same medical, mental health, substance abuse, and other services that are available to men; and (2) where significant gender differences exist or when providing services to meet needs that are unique to women, these services should be modified or expanded to address the specific needs of women.

CHARACTERISTICS OF WOMEN IN U.S. JAILS

The increase in the number of women in U.S. jails is due in large part to changes in criminal justice policy, particularly the "war on drugs" and "getting tough on crime" policies. These policies mean that more women are being incarcerated for all crimes, especially crimes involving drugs.[4,5] Due to mandatory sentencing laws, the courts have less discretion in incarceration and term-length decisions. Because of these facts, a study of women in California prisons concluded that "the 'war on drugs' has become a war on women."[6]

While both the popular and news media have attempted to link the growing female offender population with the emergence of a new, more violent female criminal, current evidence does not support this conclusion. Female arrestees are being booked into U.S. jails predominantly for drug charges or nonviolent crimes that are often economic crimes committed to support drug habits. This fact alone accounts for most of the increase in the size of the population and does not represent a fundamental shift toward a new population of violent female offenders.[5,7]

Table 17.1 displays some key characteristics of male and female jail detainees. As can be seen, men and women in U.S. jails are similar in terms of age and race/ethnicity. The median age of both men and women in jail is 28. Slightly less than 40 percent of male and female detainees are White non-Hispanic, a little over 40 percent are Black non-Hispanic, about 16 percent were Hispanic, and less than 3 percent belonged to other racial and ethnic groups, such as Native Americans, Pacific Islanders, and Asian Americans. In comparison to men, however, a greater proportion of women have been married at some time (51.1 percent vs. 42.3 percent) and have completed high school or more (50.6 percent vs. 45.8 percent). In comparison to men, a smaller percentage of women were charged with violent crimes and a greater proportion with property and drug offenses.[8] Only 13 percent of women, compared with 24 percent of men, were arrested for violent crimes.

TABLE 17.1 Characteristics of Jail Detainees, by Gender

Variable	*Female*	*Male*
Median age	28	28
Race/ethnicity (%)		
White	37.8	38.7
Black	43.4	41.5
Hispanic	16.3	17.5
Other	2.5	2.3
Never married (%)	48.9	57.5
High school or more (%)	50.6	45.8
Arrest charge (%)		
Violent	13.2	23.5
Property	31.9	29.9
Drug offense	33.6	21.9
Other	21.2	24.7

SOURCE: Maguire K, Pastore AL: *Sourcebook of Criminal Justice Statistics—1993.* NCJ-148211. Washington, DC: U.S. Department of Justice, 1994.

Conversely, 34 percent of women were arrested for drug charges, while only 22 percent of men were arrested for the same kinds of crimes. This information continues to support the fact that women are increasingly being arrested and prosecuted for drug-related crimes. This also means that women are increasingly entering the criminal justice system with serious medical and mental health problems that are associated with drug use.

The association between the growth of the number of women in the criminal justice system with poverty and drug use is disturbing, particularly in an era of decreasing resources. Today, women have less access to public subsidies, including housing, health care, and financial entitlements. The change in national policies toward welfare and health care is anticipated to have a negative impact on this very group of people. In addition, these women face increasing discrimination due to their multiple statuses as offenders, mental health service users, substance abusers, and being predominantly people of color in poverty.

MENTAL HEALTH STATUS OF FEMALE JAIL DETAINEES

Many women are entering the criminal justice system diagnosed with serious mental illnesses. In addition to presenting symptoms related to serious mental illnesses, many women also enter jails with issues that complicate mental health problems and produce additional stress that affects a woman's mental health. A majority of women booked into jails have one or more of the following: substance abuse/dependence, serious physical illness, pregnancy and/or primary responsibility for minor children, history of adult or childhood physical or sexual abuse, self-esteem issues, and vocational and educational needs. These factors are not unknown among male populations, but they are much more prevalent among women. In addition, jails are typically designed and administered for a male population without regard to differences between the genders,[5] particularly differences in dangerousness and interpersonal interactional styles. This rigidly structured and controlled environment can create unnecessary stress for women, many of whom do not require high-security precautions.

Prevalence Estimates of Serious Mental Illnesses

Although women represent only a small percentage of jail inmates, studies show that they are more likely than incarcerated men to be diagnosed with serious mental illnesses.[9,10] In a prevalence study of mental illnesses among male and female admissions to a large urban jail, Teplin[9,11] found that 8.9 percent of males and 18.5 percent of females had diagnosable serious mental illnesses (see Table 17.2). Acute conditions of serious mental illnesses were found in 6.1 percent of men and 15.0 percent of women being booked into the jail. Compared with male detainees, women had fairly comparable rates of acute schizophrenia and bipolar disorder (1.8 percent females vs. 3.0 percent males diagnosed with schizophrenia, 2.2 percent vs. 1.1 percent bipolar-manic episode). However, 13.7 percent of female admissions to jail were diagnosed with a current episode of major depression, while only 3.4 percent of men were diagnosed with this disorder. In addition, a notable 22.3 percent of women in jail were diagnosed with post-traumatic stress disorder (PTSD), an additional 6.5 percent with dysthymia, and approximately 3.5 percent with anxiety and panic disorders.

The diagnosis of PTSD is noteworthy in the context of women in correctional settings, both because it reflects a common experience of many women—namely, repeated, severe, and/or long-term physical

TABLE 17.2 Lifetime Prevalence and Current Incidence of Mental Illnesses Among Jail Detainees, by Gender (in percentages)

	Current		*Lifetime*	
Diagnosis	*Female*	*Male*	*Female*	*Male*
Any severe disorder	15.0	6.1	18.5	8.9
Schizophrenia	1.8	3.0	2.5	3.8
Bipolar-manic	2.2	1.2	2.6	2.2
Major depression	13.7	3.4	16.9	5.1
Post-traumatic stress disorder	22.3	na	33.5	na
Dysthymia	6.5	na	9.6	8.5
Anxiety and panic disorders	3.5	11.6	4.0	21.0

SOURCE: Teplin LA: Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health* 1994; 84:290-293. Teplin LA, Abram KM, McClelland GM: Prevalence of psychiatric disorders among incarcerated women. *Archives of General Psychiatry* 1996; 53:505-512.

and sexual abuse—and because it has implications for service providers, corrections staff, and administrators. Women diagnosed with PTSD may exhibit a number of symptoms, including hypervigilance, startle reflex, phobias, auditory and visual flashbacks to incidents of abuse, and uncontrollable anger or rage. They may have problems that are directly associated with incidents of abuse, specifically interacting with authority figures or men in general (i.e., persons who remind them of the perpetrator of violence), being physically restrained or locked up, and being unclothed. Clearly, women with histories of physical or sexual abuse may experience extreme difficulties in jail settings.

Corrections and health care staff are often trained to recognize the symptoms of psychotic disorders and suicide risk. However, many of the psychiatric and emotional problems that women have are not so easily identified. Because corrections staff act as the gatekeepers to psychiatric evaluations, there is a significant risk that women who have serious mental health problems may not be identified and, therefore, not have access to mental health treatment during their confinement in jail. More important, some psychiatric disorders such as PTSD and anxiety disorders, if not specifically acknowledged and attended to within the jail, are likely to increase the risk that women will become management problems for security staff and may inappropriately use expensive medical and psychiatric services they would otherwise not require.

Because women represent a small proportion of jail populations, many facilities do not provide a full range of mental health services or appropriate housing options for female detainees. Furthermore, the mental health services that are offered are often based on the needs of men, including the criteria used in screening and psychiatric evaluations, the use of psychotropic medications, and specialized housing.

In addition to symptoms related to serious mental illnesses, many female detainees have substantial emotional difficulties related to separation from children, guilt and shame, conditions of confinement, and self-esteem. If these issues are addressed, women are more likely to be willing to engage in treatment services, cooperate in their adjudication process, and be less difficult to supervise.

Prevalence of Co-Occurring Substance Abuse

A majority of women diagnosed with mental illnesses in jails have current substance abuse problems. The National Institute of Justice's Drug Use Forecasting program indicates that 67 percent of female arrestees test positive for drugs.[12] Table 17.3 indicates that, compared with men, women arrestees are much more likely to abuse cocaine and opiates, while male arrestees are more likely to test positive for marijuana use. Lifetime prevalence rates of alcohol abuse/dependence and drug abuse/dependence disorders also reveal that female detainees are more likely than male detainees to be diagnosed with drug disorders. As indicated in Table 17.3, 70.2 percent of female admissions had diagnosable substance use disorders, 63.5 percent with drug abuse.[9] Among males, 61.3 percent were diagnosed with substance abuse disorders, 32.4 percent with drug abuse.[11] The rates of substance abuse are even higher for persons diagnosed with mental illnesses. Among jail detainees with serious mental illnesses, 74.9 percent of women and 72.0 percent of men have co-occurring substance abuse disorders.

Substance abuse treatment services have traditionally been designed by and for men.[4,13] However, men and women who abuse substances differ in important ways. When compared with men, women are more likely to be poor,[4,13-16] are more likely to be involved with a partner who also abuses drugs,[13,14] have lower self-esteem,[13] differ and

TABLE 17.3 Substance Abuse Among Arrestees and Jail Detainees, by Gender (in percentages)

Substance Abuse	*Female*	*Male*
Arrestees		
Any drug	67	66
Marijuana	17	30
Cocaine	50	41
Opioids	8	6
Jail detainees		
Substance abuse/dependence	70.2	61.3
Drug abuse/dependence	63.5	32.4
Alcohol abuse/dependence	32.3	51.1

SOURCE: National Institute of Justice: *Drug Use Forecasting: 1994 Annual Report on Adult and Juvenile Arrestees.* Washington, DC: U.S. Department of Justice, 1995. Teplin LA: Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health* 1994; 84:290-293.

exhibit more severe physiological effects,[4] and are more likely to be victims/survivors of violence as adults and as children.[14]

Histories of Childhood and Adult Physical and Sexual Abuse

Histories of physical and sexual abuse are common among incarcerated women. The Michigan Women's Commission[13] found that 50 percent of female Michigan jail detainees had been victims of physical or sexual abuse at some point in their lives. An American Correctional Association study[17] revealed that over half of adult female offenders had been victims of physical abuse and 36 percent had been sexually abused.

A review of histories of violence among female recipients of psychiatric inpatient and outpatient services revealed that 35 to 51 percent of women had histories of childhood physical abuse, 20 to 54 percent with childhood sexual abuse, 42 to 64 percent with adult physical abuse and 21 to 38 percent with adult sexual assault.[18] More than 70 percent of women with drug or alcohol abuse problems were victims of violence, including domestic assault by adult partners, rape, and incest.[19]

Women with histories of abuse may be diagnosed with a serious mental illness. The high prevalence rate of childhood abuse among female psychiatric inpatients (51 percent) seems to indicate that childhood trauma is a contributing, if not causal, factor to the diagnosis of a serious mental illness later in life. The factors associated with childhood sexual abuse among women diagnosed with mental illnesses are as follows: early age of onset, more sexual delusions, symptoms of depression and suicidality, and psychotic symptoms. They are also more likely to be diagnosed with borderline personality disorder and have higher rates of substance abuse and serious medical problems.[20,21]

Clearly, behavioral reactions to childhood physical and sexual abuse, including self-injury, flashbacks, instability in relationships, phobias, anger, and rage, may be misunderstood as symptoms of mental illnesses, such as schizophrenia or depression. Proper diagnosis of these symptoms has practical implications for medication and treatment. The treatment for multiple personality disorder or PTSD is significantly different than the treatment for schizophrenia, for example. While medication and treatment strategies differ depending on the diagnosis, it is important that jails do not create a two-tiered system of mental health care. Services must be available to all who need and want them and be provided with equal care, concern, and attention to the recipient.

During incarceration, women diagnosed with mental illnesses who have histories of violence are a particularly vulnerable group. Jails are designed to control the potential for violence. The jail is a highly coercive environment that is based on strict adherence to authority. It is also predominantly male, both detainees and staff. This kind of environment is extremely threatening to women with histories of abuse. The response to this perceived threat may be withdrawal, fighting back or extreme outbursts, and/or worsening of psychiatric symptoms or physical health problems.

Health Care Needs

The most pressing health problems among incarcerated women are HIV, AIDS, tuberculosis, hepatitis, and sexually transmitted diseases. According to the Centers for Disease Control and Prevention (CDC), HIV infection is increasing disproportionately among women. In the general population, HIV infection has a higher prevalence among males, African Americans, Hispanics, and persons of low socioeconomic status, with intravenous (IV) drug use being the predominant exposure source.[3] Among correctional populations, female admissions to U.S.

prison and jail systems are significantly more likely to be HIV seropositive than male admissions. Women are typically underserved in correctional settings. In the case of the HIV epidemic, this is alarming. Female jail detainees are more likely than men to be IV drug users and have greater family responsibilities.[3] In addition, many women enter the system pregnant or postpartum. This means that the health crisis extends beyond the woman to include her family.

Tuberculosis and other infectious diseases are a growing problem for correctional facilities. Not only do the populations in U.S. jails have a higher prevalence of these diseases, but the crowded conditions and poor ventilation of many facilities increase the risk of transmission.

Due to the high prevalence of sexually transmitted diseases, pregnancy, and postpartum conditions, good obstetric-gynecological (OB-GYN) care is critical. While jails are first and foremost detention facilities, the medical needs of these detainees incur a constitutional mandate to provide health care. In addition, it is good public health policy to intervene in public health crises in jails, where medical treatment can be carefully monitored during custody.

Pregnancy and Child Care

In 1991, 67 percent of women in prisons had one or more children under 18,[22] and approximately one quarter of all women who enter prison are pregnant or postpartum.[23] Estimates for jail populations are likely to be even higher, since most individuals spend a considerable amount of time in jail prior to sentencing and transfer to a prison facility. As noted above, women in jails bring with them serious mental health, substance abuse, and medical problems. Infants born to addicted mothers have a higher mortality rate than infants born to nonaddicted mothers.[23] In addition, medical and mental health conditions may present complicating factors in pregnancy that require careful prenatal care. Medications prescribed for psychiatric conditions must be carefully reviewed to ensure the health of both the mother and the developing fetus, particularly during the first trimester.

The responsibility for minor children creates additional stress for women in jail. Approximately 70 percent of incarcerated women lived with their minor children prior to being incarcerated and most expressed an intent to parent after release.[22] Women have a great concern

about where and with whom their children are living. In about one third of the cases of incarcerated women with children, child protective services and other social services agencies are involved in the out-of-home placement of their children.[24] In addition, many women are in the formal process of losing custody of their children. These stresses, plus the limited access to children during visiting hours, make incarceration an extremely difficult time for parents.

SERVICES PARITY

The 14th Amendment of the U.S. Constitution, the "due process" clause, assures "nor shall any State deprive any person of life, liberty, or property, without due process of law, nor deny to any person within its jurisdiction the equal protection of the laws." This is the clause that is typically used in case law decisions regarding conditions of pretrial detention. Case law decisions, such as *Estelle v. Gamble*, established the right to minimal medical care and subsequently to other essential treatment. Similar arguments have been made for sentenced jail and prison inmates under the 8th Amendment's "cruel and unusual punishment" clause. To the extent that these constitutional mandates exist for male detainees, they also exist for female detainees.

Parity in correctional programming for female detainees means that services and programming available to male detainees are available to women in the facility, except when those services and programs can be shown to be male-specific. For example, arguments have been made that shock incarceration or "boot camps" are not appropriate for women. A sentence to a boot camp is typically made in lieu of a jail or prison term and is designed to reduce the amount of time an offender spends incarcerated. If this program is available only to men, and women have no equivalent, female offenders will serve longer terms in jail or prison. In this instance, female offenders are not accorded equal protection under the law. For parity to exist under these circumstances, equivalent programming should be made available.

Equivalent mental health and other correctional services for female detainees means that women should have the same range of services and opportunity to use those services with the same criteria and condi-

tions for participation applied to their use. For true parity to exist in jail mental health programming, women must (1) have access to the same mental health services as men, and (2) the services must be tailored to women's unique needs. Many jails provide specialized mental health housing and services for male detainees, but not for their female population. In this case, administrators believe that it is not cost-effective to provide separate housing for women diagnosed with mental illnesses and, therefore, have adapted other procedures to accomplish the same ends, including transferring women who exhibit less severe symptoms to inpatient settings and overmedicating women to reduce behavioral symptoms so that they can remain in general population. These adaptations to procedure do not provide equal treatment.

In addition, some consideration must be given to where services are physically located, when the services may be used, and who they are designed to serve. Typically, female housing units are physically separated from the male units. Commonly, jail programming and services are located within the male housing area. This means that women must pass through or close to the male housing. When this happens, the women are often harassed by the male detainees. Administrators attempt to reduce contact to protect female detainees from harassment and assault and to reduce the risk of illicit activities, both of which compromise security. Many jails have solved this problem by bringing all services to the female housing units. The unintended consequence is that services are truncated, both in the breadth of services and the time available for specific activities.

Of critical importance in jail mental health and other programming is the question, "For whom are the services designed?" Most clinical interventions are based on the assumption that men and women will respond similarly to treatment given similar clinical characteristics.

However, there is a growing acknowledgment within the medical, psychiatric, and substance abuse treatment communities that women's psychosocial development, experiential characteristics, and physiology are sufficiently different from men to require that treatment interventions be designed specifically for them. This is especially true of psychiatric medications. Many medications have been tested only on men. Even in drug trials where women have participated as subjects, women of childbearing years are excluded. Careful consideration should be given to what medications are selected and how they affect the women for whom they are prescribed.

Given the growing population of female jail detainees and their unique characteristics, it has become increasingly necessary for jail administrators to begin developing appropriate, gender-specific services for women. This is not an option. It is a constitutional duty. In addition, providing appropriate services and programming to female detainees makes sense from a management perspective. Without these services, women can be disruptive and may, in fact, be more likely to use expensive medical and mental health services.

WOMEN-SPECIFIC JAIL MENTAL HEALTH SERVICES

Jails are first and foremost correctional institutions and should remain as such.[25] Jails that provide comprehensive mental health treatment services are at risk of becoming the treatment facility of choice in communities with dwindling community-based mental health resources. At the same time, jails incur a substantial constitutional mandate to provide minimum medical and psychiatric services to all detainees who need such services. Two basic principles guide the minimum requirements: (1) Persons in detention should not leave the facility in worse condition than when they arrived, and (2) persons should not be punished for being identified as having a need (i.e., the identification of a mental illness should not affect access to other services or length of time spent in jail). Jail mental health services are typically focused on identification, crisis management, and short-term treatment. Adaptations to typical services and resources to improve services delivery to female detainees are discussed below.

Screening, Assessment, and Evaluation

Screening, assessment, and evaluation is a three-stage process by which jails identify persons in need of psychiatric care. The *initial screen* is conducted by a corrections officer at booking. The purpose of this screen is to flag persons in need of a more detailed mental health evaluation and to identify persons at risk for suicide. Officers are not trained clinicians and are not expected to make decisions regarding treatment. The booking officer's job is to refer all individuals who, because of their

responses to specific questions or by their appearance or behavior, appear to be at risk.

A *mental health assessment* is often a second step toward providing treatment. This can be done by a mental health worker or by medical staff within the context of a medical history. Both the booking screen and the medical exam are done on all individuals who are booked into the jail and assigned housing. The mental health assessment is conducted only on persons flagged by the booking screen or by the medical department. At the final stage, persons assessed as needing psychiatric services are referred for a full *psychiatric evaluation.* Psychiatric evaluations are conducted by a psychiatrist and often result in the prescription of medication.

Screening, assessment, and evaluation are critical points in the services delivery system for the provision of appropriate services to female offenders because information uncovered at these points affect classification decisions and whether women will receive mental health and other treatment services. Screening instruments used by booking officers should include a minimum set of questions related to symptoms of affective and psychotic disorders, history of mental health treatment, current use of prescribed psychotropic medication, and risk of suicide. For these screens to encompass the characteristics of women diagnosed with mental illnesses, questions should also ask about (1) symptoms of depression, (2) whether the woman was recently injured, and (3) whether she has minor children and, if so, whether they are currently being cared for.

In addition to more detailed information regarding the areas noted above, the medical and mental health assessments and the psychiatric evaluation are points where information about physical and sexual abuse should be gathered. This requires that medical and mental health staff receive training in assessing women with histories of abuse. This information is critical for the identification of the correct diagnosis and the development of appropriate mental health, health care, and substance abuse treatment plans.

Classification and Housing

Structurally, jails are designed to control the potential for violence. Their primary mandate is to hold individuals in a secure environment

and prevent physical injury to either staff or detainees. Single-cell tiers and pods, highly regimented schedules, lack of privacy, and an expectation of an unquestioning response to authority are characteristics of correctional facilities designed to maximize control and reduce opportunities for breaches in security (e.g., escapes, riots and violent incidents, use of contraband). This structure, in fact, functions well for men who tend to be socialized to hierarchical authority. However, women tend to rely more heavily on flat structures of interpersonal relationships and desire more privacy. In addition, women do not pose the same threats to jail security as men. Jail facilities may, in fact, create an additional unintended burden on female detainees.

Classification refers to the process by which individuals booked into the jail are assigned housing. Appropriate classification takes into account seriousness of offense and risk of violence, special needs such as medical or mental health problems, gender and age, and adjudication status. Most jails assign different security levels within their facility and have different kinds of housing, including general population, medical (where persons diagnosed with acute mental illnesses or suicide risk may be placed), and administrative segregation. Some jails also provide specialized housing such as mental health units for persons with stable conditions, substance abuse therapeutic communities, trustee housing, and juvenile units.

In many jails, there is only one classification status for women—female. Because women comprise such a small proportion of the jail population, many facilities tend to group all women together, regardless of security risk or needs. However, women diagnosed with mental illnesses in jail have the right to the same protections as their male counterparts. Because many jails do not provide special housing for women diagnosed with mental illnesses, many facilities transfer female detainees with moderate symptoms to psychiatric facilities, where a male detainee with similar characteristics would remain in the jail. While this appears to be more humane, it has serious consequences. First, a transfer out of the jail for evaluation or inpatient treatment interrupts, and may significantly delay, the adjudication process, thus extending the period of confinement. Second, the inpatient facility may not be within the locality. This means that the woman may not be able to see family and other support persons easily, if at all. Also, some persons diagnosed with chronic mental health conditions resist transfers to inpatient set-

tings, preferring the jail to a psychiatric facility. Jails must provide the same kinds of housing options to both men and women. They must also apply the same standards and procedures to both men and women when transferring detainees to psychiatric facilities.

Eighty-seven percent of female offenders are arrested for nonviolent crimes. For the most part, women do not require high-security supervision. Given this fact and the widespread prevalence of histories of abuse, several adaptions to housing and staffing may be suggested:

1. Staff must be trained in managing women in a nonaggressive and nonthreatening manner, realizing that women have been victimized predominantly by men and abandoned by their female protectors;
2. Housing units, particularly in jails with podular designs and direct supervision, should consider cell doors that are not locked; and
3. Jails should consider ways to normalize the jail environment, including more time out of the cells for the detainees to interact socially and more protections for personal privacy, such as shower curtains and doors on bathroom stalls.

Medication and Psychiatric Follow-Up Services

Medication and medication monitoring of women are major issues for jail psychiatry. Women are diagnosed at a much higher rate with unipolar depression. However, some jails do not allow the prescription of certain antidepressants, because of their potential for abuse. Despite indications or previous treatment, some women cannot receive the medication of choice due to standing policies. On the other hand, these policies exist for good reason. Women and men with significant addictive disorders may request antidepressants as a substitute for their drug of choice. Each individual case must be reviewed carefully prior to the prescription of medication, and at regular intervals thereafter, to assure that the medications are appropriate to the need.

Overprescription of medication is as problematic as underprescription. Because women's housing is limited and because women are not as easily managed as men in general, there is a tendency to overprescribe medications for the sole purpose of tranquilizing the detainee. From the jail's perspective, this is a reasonable policy, because it enhances the jail's security. From a human rights perspective, it is an unjustified use of chemical restraints and violates constitutional rights. In addition, the medication may interfere with the detainee's ability to participate in her adjudication process.

Crisis Intervention and Suicide Precautions

Women diagnosed with mental illnesses in jail do not typically exhibit the same symptoms as men. Nor should the crisis intervention responses be the same. Clinicians must be trained to identify suicide risk in women and how to appropriately intervene in mental health crises without retraumatizing a woman who typically has been repeatedly traumatized.

The policies and procedures governing the use of physical and chemical restraints should be carefully reviewed for their application on all female detainees, both those with diagnoses of mental illness and those without. Because histories of abuse are so prevalent among women in jail, these procedures should be developed for all women. Some mental health systems are beginning to review these issues in response to a growing awareness of the damage that these procedures have on individuals' physical and emotional well-being. This is critically important when managing women with significant histories of physical and sexual abuse.

If staff of jail psychiatric services expect to have a continuing relationship with a female detainee, it may be helpful to understand what actions or events cause distress and what interventions staff can use that will help to calm the detainee. It is also helpful to tell women diagnosed with mental illnesses who might require restraint what procedures are used in the facility early on in their confinement.

Other Mental Health Treatment

In jails where other kinds of mental health treatment are available, several considerations for women should be addressed. Single-gender groups are critically important. Women who have been victims of abuse do not function well in mixed-gender treatment groups. In addition, women who have experienced physical or sexual abuse as well as

women diagnosed with mental illnesses appear to benefit from peer-support groups. Given the prohibitive costs of professional services and the benefit of peer support, jails may want to consider using community resources to supplement core psychiatric services.

Case Management and Discharge Planning

Most jails do not provide case management or discharge planning services. Arguably, release planning can be the most important service a jail can provide to reduce the probability of return. For all persons with special needs, both male and female, linkages to community services, particularly if the linkage is more than a telephone appointment, can make a significant difference in engagement in community-based services.

While most jails acknowledge this important service, the manner by which individuals are processed limits a jail's ability to develop effective linkages. Most important, it is critical to understand that release decisions are made from the court. Except when inmates serve specific sentences, jails do not typically know when someone will be released, whether it is pretrial or upon sentencing.

Beginning discharge planning early in confinement is important. Upon release, women in general, and women diagnosed with mental illnesses in particular, will require more community services, including housing for the women and their children, mental health and substance abuse services, social services and entitlements, and health care and vocational services. In the case of female detainees, discharge planning involves not only services for the individual released from jail but a web of services for single-parent families.

Because release from jail is complicated by the re-integration of a woman into multiple contexts—her family, significant relationships, and community—and requires a lifestyle change in all domains of her life if she is to remain free, lead time is important. Women recently released often express being overwhelmed by all the demands. To whatever extent possible, issues around release should be addressed early and often in mental health and substance abuse counseling. In addition, slow re-integration through halfway houses or other residential facilities is helpful.

IMPLICATIONS FOR MENTAL HEALTH SERVICES DELIVERY: APPROPRIATELY RESPONDING TO WOMEN'S SPECIAL NEEDS

To address the special needs of women diagnosed with mental illnesses in correctional settings, comprehensive and integrated strategies are necessary. To provide leadership in this area, specific attention should be given to the following areas.

Parity of mental health services. One of the major issues regarding women's mental health in correctional settings is the lack of services. The state of mental health services in U.S. jails is poor, but for women, it is worse. Because women represent such a low percentage of correctional populations, they often do not have access to the same mental health or other services that are available to men. In addition, when they do exist, rarely do mental health services give attention to the special needs of women. But before specialized programs can be developed, basic services must be available to all women who need them. This requires a commitment on the part of the jail administration. More important, this requires the allocation of resources, including staffing, space, and money.

Targeted screening/evaluation procedures and instruments. Currently, no screening and assessment tools exist that are designed specifically for women. A critical first step in the process of treatment is proper diagnosis and treatment planning. In corrections, woman-specific tools must be developed that support appropriate classification of women and can identify issues that complicate treatment and supervision, including histories of abuse, medical problems, and child care issues.

Furthermore, because major mental illnesses, such as major affective disorders, schizophrenia, and dissociative disorders precipitated by childhood trauma, and symptoms associated with PTSD have different courses and may involve different treatment interventions, screening and evaluation tools for women who have been diagnosed with a mental illness must be highly specific and sensitive. However, if the facility has no flexibility in treatment provision, jail staff must carefully con-

sider the risks associated with identifying a woman as "mentally ill" with the benefits of more complete information.

Special crisis intervention procedures. Because so many women in jail, with and without diagnoses of mental illnesses, have experienced physical and/or sexual abuse, protocols for crisis intervention should be developed for use with all women in crisis. Jails may want to consider the use of advance directives and investigate noninvasive, nonthreatening de-escalation techniques for general use.

Peer support and counseling programs. Because some psychiatric interventions are coercive (e.g., seclusion and restraint, involuntary medication, locked rooms, and paternalistic treatment and infantilization of patients), the more so when delivered in jails, they may be resisted or rejected. Peer-counseling programs show great promise in helping women to address both mental health problems and the violent events in their lives. These programs are not designed to replace standard mental health treatment, and may, in fact, function best when coordinated with existing services. Peer-support programs also offer an opportunity to connect the woman with her community prior to release. Transition from jail to the community is often one of the most difficult steps for women to take. Continuity is critical. Many peer support programs (i.e., 12-step substance abuse programs, AIDS awareness, Double Trouble) have community groups.

Parenting programs. Research indicates that adult survivors of child abuse often repeat the behaviors of their parents with their own children. Furthermore, substance abuse is strongly associated with child abuse. To the degree that women in correctional settings are both victims of violence and perpetrators of violence, they are also at a higher risk of abusing their own children. Parenting programs directed at education, empowerment, and practical skills hold promise to break the cycle of violence in families.

Integrated services. Clearly, women in correctional settings are likely to face multiple issues, including substance abuse, mental illnesses or emotional difficulties, parenting, and dangerous or violent home environments. Integrating services, whether it is in the jail or transition to the community, holds the most promise in assisting women to remain safely in the community.

Training programs for security, mental health, and substance abuse professionals. Issues specific to women are not well-known. Even when the administration supports woman-specific programming, direct line staff do not always understand the need and therefore do not act in accordance with the program procedures. Training is necessary not only for criminal justice personnel, but also for mental health, medical, and substance abuse workers. Misdiagnosis, the medicalization of social problems, and sexist attitudes contribute to the continuing abuse of women in jail.

Outcome measures. How do we know when we are making progress? In regard to woman-specific services, this is an especially cogent question. Attention must be given to the development of appropriate outcome measures for treatment interventions designed to affect women diagnosed with mental illnesses in jails. Where most programs are designed for men, so too are most outcome measures. It is not that these indicators are not applicable; rather, they are insufficient. Attention must be given to outcomes that acknowledge the wide variation in women's life experiences, adaptive styles, and modes of recovery. Measures should be developed through a joint effort by mental health professionals, researchers, and the women using services. While this is a generic issue, it is equally valid in the assessment and evaluation of mental health programs in correctional settings.

U.S. jails vary enormously in size and resources. Not all facilities are large enough to provide a full array of mental health services and housing options on-site. However, all jails are required to provide *access* to necessary services. Small jails access psychiatric care typically by contracting with community providers. To ensure that the rights of women held in jails are protected, administrators and services providers should carefully review the services options and protocols applied to women to guarantee that (1) they have access to basic psychiatric care, (2) they have the same access as men in the same facility to other housing and support services, and (3) the services provided are modified to address woman-specific treatment issues and needs, where necessary.

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