The National Institute of Corrections
Prison Health Care: Women Offenders

Program Coordinator:	Madeline Ortiz
Contributors:	Katherine McVey
	Anisse Schmidt
	Rosemary Jackson, MD
	Cassandra Newkirk, MD
Technical Assistance:	Betty Gurnell

The lesson plans in this package are designed to be a series of presentations, facilitated discussions and guided activities that sequentially and cumulatively help participants examine and increase their understanding of working with women's health care issues in a prison setting. The lessons guide them further through an examination of what they might do individually, with the program staff, and in the community.

It is recommended that trainers/facilitators for this training have at a minimum:

- ❒ experience facilitating discussion and activities
- ❒ have a working knowledge of gender-specific programs in prisons
- ❒ be a content expert in the topic of the lesson plan

II. An Overview of the Training Package

The training package is made up of eight lesson plans that are designed for 1 - 2 hour individual workshops. If a training/conference coordinator wishes to offer all eight as a series, the overview outline represents recommendations for the most useful sequence of topic areas. It will be necessary to adapt the lesson plans for use as a series to create segues between topics and to eliminate duplicate content. The following overview chart describes the objectives of each lesson in the package:

Prison Health Care: Women Offenders
Lesson Plan Overview

Time	Title and Objectives
1 hour and 50 minutes	**Introduction and Overview** • to determine the potential impact of care of women offenders on their families, their health, and their potential recidivism • to identify the essential features of an infrastructure that will maximize the delivery of services to women • to describe gender-specific issues of women offenders and the impact of those issues on health, mental health, and substance abuse services
1 hour	**Litigation** • describe factors that influenced the increase in prison litigation • describe the constitutional issues that are addressed in prison litigation • describe the impact prison litigation has had on the delivery of health care in prisons
1.5 hours	**Substance Abuse** • describe the correlation between substance abuse and criminal activity in women • explain how women's needs for substance abuse treatment are different from men's • describe the health risks for women who use alcohol • explain issues to address in a substance abuse program for women
1 hour and 20 minutes	**Mental Health Issues** • describe the relationship between abuse and other traumatic events with mental illness • list the basic symptoms of the major mental illnesses that are most prevalent among women who are incarcerated • determine staff's role in accessibility of mental health care for women
1 hour and 15 minutes	**Co-Occurring Disorders** • define "co-occurring disorders" • describe the basic components of treatment programs for co-occurring disorders in women in a correctional setting • explain steps correctional facilities need to take to ensure effective service-delivery to women with co-occurring disorders

1 hour and 15 minutes	**Crisis Intervention** • define what we mean by *crisis* • describe behaviors in the prison setting that are *psychiatric* crises • explain key components of a screening that can prevent or predict suicide • explain critical actions in preventing "successful" suicides with women offenders
1.5 hours	**Health Issues** • describe the primary medical conditions unique to women and women offenders • explain the most common barriers to adequate health care for women in our prisons • develop strategies for prison administrators and medical staff to improve health car delivery to incarcerated females
1.5 hours	**Infrastructure** • define "infrastructure" • describe the key components of an infrastructure to support an effective women's health program in prison

III. Guidelines for Using the Curriculum

As you prepare to teach from any of the lesson plans, here are some guidelines to follow and notes about the design format that will help you best use the materials and conduct an effective workshop.

Guidelines for Preparation

- study the entire design, including participant materials
- make necessary changes to adapt the design for your target population or to add new materials
- anticipate questions that participants might have as you guide them through the workshop
- make note of questions you have about the material; call the author or refer to the resources to clarify

Equipment and Materials

- Laptop and LCD projector
- Overhead projector (extra backup bulb)
- Easel and chart pads
- Markers and tape
- Table for materials and supplies
- Handout materials
- Pens, pencils and paper for activities
- Name tags/ name tents
-

B. Adult Learning Principles

This curriculum is written to address the learning interests and needs of adults and is based on a set of principles that views participants as equal partners in the learning process.

Adult Learners

- are more likely to learn to solve perceived problems or challenges in work and life in general rather than theory in isolation.
- have extensive life and work experience; therefore, they learn best by participating actively in a series of planned experiences, having the opportunity to analyze those experiences, and then determine the application to work and life experiences.
- need to be self directed. The role of the trainer/facilitator is to engage them in a process of inquiry, analysis and decision-making rather than to transmit knowledge and evaluate the learner's conformity to it.
- learn best when learning programs make optimum provision for difference in style, time, place and pace of learning since individual differences among adult learners increase with age and experience.

C. Trainer/Facilitator Roles and Skills

In this training, the leader's role is that of a facilitator, one who leads participants through the learning process

Facilitator Roles

- ❖ discussion leader + information provider
- ❖ encourage and welcome participant input through word and demeanor
- ❖ create/maintain atmosphere in which participants feel comfortable to challenge information and ask questions
- ❖ refrain from long lectures
- ❖ use open-ended questions to invite participant interaction
- ❖ demonstrate credible knowledge about gender-specific programs and services
- ❖ demonstrate a high level of energy and a sincere communication of belief in the purpose of the training

The facilitator can provide the opportunity for optimal learning through the use of group discussions and by responding to participant questions. The following guidelines are presented to assist you in that endeavor.

Guidelines for Conducting Group Discussions

- ❖ Know the desired outcomes (new knowledge, viewpoint, behavior) of the group discussion.
- ❖ Anticipate controversial issues, questions or situations which may arise. The more accurately you can predict these situations, the less likely you are to be thrown off balance during the discussion groups.
- ❖ Know the limits of your role. You are there to impart information and facilitate/guide the discussion process, not to validate your own ideas.
- ❖ Define the intended purpose of the discussion for the group.
- ❖ Anticipate the "so what" or "what's in it for me" questions on people's minds.
- ❖ Give everyone an equal opportunity to participate. If the group is large and/or if some people are being left out of the discussion, consider breaking the group down into smaller groups. Provide quiet time for participants to jot down their responses to a question you pose, then get responses from all "round robin" style.
- ❖ Avoid "yes" or "no" questions. Use thought-provoking questions to stimulate discussion.
- ❖ Keep the discussion progressive, staying on the topic. If the planned approach is not going to achieve your objectives, be flexible and prepared to a adopt a different approach.
- ❖ Listen carefully and intently. Show interest in the thoughts of others and build on their comments.
- ❖ Give occasional summaries. Re-state the highlights of the discussion and paraphrase any conclusions or generalizations from the group.
- ❖ Know when to end the discussion: outcomes reached; body language; time-limit.

Guidelines for Asking Questions

The ability to ask questions is a critical skill for trainers. The effective trainer must know what questions to ask, what types of questions to ask at each step in the discussion, how to phrase the questions to get the result he/she wants, and how to re-state if his/her first effort does not work.

Four types of Questions

- Overhead: Addressed to the group as a whole; anyone may answer.
- Direct: The trainer directs the question to a particular individual, usually because s/he has the best information.
- Reverse: The trainer, when asked a question, turns it back to the person asking the question. Often when a person asks a question, s/he wants to make a statement but needs encouragement.
- Relay: The trainer passes the question asked by one participant to another for a response, or s/he may put it out as an overhead question.

Shaping the Question According to Its Purpose

- To open discussion
- To amplify, expand and explain a member's contribution
- To move discussion ahead to another point and to close discussion on the proceeding point
- To introduce a point that is being missed
- To provoke and sharpen distinctions, including evaluations and judgment on ideas that have been presented

- ❖ To promote collaboration
- ❖ To summarize and/or give unity to divergent ideas.

D. Using Visual Aids

The trainer must be familiar with the proper creation and use of training aids: overhead transparencies/Corel presentation, and chart pads. The training aids needed for this training will be provided in Corel Presentationst. It is recommended that the trainers make overhead transparencies of the slides as a backup. The trainer may be recording information generated from group discussion/brainstorming on chart pads. The following guidelines are important to remember when using visual aids.

Overhead Transparencies

- ❖ Position the projector so that you:
  - create an undistorted image,
  - completely fill the screen, but do not spill over,
  - avoid blocking viewer sight lines to the screen.
- ❖ Move around so you do not block sight lines to the screen.
- ❖ Use a piece of paper to reveal sections of information one at a time (if necessary).
- ❖ Do not darken the room but do control the light that falls on the screen by dimming front lights and draping nearby windows.
- ❖ Keep visuals on the screen only as long as needed for the teaching point.
- ❖ Turn off the projector to remove the center of attention from the screen when not in use.
- ❖ Use a pencil to point on the bed of the projector rather than walking into the image on the screen to point to information.
- ❖ Take a quick glance behind you to the screen each time you put up an overhead to be certain that it is clear and aligned.

- When developing your transparency text, graphics, charts, and pictures be sure to keep it simple. Use your handouts for detailed information. General rule: 6x6 - no more than six words across, no more than six lines down.

Computer-Generated Slide Presentations

With the advent of laptops and LCD projectors, presentations are being created and displayed using software available with most word-processing program packages. These programs allow you to create slides that can incorporate vivid color, graphics, charts, sound clips, pictures and movies. Regardless of the software you choose you must be prepared to manage your technology and balance it with group participation.

- Ensure that you have the proper equipment, including laptop, screen and LCD projector with cables to connect your equipment.
- Have overhead transparencies as backup in case of a technology failure.
- Be certain to test your equipment and, if you are bringing a floppy disk, make sure your file can be read and displayed with the equipment provided.
- Dim lights but do not darken the room. Dimming will illuminate the text and brighten the color.
- Balance your use of dramatic visuals with the engagement of the group. Decide how much attention you want to have given to your visuals versus other group members and/or the trainer.
- Use the guides provided by the software program for print size - try to keep the text simple and short. Use your handouts for long detailed information.
- Choose animations within your slides carefully. Some animations can take precious time to load and become legible. The same rule is true for text bullets that appear with sound; they too can take more time and interrupt the flow of your spoken presentation.

- ❖ Do not over-complicate the presentation with unnecessary audiovisuals; they may be fun but remember to focus on your learning objectives.

Chart Pads

Some of the lesson plans call for the trainer to record group responses to questions.

- Title chart paper sheets with topics you plan to discuss before you begin the session.
- Use a dark colored, broad tipped marking pen.(check the markers before you begin to ensure they are not dried-out and illegible.)
- Write in large print, using capitals and lower case - it is easier to read than all capital letters.
- Print as neatly as possible and avoid script or cursive.
- Talk to the participants, not the chart pad.
- When writing quickly to record responses it is hard to ensure that you are spelling correctly or getting the whole idea. Let the group know that spelling doesn't count and check with the participants to make sure you have accurately captured their ideas.

The Trainer As a Visual Aid

Since the group will be watching and listening to you as the central focus of the presentation, *you* are the most important training aid. How you communicate your message/information and the platform presence you exhibit will be the key ingredient to establishing a climate and motivation for learning.

- *Facial expression:* Express interest and enthusiasm with your eyes and a smile. Maintain a neutral expression when receiving participant input; be careful about letting disapproval, concern or judgement show.
- *Posture:* Keep your posture open and straight, yet relaxed to show that you are attentive.
- *Gestures:* Use your hands and arms comfortably to be expressive or appear relaxed. Avoid habitual tapping, jingling of coins and other distracting motions.
- *Movement:* Move around the room to maintain contact with all and to move a bit closer to any person talking.
- *Eye contact:* Make eye contact with *all* participants.
- *Voice:* Vary the tone and speed of your voice and project to the entire room. If there is a microphone, check volume control so that you can be heard without being too loud.
- *Language:* Use clear language; avoid or explain acronyms or jargon.

C. Evaluating The Training

The measure of true success for any training is the post workshop application of the content, but we also know that immediate feedback from the workshop experience can tell us how likely people are to use the content and can provide us with valuable information for improving the format, content and materials. We encourage the trainer to have time allocated at the end of the workshop for completing evaluations. The trainer may want to explain the evaluation process at the beginning of the session so that participants are aware that they will be expected to complete a form at the end of the session.

Evaluation questions should go beyond what the participant liked and disliked. For example,

questions should be included that address how the content will be used, who else could benefit from this training, how it can be enhanced/improved and what other training would be helpful to judges in their juvenile drug court program planning efforts.

(Portions of this section have been adapted from the: *Training Package for Line-Staff and First-Line Supervisors to Reduce Disproportionate Minority Confinement*, Cygnus/OJJDP, 2000)

Module II: Litigation — Time: One hour

A. Introduction and Performance Objectives — Time: 10 minutes

1.	Ask participants, "Why is it important for correctional personnel to be aware of litigation issues concerning women's health and mental health in prison?" Have them discuss this question for about 5 minutes with their table groups, then have a spokesperson report out from their discussion. Responses will vary. This question will get participants to begin to think about ways to apply the information they are about to receive at their own facility.	
2.	Share the performance objectives for this module: After completing this module you will be able to . . . • describe factors that influenced the increase in prison litigation • describe the constitutional issues that are addressed in prison litigation • describe the impact prison litigation has had on the delivery of health care in prisons and	Slide 2-1

B. Instructional Input - Litigation — Time: 30 minutes

1.	Use the following narrative as a guide to explain the factors that have influenced prison litigation in health care issues: Much of the reform in correctional health care has come about since 1970 because of prison litigation. Prior to that time there were no standards, nor was there any organization reviewing health care services; therefore correctional agencies provided services that they wanted to.	
2.	As a result of the riots at Attica in upstate New York in the early 70's, organizations began to study the health care in correctional settings. Many assumptions were made by these groups: • inmates were in poor health • institutions lacked medical care • when available, the medical care was inadequate • living conditions caused many health problems.	Slide 2-2

3.	Several studies found that these assumptions were true. Why was the treatment so poor? Inmates were considered "slaves of the state" (Zalman, 1972) and therefore had few rights after incarceration. Many courts took a "hands off" approach to health care as they had no idea what was necessary.	Slide 2-3
4.	1962 - *Robinson v California* - federal courts could intervene in state courts based on the eighth amendment, the right to be free from cruel and unusual punishment The role of the penitentiary, however, was to promote respect for order and authority.	Slide 2-4
5.	What brought about changes? **Inmate riots:** Inmates began to make demands, most for improvements in diet, health care and living conditions. Media exposure and expert examination revealed that inmates had legitimate concerns. **Health concerns:** Several "outside groups" and correctional administrators recognized that if inmates returned to the community in poor health, it would have a negative impact on the community. **Legal issues:** 1972, *Newman v Alabama* was the first major federal civil rights action devoted entirely to prison health care. The court established case law that certain basic elements of adequate health care should be provided to those behind bars. Many other cases followed, dealing with such issues as hygiene, living conditions, drinking water, diet, competent medical and dental care, special diets, and the treatment of psychiatric problems. Included in several cases were the right to adequate exercise, recreation, and phone calls.	Slide 2-5

6.	Although improvements were made, there were still no standards. In 1975, the Law Enforcement Assistance Administration gave a grant to the American Medical Association to upgrade correctional health care and develop standards. The first standards to be published were from the American Public Health Association for jails and prisons in 1976. In 1977 the American Medical Association published health care standards for jails, and in 1979, for prisons. The first state prison to be accredited using the AMS's standards was at Reidsville, GA in 1982, then 13 units in Texas were accredited in 1985. Note that both Georgia and Texas were motivated by significant litigation concerning prison health care.	
7.	Since 1972 there have been hundreds of cases filed under Section 1983 of the Civil Rights Act on behalf of inmates seeking relief relating to health care. In the landmark case, *Estelle v Gamble* the court states that the Eighth Amendment establishes government's obligation to provide medical care for those whom it incarcerates. "Deliberate indifference" to serious medical needs of prisoners constitutes unnecessary and wanton infliction of pain. In order to prove their claim, inmates must have a serious medical need, and they must prove that prison officials have been deliberately indifferent to these needs.	Slide 2-6
8.	The basic rights to medical care of inmates are as follows: a) access to care b) right to the care that is ordered c) right to a professional medical judgement d) mental health and dental care	Slide 2-7
9.	In 1996, the PLRA (Prison Litigation Reform Act) was instituted. It only applies to cases filed in federal courts, the great majority of prison cases. This act has severely curtailed the filing of and the continuation of many prison condition lawsuits.	Slide 2-8

10.	When class action lawsuits are brought they are usually heard in Federal Court as constitutional issues are at stake. The settlement agreement is not monetary and usually entails a system agreeing to make improvements which have been agreed to by both sides. The court then appoints a monitor or Special Master to monitor the implementation of the changes which have been spelled out in a consent decree or order which the system must agree to in order to reach settlement. If the system does not make the changes specified in the consent order, they may be fined or held in contempt of court. Given that county and state correctional systems depend upon county and state tax dollars to fund their operations, consent orders have been one of the major ways that funds have been allocated for improvements in jail and prison conditions. This is especially true for health care for offenders. Legislators are reluctant to approve allocation for funds for basic health care for offenders when many of their constituents do not have access to adequate health care because of lack of insurance. Consent orders usually were not vacated until the court's monitor felt comfortable that changes had been made and the systems were functioning well. The PLRA has curtailed much of this in that a consent order may be vacated within 2 years unless there are major problems with a system. The PLRA also makes it much harder for inmates to initiate lawsuits and the attorneys representing them have a much harder time collecting their fees as well. All of this was done to discourage lawsuits from being filed or being resolved in meaningful ways that improved the conditions for the offenders.	

C. Summary — Time: 15 minutes

3.	Ask participants to discuss the following questions at their table groups, then report out a summary of their discussion: a) What health and mental health services are provided inmates in your facility? b) How healthy is the diet that is provided inmates in your facility? c) Describe the exercise/recreation opportunities afforded inmates in your facility. d) Are the health and mental health services provided in your facility less than, equal to, or better than those provided to the citizens in your community? e) The courts have mandated that inmates have the right to • access to care • right to the care that is ordered • right to a professional medical judgement • mental health and dental care How and why do you think these rights should be expanded? How and why do you think they should be limited?	Participant workbook

Prison Health: Women Offenders

Litigation - Performance Objectives

- Describe factors that influenced the increase in prison litigation
- Describe the constitutional issues that are addressed in prison litigation
- Describe the impact prison litigation has had on the delivery of health care in prisons

Litigation

Early 1970's - Assumptions in prison health care studies

- Inmates were in poor health
- Institutions lacked medical care
- Available health care was inadequate
- Living conditions caused many health problems

Litigation

Inmates considered “slaves of the state”

Courts took “hands off” approach to prison health care

Litigation

1962 - *Robinson v California*

Federal Courts could intervene based on Eighth Amendment: the right to be free from cruel and unusual punishment.

Role of penitentiary - to promote respect for order and authority

Litigation

What brought about changes?

Inmate riots and demands; media exposure

Health concerns - inmates returning to community in poor health will have negative impact on entire community

Legal issues - *Newman v Alabama*: Certain basic elements of adequate health care should be provided to those behind bars: hygiene, living conditions, recreation, medical and dental care, psychiatric treatment, diet

Litigation

- 1977 - American Medical Association published health care standards for jails
- 1979 - AMA published health care standards for prisons
- *Estelle v Gamble* - court states Eighth Amendment establishes government's obligation to provide medical care for those whom is incarcerates
  - Inmates must prove that prison officials have shown "deliberate indifference" to their serious medical needs

Litigation

Basic Rights to Health Care Needs

1) Access to care

2) The right to the care that is ordered

3) The right to a professional medical judgement

4) Mental health and dental care

Litigation

1996 - Prison Litigation Reform Act

Applies to cases filed in federal court; curtailed filing of many prison condition lawsuits

Consent order may be vacated in 2 years

Legislators reluctant to provide funding for health care for offenders that many constituents do not have because of lack of insurance

LITIGATION - ACTION PLAN

Please discuss the following questions in your group, then report out a summary of your discussion:

a. What health and mental health services are provided inmates in your facility?

b. How healthy is the diet that is provided inmates in your facility?

c. Describe the exercise/recreation opportunities afforded inmates in your facility.

d. Are the health and mental health services provided in your facility less than, equal to, or better than those provided to the citizens in your community?

e. The courts have mandated that inmates have the right to
- access to care
- right to the care that is ordered
- right to a professional medical judgement
- mental health and dental care

How and why do you think these rights should be expanded?

How and why do you think they should be limited?

Module II: Substance Abuse

Time: 1 hour and 30 minutes

A. Anticipatory Set

15 Minutes

1.	Review the performance objectives for this module using the following narrative as a guide: When we reviewed the profile of today's female offender, one of the characteristics we saw was that at least 60% of these women are in prison for drug related crimes, and about that many have substance abuse problems. After completing this module on substance abuse in women offenders you will be able to . . . • describe the correlation between substance abuse and criminal activity in women • explain how women's needs for substance abuse treatment are different from men's • describe the health risks for women who use alcohol, tobacco and other drugs • plan ways to overcome barriers to treating women with substance abuse problems • describe the major components of a therapeutic community for women	Slide 2-1
2.	Introduce the quiz using the following narrative as a guide: You are probably quite familiar with some of the issues concerning women and substance abuse. Although we probably can't completely eliminate these problems, we can take some steps toward understanding the issues better, and in doing so at least make a difference in the programs we offer in order to help these women deal with their problems in a healthier way. As we begin to explore the myriad of issues concerning women and substance abuse, I would like to take a few minutes to score this quiz, then compare your answers with the answers of the others in your table group.	Quiz in workbook or as a handout
3.	Give participants about 10 minutes to score and discuss the quiz at their tables, then conduct a discussion and present additional information using the quiz and the format in the instructional input as a guide	

B. Instructional Input **Time: 30 minutes**

1. **Question 1:** The numbers of women in the criminal justice system has escalated rapidly over the past decade because: a. Women are more involved in the same criminal behavior as men b. Law enforcement is regarding women on a more equal basis with men, increasing the likelihood of arrest c. Mandatory drug sentencing laws enacted in the late 1980's specify that anyone caught in possession of drugs would automatically be sentenced d. Parents are not supervising their children well How many of you answered a? b? c? d? The correct answer is **c,** Mandatory drug sentencing laws enacted in the late 1980's specify that anyone caught in possession of drugs would automatically be sentenced	Slide 2-2
2. Use the following information to substantiate and clarify this response: According to a study by Mauer, Potler and Wolf in 2000, between 1995 and 1996, the number of women in state prisons for drug offenses increased by 95% compared to a 55% increase for men. Between 1986 and 1996 the number of women incarcerated for drug offenses rose by 888%. Currently, 35.9% of women serving time for drug offenses were charged solely with possession. Some researchers and investigators believe that this pattern of illegal behavior is decidedly gender-related - that drug sales and other nonviolent crimes are "survival crimes" that women commit to earn money, feed a drug-dependent habit, or escape terrifying intimate relationships and brutal social conditions. (National Institute of Justice, Research on Women and Girls in the Justice System, September, 2000)	Slide 2-3

3. **Question 2:** Women offenders are likely to use alcohol and drugs because: a. They are so readily available b. They want to please their husbands and/or boyfriends c. They need to dull the emotional pain from a history of abuse and other traumas d. They lack an emotional support system How many of you answered a? b? c? d? While all of these responses are "true", the *most* prevalent reason women use alcohol and drugs is **c**, to dull the emotional pain from a history of abuse and other traumas	Slide 2-4
4. Women experience tremendous emotional pain for a number of reasons: they feel guilty about being absent from their children's lives and worry about whether they will have custody upon release; they have unresolved issues of physical and sexual abuse from childhood as well as in their adult life; they experience numerous health problems due to poverty, low self-esteem, lack of education. Several recent studies indicate that at least half of all women in detention, jails and prisons had been physically or sexually abused before their imprisonment, a much higher rate that reported for the overall population. Nearly 70% of the abused women serving time in correctional facilities said they used illegal drugs during the month before their current offense compared with 54% of the women who had not been abused.	Slide 2-5
5. **Question 3:** Substance Abuse, Mental Health, Education, Health and Vocational programs for women in prisons need to be integrated and coordinated because: a. It would be a lot cheaper to operate the programs b. Of the confusion caused by contradictions from one program to another c. Training for staff would be easier d. Women and men could then attend the same programs How many of you answered a? b? c? d? The correct answer is **b**, because of the confusion caused by contradictions from one program to another.	Slide 2-6

6.	According to an article by Stephanie Covington in the February, 2001 issue of Corrections Today, a woman might be in the following programs simultaneously: a therapeutic community that regards addiction as a secondary issue; a 12-step program that views addiction as a primary disease and advocates abstinence; a cognitive-behavioral program that treats addiction as a learned behavior. A woman might also experience one treatment model while incarcerated, then a different model when released into the community. These contradictions create confusion and can lead to relapse.	
7.	**Question 4:** Women are more likely than men to a. Drink in a social setting and binge more b. Begin to drink at a younger age and take longer to become addicted c. Seek treatment for their substance abuse problems d. Use heroin and cocaine and experience health problems sooner How many of you answered a? b? c? d? The correct answer is **d**, use heroin and cocaine and experience health problems sooner.	Slide 2-7
8.	The first three responses are actually false. Women are more likely to drink alone than men and less likely to binge. Women begin to drink at an older age than men and become addicted more quickly. And women are less likely than men to seek treatment. Regarding the last statement, women usually encourage or insist that their partners get help, while men are more likely to leave their alcoholic partners. The fact that women are more likely to drink alone means that it is less likely that others know of the problem. Women are also likely to experience strong guilt feelings because of responsibility to care for their children and because society is more harsh in their view of alcoholic women than alcoholic men. Women are more likely to get into treatment by a more circuitous route, seeking help first for physical and mental problems. Alcohol use is linked with higher rates of breast cancer, osteoporosis, liver disease, PMS and menstrual disorders. Female drug users have a much higher rate of sexually transmitted disease, including AIDS, due to unprotected sex with high risk partners. Drug addicted women also frequently trade sex for drugs.	Slide 2-8

9. **Question 5.** Women who have recovered from substance abuse addictions list the following issues as most important to them in recovery and relapse prevention: a. Awareness of self, healthy relationships, healthy sexuality, spiritual connection b. Money, family support, marriage and friends c. Vocational training, good job, healthy relationships, money d. Education, vocational training, spiritual connection, support groups How many of you answered a? b? c? d? The correct response is **a**, awareness of self, healthy relationships, healthy sexuality, spiritual connection.	Slide 2-9
10. The following information is from Stephanie Covington, Ph.D., LCSW, co-director of the Center for Gender and Justice in La Jolla, California. When women across the country who recovered in 12-Step programs described what had changed the most for them in their journeys to recovery and the issues that contributed to relapse, they listed the self, relationships, sexuality and spirituality as most important. These four issues incorporate the list of issues that reflect a comprehensive treatment model for women developed by the Center for Substance Abuse Treatment (CSAT). The Self: Many women enter the prison system with a poor self-image and histories of trauma and abuse. They have a need to describe who they are apart from roles such as wife, mother, daughter. Relationships: Some women use addictive substances to maintain relationships with using partners, some to fill relationship void, and others to deal with the pain of abuse. Women in prison often have unhealthy, illusory or unequal relationships with spouses, partners, friends and family. It is important for recovery programs to model healthy relationships among staff and participants, providing a safe place for healing.	Slide 2-10

11.	Sexuality: Many women entering the early stages of recovery report sexual dysfunction, shame, prostitution, sexual abuse and fear of sex while clean and sober. These issues must be addressed if women are expected to maintain their recovery. Spirituality: Helping women reconnect with their spirituality is critical to the recovery process. It is essential that women find their own definitions of a "higher power."	Slide 2-10 continued
12.	**Question 6:** Components of a comprehensive treatment model for women include a. Daily meetings, drug education, vocational training b. Well-trained staff, strictly enforced rules, vocational training c. Connections with community treatment programs, visits with children, clearly defined rules d. Education on: addictions and consequences, relationships with family and significant others, child care and custody How many of you responded a? b? c? d? The correct response is **d**, education on addictions and consequences, relationships with family and significant others, child care and custody	Slide 2-11

13. The Center for Substance Abuse Treatment (CSAT) has developed the following list of issues that reflect a comprehensive treatment model for women: • The etiology of addiction, especially gender-specific issues related to addiction, including social, physiological and psychological consequences of addiction, and factors relating to the onset of addiction • Low self esteem • Race, ethnicity and cultural issues • Gender discrimination and harassment • Disability-related issues, where relevant • Relationships with family members and significant others • Attachments to unhealthy interpersonal relationships • Interpersonal violence, including incest, rpe, battering and other abuse • Eating disorders • Sexuality, including sexual functioning and sexual orientation • Parenting • Grief related to the loss of alcohol or other drugs, children, family members or partners • Work • Appearance and overall health and hygiene • Isolation related to a lack of support systems • Life plan development • Child care and custody	Slides 2-12, 2-13 and 2-14
14. **Question 7**: When working with women with substance abuse problems it is important that staff a. Enforce rules consistently and fairly b. Model appropriate relationship behaviors c. Communicate well with each other d. Help women bond and develop trust How many of you responded a? b? c? d? Actually **ALL** of these answers are correct this time.	Slide 2-15

15.	Enforce rules consistently and fairly: most women offenders are substance abusers, are committed for drug related offenses, and have experienced physical, sexual or emotional abuse; they have experienced little consistency and fairness in their lives. One component of a Therapeutic Community is clear rules that are consistently and fairly enforced through immediate consequences. Relationships: "Women in prison often have unhealthy, illusory or unequal relationships with spouses, friends and family members. For that reason, it is important for recovery programs to model healthy relationships among both staff and participants, providing a safe place for healing." (Covington, 2001) Communicate well with each other: It is vitally important for staff to communicate well with each other and with the offenders in order to provide a) Consistency and fairness in rules and to b) Model appropriate relationship behaviors. Help women bond and develop trust: According to Naya Arbiter, Extensions and Amity in California (December 1999), "Women need to voice their past experiences in peer support groups and in safe places where they can feel comfortable speaking freely, learn how to deal more effectively with their problems, and heal."	

C. Guided Practice - Implications for Programs **40 minutes**

1.	Guide participants to relate the information about women offenders and substance abuse to their work in their particular institution by having them discuss the following questions. Ask them to take 5 minutes to respond individually, then 10 minutes to discuss their responses with the others at their table	Participant workbook: Implications for Programs

2.	Questions: • In what areas did this information confirm what you already knew? • What information was new to you? • What evidence of this information have you seen in your facility or institution? • If all staff in your institution or facility were aware of this information, what difference do you think it would make? • Based on this information, what changes need to be made in your institution or facility? • Who needs this information for these changes to take place? What is your role in making that happen? What other resources do you need to make that happen? • What additional resources does your institution or facility need in order to make these changes? • What needs to happen in your community to facilitate better services for the female substance abusing offender?	
3.	Ask a spokesperson from each table group to give a brief summary of issues and responses from their discussion.	

D. Summary — 5 minutes

1.	Use the following quote and narrative as a guide to summarize this module and transition to the next module on mental health issues. According to Stephanie Covington, "The task of corrections is to provide better services for the invisible women caught in our criminal justice system, imprisoned for substance abuse and their attempts to survive poverty and trauma. It is crucial that the link between the crimes and each woman's drug addiction, mental illness, and/or economic distress be acknowledged." Transition: In our next module we will examine more closely the issues of women offenders and mental health.	

SUBSTANCE ABUSE AND THE FEMALE OFFENDER

1. The numbers of women in the criminal justice system has escalated rapidly over the past decade because:
   a. Women are more involved in the same criminal behavior as men
   b. Law enforcement is regarding women on a more equal basis with men, increasing the likelihood of their arrest
   c. Mandatory drug sentencing laws enacted in the late 1980's specify that anyone caught in possession of drugs would automatically be sentenced
   d. Parents are not supervising their children well

2. Women offenders are likely to use alcohol and/or drugs because:
   a. They are so readily available
   b. They want to please their husbands and/or boyfriends
   c. They need to dull the emotional pain from a history of abuse and other traumas
   d. They lack an emotional support system

3. Substance Abuse, Mental Health, Education, Health and Vocational programs for women in prisons need to be integrated and coordinated because:
   a. It would be a lot cheaper to operate the programs
   b. Of the confusion caused by contradictions from one program to another
   c. Training for staff would be easier
   d. Women and men could then attend the same programs

4. Women are more likely than men to
   a. Drink in a social setting and binge more
   b. Begin to drink at a younger age and take longer to become addicted
   c. Seek treatment for their substance abuse problems
   d. Use heroin and cocaine and experience health problems sooner

5. Women who have recovered from substance abuse addictions list the following issues as most important to them in recovery and relapse prevention:
   a. Awareness of self, healthy relationships, healthy sexuality, spiritual connection
   b. Money, family support, marriage and friends
   c. Vocational training, good job, healthy relationships, money
   d. Education, vocational training, spiritual connection, support groups

6. Components of a comprehensive treatment model for women include:
   a. Daily meetings, drug education, vocational training
   b. Well-trained staff, strictly enforced rules, vocational training
   c. Connections with community treatment programs, visits with children, clearly defined rules
   d. Education on: addictions and consequences, relationships with family and significant others, child care and custody

7. When working with women with substance abuse problems it is important that staff
   a. Enforce rules consistently and fairly
   b. Model appropriate relationship behaviors
   c. Communicate well with each other
   d. Help women bond and develop trust

Substance Abuse

Performance Objectives

- Describe the correlation between substance abuse and criminal activity in women
- Explain how women's needs for substance abuse treatment are different from men's
- Describe the health risks for women who use alcohol
- Explain the issues to address in an effective substance abuse program for women

Substance Abuse - Quiz

Question 1: The number of women in the criminal justice system has escalated rapidly over the past decade because

A. Women are more involved in the same criminal behavior as men

B. Law enforcement is regarding women on a more equal asis with men, increasing the likelihood of arrest

C. Mandatory drug sentencing laws enacted in the last 1980's specify that anyone caught inpossession of drugs would automatically be sentenced

D. Parents are not supervising their children well

Substance Abuse - responses

- Between 1995 and 1996, the number of women in state prisons for drug offenses increased by 95% (55% increase for men)
- Between 1986 and 1996, the increase in women incarcerated for drug offenses = 888%
- 35.9% of women serving time for drug offenses charged solely with possession
- Drug crimes = "survival crimes" for women

Substance Abuse - Quiz

Question 2: Women offenders are likely to use alcohol and other drugs because

A. They are so readily available

B. They want to please their husbands and/or boyfriends

C. They need to dull the emotional pain from a history of abuse and other traumas

D. They lack an emotional support system

Substance Abuse - responses

- Guilt feelings - absent from children
- Anxiety - child custody issues upon release
- Unresolved issues of physical and sexual abuse
- Health problems - poverty, low self-esteem, lack of education
- Victim ➜ Substance Abuser ➜ Offender

Substance Abuse - Quiz

Question 3: Substance Abuse, Mental health, Education, Health and Vocational Programs for women need to be integrated and coordinated because

A. It would be a lot cheaper to operate the program

B. Of the confusion caused by contradictions fromone program to another

C. Training for staff would be easier

D. Women and men could then attend the same programs

Substance Abuse - responses

- Disciplines have different program philosophies
- Treatment models often vary between institutions and community
- Contradictions between programs lead to confusion and can lead to relapse

Substance Abuse - Quiz

Question 4: Women are more likely than men to

A. Drink in a social setting and binge more

B. Begin to drink at a younger age and take longer to become addicted

C. Seek treatment for their substance abuse problems

D. Use heroin and cocaine and experience health problems sooner

Substance Abuse - responses

Substance Abuse - Women compared to men

- Women more likely than men to drink alone; less likely to binge
- Women are older when begin to drink and become addicted more quickly than men
- Women are less likely than men to seek treatment
- Women's related health problems: increased risk of breast cancer, osteoporosis, liver disease; PMS; menstrual disorders, STD's (including AIDS); unplanned and problem pregnancies

Substance Abuse - Quiz

Question 6: Components of a comprehensive treatment model for women include

A. Daily meetings, drug education, vocational training

B. Well-trained staff, strictly enforced rules, vocational training

C. Connections with community treatment programs, visits with children, clearly defined rules

D. Education on: addictions and consequences, relationships with families/significant others, child care and custody

Substance Abuse - responses

Issues to address: from The Center for Substance Abuse Treatment (CSAT)

- **Etiology of addiction, especially gender-specific issues (social, physiological and psychological consequences, factors relating to onset)**
- **Low self-esteem**
- **Race, ethnicity and cultural issues**
- **Gender discrimination and harassment**
- **Disability-related issues, where relevant**
- **Relationships: family and significant others**

Issues to address - continued

- Attachments fo unhealthy interpersonal relationships
- Interpersonal violence, including incest, rape, battering and other abuse
- Eating disorders
- Sexuality, including sexual functioning and sexual orientation
- Parenting
- Grief related to the loss of alcohol and other drugs, children, family members, partners

Issues to address - continued

- **Work**
- **Appearance; overall health and hygiene**
- **Isolation related to a lack of support**
- **Life plan development**
- **Child care and custody**

Substance Abuse - Quiz

Question 7: When working with women with substance abuse problems it is important that staff

A. Enforce rules consistently and fairly

B. Model appropriate relationship behaviors

C. Communicate well with each other

D. Help women bond and develop trust

Substance Abuse - responses

All of the responses are correct!

- **Enforce rules consistently and fairly - these women have experienced little of this**
- **Model healthy relationships - they have history of unhealty, illusional or unequal relationships**
- **Communicate well with each other and with offenders to accomplish the above**
- **Women need to feel safe in order to trust, to share freely and to begin to heal**

SUBSTANCE ABUSE AND THE FEMALE OFFENDER

1. The numbers of women in the criminal justice system has escalated rapidly over the past decade because:
   a. Women are more involved in the same criminal behavior as men
   b. Law enforcement is regarding women on a more equal basis with men, increasing the likelihood of their arrest
   c. Mandatory drug sentencing laws enacted in the late 1980's specify that anyone caught in possession of drugs would automatically be sentenced
   d. Parents are not supervising their children well

2. Women offenders are likely to use alcohol and/or drugs because:
   a. They are so readily available
   b. They want to please their husbands and/or boyfriends
   c. They need to dull the emotional pain from a history of abuse and other traumas
   d. They lack an emotional support system

3. Substance Abuse, Mental Health, Education, Health and Vocational programs for women in prisons need to be integrated and coordinated because:
   a. It would be a lot cheaper to operate the programs
   b. Of the confusion caused by contradictions from one program to another
   c. Training for staff would be easier
   d. Women and men could then attend the same programs

4. Women are more likely than men to
   a. Drink in a social setting and binge more
   b. Begin to drink at a younger age and take longer to become addicted
   c. Seek treatment for their substance abuse problems
   d. Use heroin and cocaine and experience health problems sooner

5. Women who have recovered from substance abuse addictions list the following issues as most important to them in recovery and relapse prevention:
   a. Awareness of self, healthy relationships, healthy sexuality, spiritual connection
   b. Money, family support, marriage and friends
   c. Vocational training, good job, healthy relationships, money
   d. Education, vocational training, spiritual connection, support groups

SUBSTANCE ABUSE - ACTION PLAN

1. In what areas did this information confirm what you already knew?

2. What information was new to you?

3. What evidence of this information have you seen in your facility or institution?

4. If all staff in your institution or facility were aware of this information, what difference do you think it would make?

5. Based on this information, what changes need to be made in your institution or facility?

6. Who needs this information for these changes to take place? What is your role in making that happen? What other resources do you need to make that happen?

7. What additional resources does your institution or facility need in order to make these changes?

8. What needs to happen in your community to facilitate better services for the female substance abusing offender?

6. Components of a comprehensive treatment model for women include:
   a. Daily meetings, drug education, vocational training
   b. Well-trained staff, strictly enforced rules, vocational training
   c. Connections with community treatment programs, visits with children, clearly defined rules
   d. Education on: addictions and consequences, relationships with family and significant others, child care and custody

7. When working with women with substance abuse problems it is important that staff
   a. Enforce rules consistently and fairly
   b. Model appropriate relationship behaviors
   c. Communicate well with each other
   d. Help women bond and develop trust

Module I: Introduction and Overview — Total Time: 1 hour 50 minutes

A. Objectives and Expectations — 15 minutes

1.	Trainers provide brief professional background	
2.	Show slide and explain the workshop outcome Use the following narrative as a guide: The purpose of this workshop is to improve the health and mental health services provided to women in correctional facilities in hopes of reducing their rate of recidivism, improving their overall health, and reducing the likelihood that their children will become incarcerated in the future.	Slide 1-1 Workshop Outcome
3.	Review the workshop goals • to determine the potential impact of care of women offenders on their families, their health, and their potential recidivism • to identify the essential features of an infrastructure that will maximize the delivery of services to women • to describe gender-specific issues of women offenders and the impact of those issues on health, mental health and substance abuse services • to develop strategies to enhance care and services to women offenders	Slide 1-2 Workshop Goals
4.	Ask participants to write two expectations they have for this workshop (what would they like to be able to do as a result of completing this workshop?) After they have completed their writing, conduct an introduction and expectation sharing round robin: starting with a volunteer, have each person introduce him/herself, explain his/her role in working with women in the correctional setting, and share their expectation. Trainer record expectations on chart paper.	Note: If class is over 25 or so participants, have them conduct table group introductions and expectations, then ask each table to introduce the members and share their collective expectations. They can write these on chart paper at their tables
5.	Review the agenda and explain how the content will address the stated expectations. Explain which, if any, expectations are not within this course content.	
6.	Review logistical/housekeeping issues.	

B. Anticipatory Set: Issues in Working with Women Offenders — 20 minutes

1.	Transition to this section using the following narrative as a guide: While working with women in your particular role in corrections can be fulfilling, it can also be quite frustrating, presenting you with difficult decisions, conflicting values and emotional responses.	Prior to the next activity, post two large signs on opposite walls in the room so they can easily be seen: one will say AGREE and the other will say DISAGREE.
2.	Explain the activity using the following narrative as a guide: I am going to read out a series of statements concerning women offenders. After each statement, move toward and stand either near the AGREE sign posted on this side (point), or near the DISAGREE sign posted on this side (point) to indicate your position on that statement. For this activity, there are no right or wrong answers.	
3.	Read one statement at a time. After each statement, pause for a minute or two while participants take their stand. Ask for two or three volunteers on each side to *briefly* explain their response	Do not allow this to become a debate, just a sharing of ideas. This activity will give the trainer as well as all the participants, a better "picture" of the information participants have and opinions they hold about working with women.
4.	Statements • women are harder to work with than men • women should have the same punishment for their crimes as men • women are committed for the same or similar crimes as men • women's criminal history is generally very different from men's • women are more emotional than men	

5.	Transition to the overview and history of women in prison by using the following narrative as a guide: The information we believe to be true along with our values and opinions shape our perspective and the way we view programs and services. The statements we just "took a stand on" represent some of the core issues concerning our attitudes toward women offenders, our perspective about working with women in prison, and our beliefs about what constitutes good correctional programs for women. We are now going to look at the historical perspective of working with women offenders along with some of the more recent data about these women to give us an overview. In the modules that follow we will be presenting information about women and: mental health, physical health, substance abuse, litigation and then the programs that are most effective in addressing these issues for women.	

C. Instructional Input: Historical Perspective of Women Offenders 20 minutes

1.	According to Dr. Nicole Rafter of Northeastern University, (National Symposium on Women Offenders, December of 1999) there have been three historical turning points in the evolution of public policy about women offenders. a. 1820 - Philosophy: through penitence, repentance, harsh routines and heavy labor, criminals can "mend their ways." There were only 1 or 2 women for every 200 men in prison. Men and women were treated about the same, but women were seen as less able to reform than men and expectations for their long-term prospects were considerably lower. b. 1870 - American Correctional Association was founded in response to the abolitionists' view that prisons were "schools for crime." Three founding principles of ACA: 1) reform is distinct from punishment and both are necessary goals of incarceration; 2) reform should involve training, particularly reading, writing, and vocational; 3) there should be indeterminate or flexible sentencing that would take many factors into account and allow for early release for offenders who reformed. Establishment of all-women prisons. Prison programs were designed to reform women by teaching them to be "obedient servants and good wives," believing that women are different from men and that they are delicate and domestic. c. 1970 - major shift toward prisoner accountability; women's and Civil Rights movements brought issues of equality and justice to center stage. Equality meant "same as" in terms of treatment, health services, vocational training and accountability.	Slide 1-3
2.	2001: The rate of female incarceration has increased dramatically, tripling in the last decade. Since 1985 the annual growth rate has averaged 11.1%, higher than the 7.6% average increase in male inmates.	Slide 1-4

3.	The types of offenses for which women have been sentenced also have changed. Most of the women incarcerated in prison today are there for drug-related offenses, up to 60% according to the Federal Bureau of Prisons. In the 1990's, public policy shifts increased both arrests and sentences for certain crimes, including domestic violence and drug crimes. The mandatory minimum sentencing laws have disproportionately involved women.	
4.	Today we recognize that in many ways, female offenders' needs are similar to those of their male counterparts; however, they have special needs that are as unique as gender differences. Health care, parenting initiatives and innovative vocational training programs are needed. Female offenders are likely to have endured years of physical, emotional and sexual abuse before being incarcerated, and so they have special rehabilitative needs as well. (James Gondles, American Correctional Association).	

D. Anticipatory Set: The Profile of the Female Offender — 20 minutes

1.	Begin this section by posing the following questions. These are just to get participants to begin thinking, not to get responses at this point. Who IS the Female Offender today? How is she like and how is she different from female offenders in previous decades? How is she like and different from women outside prison? Ask participants to work together in their table groups to draw a picture or symbol to illustrate their idea of the "typical" woman offender. After about 10 minutes ask groups to hang their posters and have a spokesperson from their group explain. Transition to the information on women offenders by using the following narrative as a guide: We all have pictures in our minds of women offenders, either from our experience in working with them, tales we've heard or stories in the media. While some (many) of these ideas are right on the money, some are based on stereotypes. I want to share some general characteristics of theses women, characteristics that are critical in designing treatment programs to match these women's needs.	Give each table group one or two sheets of chart paper, a variety of markers, and tape or other wall hanging material. You could vary this activity by providing magazines, glue and chart paper and asking participants to make a collage that represents their ideas of the "typical" woman offender.

E. Instructional Input - The Profile of the Female Offender **15 minutes**

(From Corrections Today, February 2001 - Stephanie Covington; Bureau of Justice Statistics Special Report: Women Offenders, October, 2000; National Symposium of Women Offenders, December, 1999)

1.	Education: The majority of women involved with the justice system are at least high school graduates: 60% of those on probation, 55% of those in local jails, 56% of those in state prisons, and 73% of those in Federal prison have completed high school. 30-40% of high school graduates have attended some college.	Slide 1-5
2.	Nature of crime: Women are less likely than men to have committed violent offenses and more likely to have been convicted of crimes involving alcohol, drugs, or property. Many of these property crimes are economically driven, often motivated by the abuse of and addiction to alcohol and other drugs and/or by poverty. About 65% of women in State prisons had a history of prior convictions compared to 77% of men. About 1 in 6 women and 1 in 3 men inmates had criminal records spanning both their juvenile and adult years.	Slide 1-6
3.	Demographics: About 4 in 10 women in State prison reported that they had been employed full-time prior to their arrest compared to 6 in 10 male inmates. About 37% of women compared to 28% of men had incomes less than $600 per month prior to arrest. Nearly 30% of female inmates reported receiving welfare assistance just prior to arrest compared to just under 8% of male inmates. Of those women who reported employment just prior to arrest, 22% were on some public support, 16% made money from drug-dealing, and 15% were involved in prostitution, shoplifting or other illegal activities.	Slide 1-7
4.	Health and mental illness. In 1997 an estimated 2,200 women serving time in State prisons were HIV-positive, about 3.5% of the female population. About 20,200 males, about 2.2% of the male population, was HIV-positive. Nearly one quarter of women in State prisons have been identified as being mentally ill and most of these are on psychotropic drugs.	Slide 1-8

5.	Marital Status: Adult women under correctional care, custody, or control are substantially more likely than the equivalent general population to have never been married.	Slide 1-10
6.	Children: Approximately 70% of women under correctional sanction (probation, local jails, State and Federal prisons) have children under 18; about 64% of women with minor children had lived with those children prior to incarceration. Many of these women report feeling enormous guilt about being absent from their children's lives and worry about custody when they are released.	Slide 1-11
7.	Abuse: Nearly 60% of women in State prisons reported being physically or sexually abused at some point in their lives; about one-third of those were abused by an intimate or family member. 40% reported emotional abuse as children and 48% as adults.	Slide 1-12
8.	Race: Nearly two-thirds of women confined in local jails and State and Federal prisons are minorities; two-thirds of those on probation are white.	Slide 1-13
9.	Age: Women in prison, both State and Federal, are older than their counterparts in local jails or under probation supervision: 1 in 8 State prisoners and 1 in 11 Federal prisoners are under age 25; nearly 25% of Federal prison inmates (women) are at least 45 years old.	Slide 1-14
10.	Substance Abuse: More than half of women offenders confined in State prisons had been using alcohol, drugs, or both at the time of the offense for which they had been incarcerated; 60% were in prison for drug-related crimes while 25% were imprisoned for violent offenses. This is almost the reverse of statistics for men: 70% imprisoned for violent offenses and 25% for drug-related offenses. Drug use was reported more often than alcohol, a reverse pattern than that of men. About 60% of women in State prison described themselves as using drugs in the month before the offense, 50% described themselves as a daily drug user. Nearly 1 in 3 women serving time in State prisons said they had committed the offense which brought them to prison in order to obtain money to support their need for drugs.	Slide 1-15

F. Guided Practice - History and Profile — 10 minutes

1.	To help participants make personal connections with the historical perspective, have them respond to the following questions individually (in their workbook), then share their responses with the others in their table group. • What programs in your institution still operate on the early philosophy that women are less able to "reform" than men? How does this impact the women offenders? • What programs in your institution still operate on the long-standing philosophy that women are different from men, they are delicate and domestic? How does this impact the women offenders? • What programs in your institution operate on the philosophy from the 1970's to 90's that women are equal to men? How does this impact the women offenders? • What programs in your institution are gender-specific, focusing on the philosophy that many of women's needs are distinctly different from men's? What difference do you believe this is making in these women's rehabilitation and reintegration into the community?	Participant workbook and group activity.
2.	Have one or two participants volunteer their responses to each of the questions.	

3. Ask participants to compare the "profile of the female offender" with their poster profiles they created earlier in this module. Use the following narrative to guide the discussion: Look at the posters you created earlier, depicting your impression of the female offender. Think about the information we reviewed concerning the profile of the female offender. What differences do you see between this profile and your drawings? How do you account for these differences? How do you think the new information will impact the way you view and work with your institution's programs?	Participant responses will vary here depending on the particular institution as well as the level of experience of the offender in working with women offenders. For some the profile might match their drawings closely; for others there might be start differences. There are no "right" answers here.

G. Summary — 5 minutes

Use the following narrative as a guide to summarize and close this module: 1. From the historical perspective we see the need for change in the way we work with women as we have discovered that "equal" treatment for men and women does not necessarily mean "the same" treatment. We need to make sure that we are not viewing women as more *difficult* than men, nor do we need to view them as *different* from men, but rather that they have *unique* needs that need to be met in order to help them re-enter the community successfully 2. Not only does the change in philosophy affect the way we work with women in prison, but also the newer information we have about women, along with actual changes in the women we have in prison. Examining the profile information is a valuable and necessary step in evaluating and revising our programs to meet their needs. 3. In the modules that follow we will examine more closely women's needs in the following areas: substance abuse treatment, health issues, mental health treatment, co-occurring disorders, then look at management issues to address in balancing the need for security and treatment.	

Prison Health Care: Women Offenders

Workshop Outcome

To improve the health and mental health services provided to women in correctional facilties in hopes of reducing their rate of recidivism, improving their overall health, and reducing the likelihood that their children will become incarcerated in the future.

1

Prison Health Care: Women Offenders

Goals

To determine the potential impact of cre of women offenders on their families, their health, and their potential recidivism.

To identify the essential features of an infrastructure that will maximize services to women

2

Goals continued

To describe gender-specific isues of women offenders and the impact of those issues on health, mental health, and substance abuse services.

To develop strategies to enhance care and services to women offenders

3

History of Incarcerated Women's Care

- 1820 - "Mend their ways" philosophy; women less able to reform than men
- 1870 - ACA founded
  - Reform is distinct from punishment; both are necessary goals of incarceration
  - Reform should involve training - reading, writing and vocational
  - Indeterminate or flexible sentencing to allow for early release for prisoners who reform

4

- 1970 - shift toward offender accountability; issues of equality and justice brought to center stage with Civil Rights and Women's movements. Equality meant "same as" in terms of services
- 2001 - rate of female incarceration tripled in last decade; most women in prison for drug-related offenses

5

The Female Offender - Profile

- Education - most are high school graduates
- Crime - mostly property or alcohol/drug related crimes. Many property crimes economically driven
- Demographics - 40% of women (60% of men) inmates employed prior to incarceration; 37% of women (28% of men) had incomes < $600 per month prior to arrest; 30% on welfare (8% of men); 16% made money from drug deals; 15% made money from prostitution

6

The Female Offender - Profile continued

- Health and mental illness - 1997 3.5% of female inmates were HIV +; almost 25% female inmates identified as mentally ill
- Marital status - most have never been married
- Children - approximately 70% of women under correctional sanction have children under age 18
- Abuse - Nearly 60% of women in State prisons report being physically or sexually abused

7

The Female Offender - Profile continued

- Race - Nearly 2/3 of women in local jails and State and Federal prisons are minorities
- Age - 1 in 8 State prisoners and 1 in 11 Federal prisoners are under age 25; nearly 25% of Federal prisoners are at least 45 years old
- Substance Abuse - More than half of women confined in prison had been using alcohol/drugs at the time of offense; 60% report using drugs in the month before the offense

8

HISTORY AND PROFILE

Please respond to the following questions individually, then share your responses with the others in your group:

- What programs in your institution still operate on the early philosophy that women are less able to "reform" than men? How does this impact the women offenders?

- What programs in your institution still operate on the long-standing philosophy that women are different from men, they are delicate and domestic? How does this impact the women offenders?

- What programs in your institution operate on the philosophy from the 1970's to 90's that women are equal to men? How does this impact the women offenders?

- What programs in your institution are gender-specific, focusing on the philosophy that many of women's needs are distinctly different from men's? What difference do you believe this is making in these women's rehabilitation and reintegration into the community?

Module IV: Mental Health Issues — Time: One hour and twenty minutes

A. Anticipatory Set: Introduction and Performance Objectives — Time: 15 minutes

1. Have participants begin to think about their concepts and questions concerning the mentally ill female offender by asking them to work with the others at their table to respond to the following questions: • Based on your experience in the correctional setting, describe the behaviors of the mentally ill female offender. • What special services are offered to these offenders? • In general, how are these offenders treated by the other offenders? By the staff? • What are your concerns and issues about the mentally ill offender? Ask them to write their responses to the last question, concerns and issues, on chart paper and post it. When they have finished, have a spokesperson from each group report out their responses. This will give the presenter(s) information about the participant level of knowledge as well as issues and concerns they need to have addressed. Review the performance objectives and let them know any of their issues that you do not plan to address in this module	Participant workbook:
After completing this module you will be able to . . .	
▸ describe the relationship between abuse and other traumatic events with mental illness	Slide 4-1
▸ list the basic symptoms of the major mental illnesses that are most prevalent among women who are incarcerated	
▸ determine staff's role in accessibility of mental health care for women	

B. Instructional Input - Stress, Trauma and Mental Illness Time: 15 minutes

1.	Women are much more likely than men to enter the criminal justice system because of family problems, mental illness or sexual activity. Many have suffered from sexual abuse or domestic violence at home. In the course of trying to escape and support themselves, they get involved with prostitution, drugs and alcohol, and often are led into crimes by their association with men involved in criminal activity. (National Symposium on Women Offenders, Office of Justice Programs, December, 1999)	Slide 4-2
2.	According to the latest Bureau of Justice Statistics, 60% of incarcerated women have experienced physical, sexual or emotional abuse, either as children or adults. Although men also experience early trauma, they often become perpetrators in adulthood where women remain victims or in dependent roles with continued abuse. They are further traumatized by the abuse, learning to distrust adults because they *Tell and no one believes them* (often the perpetrator is the father, step-father, or mother's boyfriend on whom she depends for emotional and financial support) *Don't tell* because they are threatened or embarrassed.	Slide 4-3
3.	Victims of abuse often experience sleep disorders and nightmares, resulting in poor concentration, depression and disciplinary problems. Many run away from home and either are returned home to the abusive situation or end up on the street, engaging in "survival sex" (exchanging sex for food, shelter and/or drugs). The long-term consequences of this pattern of abuse include homelessness, poor self esteem, poor education, lack of job skills, health problems, drug addictions, high-risk and unwanted pregnancies, sexually transmitted diseases, depression, and post-traumatic stress disorder.	Slide 4-4
4.	Large numbers of women offenders suffer from mental illness. Without mental health services, many have found legitimate opportunities blocked and have supported themselves through prostitution and low-level drug-dealing, becoming ensnared in the justice system	Slide 4-5

5.	As we heard in an earlier module, more than half of women offenders were under the influence of alcohol or other drugs at the time of their offense with even larger numbers reporting histories of substance abuse. Often they are attempting to self-medicate the pain of trauma or of mental illness.	Slide 4-6
6.	Many women offenders have grown up in violent homes or neighborhoods, often with parents who have been involved with the criminal justice system.	

C. Instructional Input - Symptoms **Time: 20 minutes**

1.	Use the following narrative to review the symptoms of the primary mental illness diagnoses. This is not provided to help the correctional personnel diagnose the various illnesses but rather to help them become more aware of programmatic needs	
2.	*Post-traumatic Stress Disorder*: One must have experienced a life event that threatened his/her life or safety and was out of the ordinary range of events. Symptoms include those of depression, hyper-vigilance (always looking around and feeling unsafe), increased startled response (easily frightened), avoidance of places and situations that remind one of the traumatic event or situation. Flashbacks of the trauma are quite common and produce a great deal of distress. The "battered women's syndrome," has been placed as a subcategory of Post-Traumatic Stress Disorder Syndrome. Women who are beaten, or who suffer from Battered Women's Syndrome, demonstrate low self-esteem and a sense of powerlessness and worthlessness, particularly when their attempts to stop the violence are met with repeated failure. Post Traumatic Stress Disorder also includes exaggerated feelings of fear and caution, recurrent dreams and flashbacks of the abuse, an inability to bond closely with others, and an overall sense of diminished emotional capacity.	Slide 4-7

3.	*Major Depression*: One of the most common illnesses affecting all women in the United States. The symptoms vary in intensity but consist of feels sad, sleep difficulties (either too much or too little), little energy, decreased concentration, appetite changes (too little or too much), and frequent thoughts of suicide. Symptoms must be present for at least two consecutive weeks and impair one's daily functioning. Depression is often a consequence of abuse (women are more inclined than men to internalize their feelings, become depressed, and assume responsibility for the abuse) or a real or perceived loss (loss of loved one, loss of self-esteem). Ask participants, "What are some of these real or perceived losses that women offenders experience?" Responses: Loss of freedom, self-respect, control, children, dignity. Many losses, real or perceived, come with their history of abuse.	Slide 4-8
4.	*Dysthymia*: Person is depressed but functions on a day to day basis.	
5.	*Bipolar Disorder* (Manic Depressive Illness): Periods of depression as just described and episodes of mania, including the following: paranoia, little sleep, excessive spending, the need to travel, starting many projects but finishing few, hyper-speech, hyper-sexuality.	Slide 4-9
6.	*Schizophrenia*: periods of losing touch with reality, paranoia, auditory or visual hallucinations, agitation, flat or blunted facial expression. Neither schizophrenia nor bipolar disorder are the most common mental disorders among women, incarcerated or in the general population.	Slide 4-10
7.	*Self-inflicted injury*: This is often a defense mechanism used to cope with abuse by numbing of feelings. With the self-inflicted injuries, there is blood but not necessarily pain. The person feels a sense of relief after such behavior as it validates to them that they do have feelings and are alive in some way.	Slide 4-11

D. Instructional Input - Treatment — Time: 15 minutes

1.	Use the following narrative as a guide to explain mental health assessments, treatment modalities, medication issues, and the need for staff training in gender specific and abuse issues relating to mental illness:	
2.	Assessments and evaluations • to determine if inappropriate behavior is actually a symptom of mental illness • conducted by qualified mental health professionals including masters level psychiatric social workers, psychologists and psychiatrists	Slide 4-12
3.	Treatment levels • hospitalization if risk of harm to self or others • medication with ongoing monitoring • group therapies * peer support * educational - reasons for their behavior * trust and confidentiality issues	Slide 4-13
4.	Staff training • Gender-specific issues * More stressors than men, particularly issues concerning their children * Women will access services more than men * Abused women often seek attention through acting out behavior	Slide 4-14
5.	Psychopathy - The Hair Assessment (Robert Hair), validated for use with women, is the current best predictor of psychopathy in women. Women with high scores are likely to be pulled from the treatment program.	
6.	Medications Psychiatrist needs to stay up to date on drugs that work best, best supplier, cost of drugs, side effects	

7. Forced Medications • Must be knowledgeable of State law (most states prohibit forcible medication unless inmate is in danger of harming herself or others.) • Must have clear policy and procedure that follows the State law	Slide 4-15

E. Guided Practice/Action Plan — Time: 15 minutes

1.	Ask participants to respond to the following questions to complete their action plan: a) What are your facility's strengths in addressing the mental health needs of your female offenders? b) What are the gaps in these services? c) What are the challenges in filling these gaps? d) Who needs to be involved in meeting these challenges? e) What will be the advantages in doing so for the female offender? For the staff? For the community? f) What training needs to be offered to the facility staff in recognizing and dealing with the mentally ill offender? g) What policies and procedures exists that address these needs? h) What role can you take in making the necessary changes?	Participant workbook
2.	Have one or two volunteers share their action plans.	

Prison Health Care: Women Offenders

Mental Health Issues - Performance Objectives

- Describe the relationship between abuse and other traumatic events with mental illness
- List the basic symptoms of the major mental illnesses that are most prevalent among women who are incarcerated
- Determine staff's role in accessibility of mental health care for women

Prison Health Care: Mental Illness

Women are likely to . . .

- **Enter the criminal justice system because of family problems, mental illness or sexual activity**
- **Have suffered from sexual and physical abuse**
- **Get involved with prostitution, drugs, alcohol**
- **Be led into crime by their association with men involved in criminal activity**

Prison Health Care: Mental Illness

Women and Abuse

- **Bureau of Justice: 60% of incarcerated women have experienced physical, sexual or emotional abuse either as children or as adults**
- **Women tend to remain victims with continued abuse.**
- **Women tend to distrust other adults because they tell about the abuse and no one believes them, or they don't tell because of threat or embarrassment.**

Prison Health Care: Mental Illness

Women and Abuse -continued

Victims of abuse often experience sleep disorders.

Sleep disorders ➜ poor concentration, depression, discipline problems ➜ run away ➜ returned home to abuse or engage in "survival sex" on the streets

Long-term consequences: homelessness, poor self esteem, poor education, lack of job skills, health problems, drug addictions, high-risk and unwanted pregnancies, sexually transmitted diseases, depression, post-traumatic stress disorder

Prison Health Care: Mental Illness

Many women offenders who are mentally ill become ensnared in criminal justice system because they supported themselves through prostitution and low-level drug dealing.

Prison Health Care: Mental Illness

More than 50% of women offenders were under influence of alcohol or other drugs at time of offense; even more report histories of substance abuse.

Often these women are attempting to self-medicate the pain of trauma or of mental illness.

Many of these women grew up in violent families or neighborhoods with parents involved in criminal justice system.

Prison Health Care: Mental Illness

Disorders and Symptoms

POST TRAUMATIC STRESS DISORDER

Frequently experienced by those with history of abuse

Sense of diminished emotional capacity

Inability to bond with others

Depression, hyper-vigilance, easily startled, flashbacks of traumatic events

Battered women's syndrome

- **Low self-esteem, sense of powerlessness**

Prison Health Care: Mental Illness

Disorders and Symptoms continued

MAJOR DEPRESSION

One of most common illnesses among all women in US

Feeling sad, sleep difficulties, little energy, decreased concentration, appetite changes, frequent thoughts of suicide

Symptoms present for at least two weeks

Often occurs as a result of abuse or loss (real or perceived

Prison Health Care: Mental Illness

Disorders and Symptoms continued

BI-POLAR DISORDER

Periods of depression and episodes of mania

Manic Episodes: paranoia, little sleep, excessive spending, the need to travel, starting many projects but finishing few, hyper-speech, hyper-sexuality

Prison Health Care: Mental Illness

Disorders and Symptoms continued

SCHIZOPHRENIA

Periods of losing touch with reality

Paranoia, auditory or visual hallucinations, agitation, flat or blunted facial expression

Not so common, either in general population or in prison population

Prison Health Care: Mental Illness

Disorders and Symptoms continued

SELF-INFLICTED INJURY

Defense mechanism used to cope with abuse by numbing of feelings.

Person feels sense of relief - validates that they are alive in some way

Prison Health Care: Mental Illness

Assessments and Evaluations

- To determine if inappropriate behavior is actually a symptom of mental illness

- Conducted by qualified mental health professionals

Prison Health Care: Mental Illness

Treatment Levels

- Hospitalization if risk of harm to self or others
- Medication with ongoing monitoring
- Group therapies
  - Peer support
  - Education - reasons for behavior
  - Trust and confidentiality issues

Prison Health Care: Mental Illness

Staff Training

- **Gender-specific issues**
  - **Women experience more stress than men, especially issues concerning children (child care, custody)**
  - **Women access services more frequently than men**
  - **Abused women often seek attention through acting-out behavior**

Prison Health Care: Mental Illness

FORCED MEDICATIONS

Must be knowledgeable about State law

Must have clear policy and procedure that follows State law

Mentally Ill Women Offenders - Action Plan

Please respond to the following questions to complete your action plan:

a. What are your facility's strengths in addressing the mental health needs of your female offenders?

b. What are the gaps in these services?

c. What are the challenges in filling these gaps?

d. Who needs to be involved in meeting these challenges?

e. What will be the advantages in doing so for the female offender? For the staff? For the community?

f. What training needs to be offered to the facility staff in recognizing and dealing with the mentally ill offender?

g. What policies and procedures exists that address these needs?

h. What role can you take in making the necessary changes?

Mentally Ill Women Offenders - Concerns and Issues

Work with the others at your table to respond to the following questions:

- Based on your experience in the correctional setting, describe the behaviors of the mentally ill female offender.

- What special services are offered to these offenders?

- In general, how are these offenders treated by the other offenders? By the staff?

- What are your concerns and issues about the mentally ill offender?

Write your responses to the last question, concerns and issues, on chart paper and post it. Select a spokesperson to report out for your group.

Module V: Co-occurring Disorders — Time: One hour and fifteen minutes

A. Introduction and Objectives — 15 minutes

1.	After completing this module you will be able to • define "co-occurring disorders" • describe the basic components of treatment programs for co-occurring disorders in women in a correctional setting • explain steps correctional facilities need to take to ensure effective service-delivery to women with co-occurring disorders	Slide 5-1
2.	To engage the participants in thinking about issues around co-occurring disorders, ask the following (or similar) questions: How many of you have ever known or heard about someone who was being treated for more than one illness at a time? (Most likely they all have at least heard of this happening.) What are some of the problems that can occur? Responses: They might become over-medicated; medication can be expensive; several medicines taken together might have an adverse reaction; treatment for one illness might create more problems with the other illness, symptoms of one illness can mimic or mask symptoms of another and so on. What has to happen for the person to be treated effectively? Responses: If there is more than one doctor, they need to communicate about treatment programs; complete medical information must be provided to all service providers; medical service providers must ask a lot of "right" questions about the person's medical history; person must have resources to get prescribed treatment; person must follow-through on all treatment recommendations.	
3.	Use the following narrative as a guide to transition to the instructional input: And so it is with co-occurring disorders - there are many similar issues. First, let's make sure we are all talking about the same thing when we use the term, "co-occurring disorders."	

B.	**Instructional Input - the Problem**	**20 minutes**
1.	Co-occurring Disorder - What is it? Ask if anyone knows or has any idea what a co-occurring disorder is. After getting a few responses, share a common definition, using the following narrative as a guide and supplementing with the corresponding slide: "Many of you have some idea of what a co-occurring disorder is, but to make sure we all have the same point of reference, let me share with you the definition that I use in the information and programs in this module." ***Co-occurring disorder***: The combination of a substance abuse or abuse disorder along with a major mental illness, mental retardation, and/or personality disorder. Other terms frequently used are Dual Diagnosis, Dual Disorders, Chemically Abusing Mentally Ill; Mentally Ill Chemical Abusers.	Slide 5-2
2.	Co-occurring Disorder - Relevance to Women's Health Care in Prison Use the following narrative as a guide: In previous modules we have taken a look at substance abuse, mental health, and physical health issues for women in prison, but what happens when these are *co-occurring*? As noted earlier, statistics from numerous studies reveal that women tend to have more psychiatric *and* more substance abuse problems than men. It is thought by many in the corrections field that this is due to women having higher levels of stress in their lives: childcare, pregnancies and other health care issues, and histories of abuse. Because women must remain drug-free upon release to prevent re-incarceration, and because they need to be able to deal with mental health issues in order to care for children and maintain employment, it is critical that we deal with these issues while they *are* incarcerated. For some, the period of incarceration may be the first opportunity they've had to be assessed and treated for these illnesses/disorders.	

3.	**Constitutional Issues** While there *is* a constitutional mandate for the health, mental health and dental needs of incarcerated offenders to be addressed, there is *no* such mandate for treatment of substance abuse disorders. Therefore, if the substance abuse disorder is considered primary, often the person goes untreated and further assessment is not done. If the offender is on drugs at the time of arrest and intake, or if the offense was alcohol or drug related in any way, it is easy for assumptions to be made during the assessment that substance abuse is the primary disorder.	Slide 5-3
4.	**Assessment Issues** *Training:* Assessments are often done by correctional personnel who are not trained to identify and/or recognize symptoms of both substance abuse and mental illness. *Symptoms:* Use and abuse of alcohol and other drugs often cause psychiatric symptoms, leading to errors in diagnosis. Some of these symptoms can persist for weeks, months or even longer after the person has discontinued use of the substance(s). Mis-diagnosis can lead to improper or over-medication, further complicating the presenting symptoms. Mental health problems can often lead to self-medication with drugs and alcohol. *Timing:* Since many offenders are high or in withdrawal at intake, the offender's responses to assessment questions can be questionable. If they are not high, they are likely to deny having substance abuse problems to protect themselves or their boyfriends or spouses or to prevent further sanctions. Denial is a key characteristic of substance abusers. Women who suffer trauma from abuse have major problems with trust, therefore are guarded about responses they give to the professional conducting the assessment. If they have experienced abuse just prior to incarceration they are probably still fearful of or trying to cover for the abuser.	Slide 5-4

5.	**Common Barriers to Effective Service Delivery** • Differing philosophies: Mental Health - medical model; supportive Substance Abuse - self-help; confrontational • Training requirements different for each discipline • Fragmentation of services • Duplication of services and resulting lack of trust • No provision for multiple needs, therefore, some needs fall through the cracks • Separate funding and licensing requirements for each discipline • Inadequate resources • Assessments - often given by one discipline only at intake	Slide 5-5

C. Instructional Input - Recommendations **20 minutes**

1.	Use the following narrative as a guide to explain three approaches to dealing with co-occurring disorders: **Sequential Treatment:** Offender completes one treatment program before beginning another treatment program. This has not proven to be very effective because of many of the barriers just reviewed. **Parallel Treatment:** Offender goes to two treatment providers at the same time. This approach is most effective with offenders who have low to moderate needs. Both treatment providers need to be at the table to enable very clear communication and cooperation between the disciplines and to instill and maintain trust with the offender. Confidentiality issues must be addressed. **Integrated Treatment:** Offender is engaged in one treatment program that addresses both mental health and substance abuse issues at the same time.	Slide 5-6
2.	SAMHSA, the Substance Abuse and Mental Health Services Administration, issued a position statement in April of 1999, recommending the Integrated Approach for treatment of people with severe co-occurring disorders. They issued the following key principles to clarify what is meant by Integrated Services:	

3.	**Integrated Services:** • "No wrong door" approach - services must be available and accessible no matter how or where an individual enters the system • Individuals should have access to a comprehensive array of services appropriate to their needs • Services should be consumer-focused and consumer-family centered • Staff should be fully oriented in each other's disciplines • Administrative functions should not become a barrier to the integration of treatment	Slide 5-7
4.	**Relapse Prevention** Relapse prevention is being used in many programs for co-occurring disorders because of the high rate of reoccurrence of symptoms of mental illness, using addictive substances, and the return to criminal behavior. The components of such programs include helping the offender identify the warning signs of relapse for themselves, looking at high risk behaviors and the influences in their lives that promoted substance use.	

D. Guided Practice/Action Planning **15 minutes**

1.	Ask participants to take 15 minutes to complete the action plan in their workbook. These questions are designed to help them look at their institution's current approach to dealing with co-occurring disorders and plan steps they can take to apply the information they have just learned. If time permits, have them share their plans with others in their table group and/or with the large class group.	Participant Handout

2.	Action Plan • What evidence have you seen of co-occurring disorders in your facility or institution? • How are the women assessed for mental health and substance abuse problems (Who does the assessments? When are the women assessed? What instruments are used? How often are assessments made?) • What treatment programs are available for these women? Are they sequential, parallel or integrated? How do you know? • What needs to happen in your institution to improve assessment of and service delivery to women with co-occurring disorders? • What action can you take toward this improvement? • What is a date you can set to take this action? • How will this benefit the women in your program? Your institution or facility? The public?	

E. Summary **5 minutes**

1.	Women's programs must be sensitive to the issue of trauma in the lives of a great majority of the women who will be in these treatment programs. Many of them began using addictive substances to deaden the pain of repeated abuse, unemployment and poverty and/or serious, untreated health problems. Individual and group therapies must be included and staff must be trained to help women deal with these traumas and to provide them the skills they need to succeed upon release.	
2.	In October of 2000 SAMHSA awarded a grant to support a national Co-Occurring and Justice Center for designing and implementing effective, substance abuse and mental health services for youth and adults with co-occurring substance abuse and mental disorders who are involved with the criminal justice system. The purpose of the national Center is to provide, at both the community and national levels, information and technical assistance that enable professionals and organizations to improve service Deliver within systems, and to effect system change where needed. You can access the SAMHSA web site at www.samhsa.gov	

Prison Health Care: Women Offenders

Co-Occurring Disorders -Performance Objectives

- **Define "co-occurring disorder"**
- **Describe the basic components of treatment programs for co-occurring disorders in a treatment setting**
- **Explain steps correctional facilities need to take to ensure effective service-delivery to women with co-occurring disorders**

1

Women Offenders: Co-occurring Disorders

Co-occurring disorder: The combination of a substance abuse or abuse disorder along with a major mental illness, mental retardation, and/or personality disorder.

Also called Dual Diagnosis, Dual Disorders, Chemically Abusing Mentally Ill, Mentally Ill Chemical Abusers

2

Women Offenders: Co-Occurring Disorders

Constitutional Issues

Consitutional Mandate for health, mental health, dental care in prison

NO constitutional mandate for treatment for substance abuse disorders in prison

3

Women Offenders: Co-occurring Disorders

Assessment Issues

- **Training: assessment staff need ability to recognize symptoms of mental illness AND substance abuse**
- **Symptoms: Substance abuse can cause psychiatric symptoms that persist for weeks and months. Mis-diagnosis can lead to improper or over-medication. Mental health problems often lead to self-medication with alcohol and/or drugs.**
- **Timing: Assessments need to be ongoing; trust is necessary to overcome guarded responses of abuse victims**

4

Co-occurring Disorders: common barriers to service delivery

- Different philosophies: mental health - supportive medical model; substance abuse - self-help and confrontational
- Different training requirements for each discipline
- Fragmentation of services
- Duplication of services resulting in lack of trust
- Some needs fall through cracks
- Separate funding and licensing requirements
- Inadequate resources
- Assessment - often by one discipline only at intake

5

Women Offenders: Co-occurring disorders

Approaches

- **Sequential treatment - offender completes treatment in one discipline, then in the other. Not very effective**
- **Parallel treatment - offender goes to two treatment providers at one time. Most effective with offenders with low to moderate needs. Must have clear communication and cooperation between disciplines**
- **Integrated treatment - Offender is engaged in ONE treatment program that addresses BOTH mental health and substance abuse issues**

6

CO-OCCURRING DISORDERS - ACTION PLAN

- What evidence have you seen of co-occurring disorders in your facility or institution?

- How are the women assessed for mental health and substance abuse problems (Who does the assessments? When are the women assessed? What instruments are used? How often are assessments made?)

- What treatment programs are available for these women? Are they sequential, parallel or integrated? How do you know?

- What needs to happen in your institution to improve assessment of and service delivery to women with co-occurring disorders?

- What action can you take toward this improvement?

- What is a date you can set to take this action?

- How will this benefit the women in your program? Your institution or facility? The public?

Module VI: Crisis Intervention Time: One hour and fifteen minutes

A. Anticipatory Set: Introduction and Objectives 20 minutes

1.	In order to have participants begin to identify what they perceive as a crisis, have them participate in the following activity with their table groups. Use the following narrative as a guide to explain the activity. "In corrections we sometimes feel that each day is one crisis after another, that we spend all our time 'putting out fires.' In order to focus our definition of *crisis* and make the information relevant to your situation, I would like for each of you to think of one or two crises that have occurred in your particular facility or program. Share that with the others at your table, then work as a group to come up with a definition of *crisis*. Write this definition on chart paper and attach it to the wall. Please select a spokesperson to share this with the rest of the class." Give groups about 10 minutes to share situations and write their definition.	
2.	After groups have shared their definitions, walk to each chart and highlight (underline with red marker) those words or phrases that are common in each definition. Use the following narrative as a guide to transition from this activity to sharing of performance objectives: "As you can see, we have a lot of similar ideas about what constitutes a crisis, and probably many different ways of dealing with them. In a few minutes I will share a definition of *crisis* that we will use in this module, for today we will be dealing specifically with the *psychiatric* crisis."	
3.	Share the performance objectives for this module After completing this module you will be able to • define what we mean by *crisis* • describe behaviors in the prison setting that are *psychiatric* crises • explain key components of a screening that can prevent or predict suicide • explain critical actions in preventing "successful" suicides with women offenders	Slide 6-1

B. Instructional Input — Time: 40 minutes

1.	Use the following narrative as a guide to explain/define *crisis* and *crisis intervention*: "A psychiatric emergency, as defined by Sadoff, et al, is any behavior, mood or thought, which if not rapidly attended to, may result in harm to an individual or others. Crisis intervention can be thought of as taking care of the psychiatric emergency, but is more broadly defined as helping individuals deal with crises in their lives. In this module, we will deal specifically with the psychiatric emergencies and the response to those in the correctional setting."	Slide 6-2
2.	Continue, using the following narrative as a guide: "In a correctional setting, the behavior that usually falls under this category includes • suicidal gestures or attempts (including any self-injuries) • agitated behavior • aggressiveness	Slide 6-3
3.	The most common psychiatric emergency or crisis in the correctional setting is the threat of suicide. In jails, the suicide rate is 9 times that of the general population; in prisons it is approximately twice that of the general population. In jails, the highest rate of suicides occur among young, white, single, first-time, non-violent offenders with a substance abuse history and occurs within the first 24 hours of arrest. Ask participants, "Why do you think suicide is such a tremendous risk with this population at this time?" Response: This population has just experienced a tremendous loss, and during the first 24 hours of arrest they are likely to feel totally hopeless, that they cannot face themselves or others in their lives, that there is no way out of this predicament.	Slide 6-4

4.	Men actually commit more suicides than women; women make more suicidal *attempts*. Ask, "Why do you think this is so?" Responses: Men use more lethal means (guns, hanging), more likely to be considered "macho"; it is more acceptable for women to cry out for help, using less lethal means such as wrist-slashing or over-dosing.	
5.	Risk factors: Use the following narrative and the slides to guide a discussion of those factors which increase the female offender's risk of potential suicidal thoughts and attempts. • Authoritarian environment (have problems living up to expectations; unwilling or unable to follow strict rules) • Isolation from family and friends (loss of support system, no matter how weak that was) • Dehumanizing aspects of incarceration (ask for examples) • Fears (ask participants what some of these offenders fears might be) • Recent use of drugs or alcohol (especially intake) • Guilt or shame regarding the arrest (primarily first arrest or incarceration) • Mental illness • Excessive worries about family and children • Holidays (perceives that everyone else is celebrating with family; very depressing time)	Slide 6-5 Instructor add examples from personal experience with offenders and inmates
6.	Ask participants, "What do you notice about this list of risk factors?" Response: Most of our female offenders have one or more of these risk factors. Continue, using the following narrative as a guide: We need to be vigilant, paying particular attention to the warning signs we will review next.	

7.	Warning signs to assess Use the following narrative and the slides to guide a discussion of those factors which likely indicate that the offender/inmate is considering suicide as a means to solving her problems. The more warning signs that are present the higher the risk. • depression • history of prior suicide attempt • talks about or threatens suicide (statements such as "You'll be sorry when I'm gone." "I won't be around to bug you much longer." "I wish I had never been born." "I'd be better off dead.") • withdrawal from alcohol or other drugs • paranoia • gives away possessions, particularly prized possessions • marked change in behavior (the usually quiet person becomes loud and obnoxious; the aggressive or lively person becomes withdrawn; change in eating or sleeping patterns)	Slide 6-6 Again, add examples from work with female offenders
8.	Ask, "When should assessment of risk begin?" Desired response: at intake. The health care screen should include questions relating to history of suicide attempts, current feelings of depression and other mental health symptoms, and observations made as to the behavior at the time of arrival into an institution. Research has shown that when asked questions about their histories and feelings, inmates are generally truthful and often relieved that someone has asked. This type of interview will also give the inmate some feeling of support and comfort with the idea that someone cares.	Slide 6-7

9.	If *any* staff has any indication that an inmate is suicidal, they should immediately follow procedure to refer for evaluation by a qualified mental health professional. The facility's policies should be clear as to how inmates are placed on suicide watch, at what levels, how often they are monitored, and who can order suicide watch. Levels of watch should include continuous and 15 minute checks (with the 15 minute checks done at irregular intervals.) Rooms or cells used for suicide watch must be "safe" from anything that could be used as an instrument of self-harm. Ask participants, "What are some things that might need to be removed from a cell to make it 'safe'?" Responses: (add any of these that participants do not mention.) Furniture with sharp edges, raised furniture, mirrors, accessible and/or breakable glass windows, bars, grates, exposed sprinkler heads, sheets/blankets. The medical authority who orders the watch should determine the personal clothing the woman may have. If all clothing is taken away, the facility must have special suicide smocks and/or blankets to cover her body and provide warmth but that cannot be used to hurt herself.	
10.	Isolation - it is important for a woman *not* to be or feel isolated from others, even on suicide watch. Some systems use inmate observers to talk to inmates placed on suicide watch with officers present in the immediate area.	

11.	Self-inflicted injury All attempts at suicide must be taken seriously even though women are much more likely to make "attempts" than to actually commit suicide. Ask participants, "Why do you think it is so critical to take every attempt seriously, even when the person has a history of such attempts?" Desired response: You never know when they might be more serious and actually succeed; you don't know when they might accidentally injure themselves more than intended and actually succeed. Continue, using the following narrative as a guide: You have heard (or perhaps already knew) that most women inmates have a history of abuse, either as a child or as an adult. Often these women engage in behavior that elicits pain as a way of feeling something they can identify with - either to numb the pain that they remember, or to experience "feeling" when they actually feel so empty. Seeing the blood or feeling the pain (burn, cut, etc.) can validate to them that they are alive. Often there is a sense of relief and decrease of anxiety after engaging in such behavior. Ask participants, "How many of you have had women in your facility who injure themselves? How does staff usually respond?" Responses: Probably they have all experienced this in their facilities. Staff responses will vary from nonchalance to panic to referral. We need to train staff in these risk factors and warning signs, let them know that the self-inflicted injuries constitute a psychiatric emergency, and make the appropriate referral.	Slide 6-8

12.	Agitation and/or aggressive behavior This behavior might be secondary to a mental illness as we described in a previous module. In these situations, paranoid thoughts might exist which manifest as mis-perceptions of being harmed by someone else. Some people who suffer from these mental disorders might experience auditory hallucinations, hearing voices that tell them to harm themselves or others. These behaviors usually constitute a psychiatric emergency as this inmate or others may be at risk of being harmed. Usually medication is given to calm the person down, but when this fails to work, the inmate might need to be restrained or secluded. Sometimes seclusion offers a safe environment, away from others the inmate thought was out to hurt her. But for women who have experienced abuse, restraints or seclusion may bring back memories of such treatment during the abuse and actually escalate the behavior.	Slide 6-8
13.	To deal with these issues (conflicting responses to seclusion and restraint), many psychiatric hospitals ask patients with known histories of suicide attempts and agitated behavior what helps the most when they are in such states. The treatment team then works with the inmate when they are not in such a state to develop a strategy; the strategy becomes part of the treatment plan.	

C. Guided Practice/Action Planning — Time: 15 minutes

1.	Ask participants to respond to the following questions: a) What training is provided to staff at your facility on risk factors and warning signs of suicide? b) If there is training, who is required to attend? c) How, when and by whom is risk of suicide assessed? What happens to this information (to whom is it communicated?) d) What is the policy on reporting and referring suicidal inmates? e) How are suicidal inmates managed? f) Describe the steps that your facility needs to take to prevent and manage psychiatric crises more effectively. What role do you need to take in making this happen?	Participant workbook

2.	Ask a few volunteers to share their action plan. If time permits, have participants share their action plan with a seat-partner or with the others at their table group.	
3.	Ask participants, "How will the information we reviewed help you with other crises in your facility?" Responses will vary but will likely include the following: plan for thorough assessment and screening processes; learn to predict crises; have policies in place for action for staff to take when they recognize indicators of impending crises; clear communication among all staff; individualize treatment of offenders.	

Prison Health: Women Offenders

Crisis Intervention - Performance Objectives

- Define “crisis”
- Describe behaviors in the prison setting that are *psychiatric* crises
- Explain key components of a screening that can prevent or predict suicide
- Explain critical actions in preventing “successful” suicides with women offenders

Prison Health: Crisis Intervention

Definitions

A psychiatric emergency is any behavior, mood or thought, which if not rapidly attended to, may result in harm to an individual or others. (Sadoff)

Crisis intervention - helping individuals deal with crises in their lives.

Prison Health: Crisis Intervention

Crisis Behaviors

Suicidal gestures or attempts

Agitated behavior

Aggressiveness

Module VII: Health Issues — Time: 1 hour and 30 minutes

A. Anticipatory Set: Introduction and Objectives — Time: 15 minutes

1.	Ask participants to discuss their responses to the following questions in their table groups for about 10 minutes. Ask them to write their responses on chart paper and have them select a spokesperson to report out for them. a) What are some of the health issues that are unique to women, or that affect women differently than men? a) What health care issues or concerns are unique to women offenders? b) How are women's unique health care needs currently addressed in your facilities? c) What problems do women's unique health care needs pose for your facilities (staff, procedures, funding, facilities, training and so forth)? The responses to these questions will vary. The purpose for having them to discuss these is to find out some of the information, or mis-information, that they already have and to find out what programs exist to care for these concerns. This will enable the instructor to target the presentation to meet the needs of the participants.	Participant workbook
2.	Comment on their responses (tailor these as appropriate for their particular responses, but something like the following comments) Most of us are aware of many of the distinct differences between women and men's health care needs, and some of your programs already work to meet these needs. However, because of tradition, shortage of staff, inadequate facilities, inadequate funding, or simply lack of information, many of our programs are sorely lacking in meeting these needs. We learned earlier that our programs are mandated by legislation to address health care issues. We have also discussed many of the benefits to these women, to their children and families, and to society at large in doing so.	

3.	After completing this module you will be able to • describe the primary medical conditions unique to women and women offenders • explain the most common barriers to adequate health care for women in our prisons • develop strategies for prison administrators and medical staff to improve health care delivery to incarcerated females.	Slide 7-1

B. Instructional Input - Health care for Women Offenders — Time: 45 minutes

1.	*Women's unique health care needs* a) The number one cause of death in all women is **cardiovascular disease**. While this in and of itself is not different from men, we still as a society pay less attention to heart disease in women - prevention, assessment *and* treatment. b) **Cancers** comprise the next leading cause of death in women, with **lung cancer** rated the number one killer for women. **Breast cancer** is the leading cause of death in women ages 40-55, yet less than 50% of women ages 50-64 report receiving a recent mammogram; the screening rates are much lower among the uninsured, the elderly, and minority groups. c) **HIV/AIDS** is the fourth leading cause of death among women ages 25-44; 77% of cases are among minorities; 41% of cases are among drug injecting women. d) **Arthritis, osteoporosis and Alzheimer's** disease impact women more frequently than men. e) **Depression** - women are more likely than men to suffer from depressive disorders. f) **Ob/Gyn** issues - birth control, pregnancy, pre- and post-natal care, menstrual periods, menopause, ovarian and cervical cancers are all health needs unique to women. g) **Obesity** - women need fewer calories than men h) **Dietary** - women need more calcium and iron than men, and pregnant/lactating women need additional nutrients	Slides 7-2 and 7-3

2.	Use the following narrative as a guide to begin to connect these health care issues with facility health care practices and concerns: Studies show that incarcerated women utilize health care services much more than men. Ask participants, "Considering the unique health care needs that you listed and that we just reviewed, why do you think this is so?" Responses (add any that participants do not offer): women's more complicated reproductive system, sexually transmitted diseases, pregnancies, and women's need for care and concern.	
3.	*Women in Prison - health care issues* a) Because of poor economic conditions and the likelihood of sexual and physical abuse, most women in prison have a history of alcohol and/or drug use and abuse b) Women who abuse alcohol are at greater risk of STD's and HIV from unprotected sex or from using dirty needles c) Women in prison are less likely to be educated about family planning issues d) Women in prison are more likely to suffer from poor nutrition (economics, care for children, lack of education about nutritional needs) e) Because of the likelihood of a history of physical or sexual abuse, women in prison are more likely to suffer from depression, Post Traumatic Stress Disorders, and other psychiatric problems f) Women in prison, due to economic situations and lack of education, are less likely to have had routine health screenings, including ob/gyn examinations. g) Women in prison are more likely to have problem pregnancies	Slide 7-4

4.	*Health Assessment and Screening:* Ask participants to complete a chart on chart paper listing questions asked and test administered as part of the initial health assessment and screening, and what questions *should* be asked and tests that *should* be administered. Remind them to consider not only what you have just presented, but also information from previous modules. Allow about 15 minutes for them to complete this chart, then ask them to post and present their information. Use the following information to "fill in the gaps."	Participant Activity
5.	*Initial Assessment and Screening - questions:* Categories for questions to ask include a) History of alcohol and drug abuse b) General health history: diet, exercise, headaches, fatigue, shortness of breath c) Sexual history d) Gyn history - exams and tests, menstrual history, breast exams, birth control practices/information e) Obstetric history - pregnancies, miscarriages, abortions, prenatal and postnatal care	Slide 7-5
6.	*Initial Assessment and Screening - tests/examinations:* a) Sexually transmitted diseases (STD's) including gonorrhea, syphilis, chlamydia b) Pregnancy c) Pap smear d) Chest x-ray for tuberculosis and lung cancer detection e) Mammogram f) Breast examination	Slide 7-6
7.	*Ongoing assessments* The frequency of repeating certain tests, exams, and procedures (e.g. Pap smears, mammograms, etc.) should be based on guidelines established by professional groups such as the American Cancer Society, and the American College of Obstetricians and Gynecologists, and should take into account age and risk factors of the female correctional population (Anno, 1991).	

C. Instructional Input - Women's Health Care: Operational Issues — Time: 10 min

1.	Based on the information concerning the female offender's health care, what operational concerns become apparent? Ask participants, looking for the following responses, or present the following responses using the slide: a) **Dietary needs** - diet and nutrition to meet the unique needs of the female offender, the pregnant female, the older female b) **Ob/Gyn medical staff** - to administer tests and examinations, both at intake and ongoing c) **Examination areas** - to afford privacy and to accommodate examinations and tests d) **First Aid kits** that include supplies for menstrual periods e) **Educational programs** - to include breast self-exam; nutritional requirements (women in general, pregnant women, older women, special dietary needs); family planning and birth control; community resources; HIV prevention, health care practices f) **Labor and delivery procedures** for pregnant inmates (location - in-house or hospital, transportation, aftercare) g) **Training** for correctional personnel in women's health-care needs (how and when to refer for help, the need for support for diet/exercise/nutrition/meds)	Slide 7-7

D. Guided Practice and Action Planning — 10 minutes

1	Ask participants to complete their action plan by responding to the following questions individually a) What are the strengths of your facility's health care program for women? b) What are the gaps? c) What challenges do you foresee in filling in the gaps? d) Who needs to be involved in meeting these challenges? e) What is your role in making that happen? f) What steps do you need to take?	Participant workbook
2.	Ask a few volunteers to share their action plan.	

Prison Health Care: Women Offenders

Health Issues - Performance Objectives

- Describe the primary medical conditions unique to women and women offenders
- Explain the ost common barries to adequate health care for women in prison
- Develop strategies for prison administrators and medical staff to improve health care delivery to incarcerated females

Women's Unique Health Care Needs

- Cardiovascular Disease - #1 cause of death in women
- Cancer - #2 cause of death in women
  - Lung cancer - #1 cancer death in women
  - Breast cancer - #2 cancer death in women; #1 cancer death in women 40-55; low screening rates among uninsured, elderly, minority groups
- HIV/AIDS - #4 cause of death in women 25-44; 77% of cases are minorities; 41% are drug-injecting women

Women's unique health care needs continued

- Arthritis, osteoporosis and Alzheimer's - more common inwomen than in men
- Depression - more common in women than men
- Ob/Gyn issues: birth control, pregnancy, pre- and post-natal care, menstrual periods and difficulties, PMS, menopause, ovarian and cervical cancers
- Obesity
- Dietary - women need more iron and calcium and fewer calories than men; pregnant women need additional nutrients

Women in Prison: Health care issues

- Most have history of alcohol and drug abuse
- Substance abusers are at higher risk for STD's and HIV from unprotected sex and dirty needles
- Less likely to be educated about family planning
- More likely to suffer from poor nutrition
- More likely to suffer from Post-traumatic stress disorder, depression, other psychiatric problems (abuse history)
- Less likely to have had routine health screenings
- More likely to have problem pregnancies

Women in Prison: Health Issues

Initial Assessment and Screening - Questions

1. History of alcohol and drug abuse
2. General health history: diet, exercise, headaches, fatigue, shortness of breath, illnesses, family history
3. Sexual history
4. Gyn history - exams and tests, menstrual history, breast exams, birth control practices and information
5. Ob history - pregnancies, miscarriages, abortions, pre and postnatal care

Initial Assessment and Screening - Tests and Examinations

1. Sexually transmitted diseases, including gonorrhea, syphilis, chlamydia
2. Pregnancy
3. Pap smear
4. Chest X-Ray for TB and lung cancer
5. Mammogram
6. Breast examination

Women Offenders' Health: Operational Concerns

1. Dietary needs
2. Ob/Gyn medical staff
3. Examination areas - privacy
4. First Aid Kits - supplies for menstrual periods
5. Educational programs: breast self-exam, nutritional requirements, family planning and birth control, community resources, HIV prevention, health care
6. Labor and delivery procedures
7. Training for personnel in women's health care needs

HEALTH CARE ISSUES - ACTION PLAN

Please complete your action plan by responding to the following questions:

a) What are the strengths of your facility's health care program for women?

b) What are the gaps?

c) What challenges do you foresee in filling in the gaps?

d) Who needs to be involved in meeting these challenges?

e) What is your role in making that happen?

f) What steps do you need to take?

Please discuss your responses to the following questions in your table groups for about 10 minutes. Write their responses on chart paper and select a spokesperson to report out.

) What are some of the health issues that are unique to women, or that affect women differently than men?

) What health care issues or concerns are unique to women offenders?

) How are women's unique health care needs currently addressed in your facilities?

) What problems do women's unique health care needs pose for your facilities (staff, procedures, funding, facilities, training and so forth)?

Module VIII: Infrastructure — Time: One and half hours

A. Anticipatory Set: Introduction and Objectives — 45 minutes

1.	Begin to get participants to think about infrastructure - their concept, their current institutional infrastructure, and what they would consider necessary in an infrastructure to support the programs reviewed to this point. The time participants spend on this activity will serve not only as an opening for this module, but also as a critical review of the key concepts they have received so far. Here are the questions in their workbook: Respond to the following questions individually (10 minutes). 1) Describe the key components of your current institutional or program infrastructure. How does this support the women's programs you have in place? 2) Take a few moments to review the key concepts we have discussed concerning women and mental health, health, substance abuse, crisis intervention and co-occurring disorders. What would you consider to be the critical components of an infrastructure to support effective women's programs? Discuss your responses with the others at your table. Work together to come up with a consensus for a recommended infrastructure. Write your response(s) on the chart paper provided and select a spokesperson to report out for your group. (20 minutes)	Participant workbook
2.	Have groups report out on their recommendations. Ask that they make note of any from their group or others that they might want to take back and consider implementing. Explain that you have a number of ideas to add to complement what they have suggested as well as some additional information on programs that work.	

3.	Review the performance objectives for this module: After completing this module you will be able to • Define "Infrastructure" • Describe the key components of an infrastructure to support an effective women's health program in prison	Slide 8-1

B. Instructional Input — Time: 45 minutes

1.	Show and explain the definition of Infrastructure: Infrastructure is the organizational culture, the coordination of functions and the establishment of essential positions, all integrated with and toward a common mission.	Slide 8-2
2.	Explain the components of Infrastructure: a) Appropriate staff-to-inmate ratio b) Specialized staff training c) Policies and procedures d) Interdisciplinary teamwork and support e) Consensus about meaning of mission f) Clear structure for communication	Slide 8-3
3.	Explain three phases of Treatment Delivery supported by infrastructure: • Intake • Incarceration • Reintegration	Slide 8-4

4.	Ask participants, "What constitutes a 'gender-specific' infrastructure?" Desired response(s): "Gender-specific" refers to program content designed to respond to the female offenders' needs "Gender-specific" refers to the method in which health and mental health services are delivered "Gender-specific" refers to the way in which staff are trained to respond to and communicate with female offenders "Gender-specific" refers to the way in which staff are trained to understand what stimulates the female offenders' level of response to services. "Gender-specific" refers to security measures that balance a woman's need for privacy and self-respect with the institutional need for safety and security.	
5.	Ask participants, "How is the female offender different from males emotionally and in the way they communicate?" Responses: Women talk more Women need more compassion and empathy Women are more emotional in their reactions and responses Women tend to be more manipulative in dealing with others, particularly authority figures. (Add any of these responses that participants do not offer.)	
6.	How do these differences impact the way we work with the female offender? Staff need to be trained to • encourage independence • increase interaction • reinforce desired behavior • listen • show empathy • be fair, firm and consistent • avoid authoritarian control • integrate all program components • respect privacy while following procedure • conduct searches respectfully and in least intrusive manner possible	Slide 8-5

7.	Expand on these by using the following narrative as a guide: Females typically need a less authoritarian manner of program delivery with a higher degree of interaction, one that provides reinforcement and support as the female progresses in treatment. Because so many of the women in prison have come from abusive situations, situations where someone (often a partner) used power to control them, they do not respond well to authoritarian control. Many prison procedures cause vulnerable women to relive their abusive experiences and communicate to them a renewed sense of powerlessness. For example, having male officers conduct pat-down, body, and strip searches. Female offenders seem to respond most favorably to staff who can maintain a clear empathy for their individual issues, yet not lose sight of institutional protocol. Even in searches for contraband, staff need to be aware of the trauma these women experience when they sense a violation of their personal space. Many female offenders have used manipulation to get what they want rather than directly asking, therefore they need staff to listen empathically to their issues and concerns while responding firmly and consistently.	

8.	Explain the importance of consistent support by **all** institutional staff, clinical and non-clinical, for program and treatment: *Health issues:* • medication compliance • therapeutic diet • smoking cessation • exercise • nutrition • educational programs, i.e., nutrition and parenting *Mental Health issues:* • counseling • interaction with children • family visitation • crisis intervention • self-esteem strategies (encouragement, listening, empathy, consistency) • family support counseling groups Ask participants, "What are some other ways that institutional staff can support women's programs?" Responses will vary.	Slide 8-6
9.	Ask participants, "Do most of your institutional staff view women inmates as *different from* men inmates, or do they view them as *more difficult than* men inmates? How does this impact the way they behave toward these women?" If time permits, give them about 10 minutes to discuss these two questions in their small groups, then report out a summary of their discussion. If not, lead a large group discussion, summarizing their key points after about 10 minutes. Responses will vary but will likely indicate that many institutional staff view women as *more difficult* than men inmates because of their need for attention, perceived or real whiny tones and manipulative behavior. This definitely impacts staff behavior toward the inmates. Often staff position in women's institutions or programs are less desirable. Staff can be cautious, curt and authoritarian towards the females as a result, the very antithesis of effective treatment.	

6.	Two levels of planning for reintegration: • Mechanics of release issues • Emotional preparation for release Ask participants, "Which of the key points of release preparation would be considered "mechanics of release issues?" Desired responses (add any that they don't mention): • Consistent and timely release notification • Inter-agency task force to analyze process, policies and procedures • Memorandum of Understanding • Pilot project Ask participants, "Which of the key points of release preparation would be considered "emotional preparation for release?" Desired responses (add any that they don't mention): • Self-care • Education • Realistic, taking into account the impact of the family • Consistent and timely notification of release	Slides 8-10 and 8-11

D. Guided Practice/Action Planning **Time:**

1.	Ask participants to go to their wall charts that outline the infrastructure they proposed at the beginning of this module and revise it based on information presented and discussed in this module. Have them share their revisions and explain the changes they have made. Allow 10-15 minutes for the revisions.	Listen carefully for their revisions and explanations. Ask questions for thought and for clarification

2.	Ask participants "What do we mean by 'looking at the *totality* of the female offender'? What are the challenges in doing so?" If time permits, have them discuss these questions in small groups for about 10 minutes, then report out a summary of their discussion. If time does not permit, conduct this discussion in the large group, asking volunteers for responses. Responses: *Totality* of the female offender - who she is in addition to seeing her in the role of offender, perpetrator, drug addict and inmate. She is also a woman, a mother, a human being, a creative person. *Challenges* - Questioning why or if she was concerned about her children prior to offending and becoming incarcerated; concern for follow-through on changes in behavior once she is released	
3.	Ask participants to work on the following questions individually for about 10 minutes. Have a few volunteers share their action steps. a) What changes need to be made in your program in order to have an effective infrastructure for women's programs? b) What specific steps do *you* need to take to make these changes happen? When will you take these steps? c) What benefits will likely occur when these changes are made (to the offenders, the institution, the staff, the community?) d) What challenges do you foresee in making this happen? What can *you* do to turn these challenges into strengths or opportunities? What support or help do you need in doing so? e) Who else needs to know this information? Why? How can you make sure this happens? f) What support or resources are needed within and outside your institution to implement the changes you propose?	Participant workbook

Prison Health Care: Women Offenders

Creating an Infrastructure for Health and Mental Health Service Delivery - Performance Objectives

- Define "Infrastructure"
- Describe the key components of an infrastructure to support an effective women's health program in prison

1

Prison Health Care: Women Offenders

Infrastructure - Definition

Infrastructure - The organizational culture, the coordination of functions, and the establishment of essential positions, all integrated with and toward a common mission.

2

Prison Health Care: Women Offenders

Infrastructure components

- Appropriate staff-to-inmate ratio
- Specialized staff training
- Policies and procedure
- Consensus about meaning of mission
- Interdisciplinary teamwork and support
- Clear structure for communication

3

Final Action Plan

Action steps	Target dates	Persons responsible	Resources needed	Desired outcome	Challenges	Opportunities

- **Action Steps** needed
- **Target Dates** the steps will be accomplished
- **Persons Responsible** (who will be responsible for each action step)
- **Resources** needed (financial, human etc.)
- **Desired Outcome** (the end result or product you anticipate after completing the task)
- **Challenges** you anticipate
- **Opportunities** you plan to meet these challenges

Bibliography - Prison Health Care: Women Offenders

Anno, BJ. *Prison Health Care: Guidelines for the Management of an Adequate Delivery System.* National Commission on Correctional Health Care, 1991.

Califano, Joseph A. "A Punishment-Only Prison Policy", February 21, 1998.

Chesney-Lind, Meda. *The Female Offender. Girls, Women and Crime.* Thousand Oaks , Sage Publications, 1997.

Clark, Wetley H., Ph.D. "Therapeutic Communities and High Functioning", Summer 1999.

Davis, Kimberly, "The Shocking Plight of Black Women", Ebony, June 2000.

DeLeon, George, Ph.D. "Therapeutic communities for Addictions: A Theoretical Framework", The International Journal of Addictions, 1995.

Estronaut, "Women and Substance Abuse", GenneX Helathcare Technologies, Inc., 1999.

Galbraith, Susan. *And So I Began to Listen to Their Stories.* The Gains Center.

Greenfield, LA, Snell, TK. Women Offenders. Bureau of Justice Statistics Special Report,, December 2001, NCJ 175688

Harris, Maxine. Modifications in Service Deliver and Clinical Treatment for Women Diagnosed with Severe Mental Illness Who are Also the Survivors of Sexual Abuse Trauma. The Journal of Mental Health Administration, 21:4 Fall 1994.

Henderson, Dorothy, "Gender-Appropriate Mental Health Services for Incarcerated Women: Issues and Challenges", Family and Community Health, October 1998.

Lockwood, Dorothy, Ph.D. M; McCorkel, Jill, MA; Inciardi, James A., Ph.D. "Developing Comprehensive Prison Based Therapeutic Community Treatment for Women", Drugs and Society, 1998.

Morash, Merry, Bynum, Timothy S. and Koons, Barbara A. "Women Offenders: Programming Needs and Promising Approaches", National Institute of Justice, August 1998

National Institute on Drug Abuse, "Assessing Drug Abuse Within and Across Communities."

National Institutes of Health, "Economic Costs of Alcohol and Drug Abuse Estimated at $246 Billion in the United States", May1998.

Ortiz, Madeline M., "Managing Special Populations," Corrections Magazine, Vol. 62 No. 7, December 2000

Otterbein, T. "Posit Statement: Drug-Alcohol Treatment", December1995.

Peters, RH, Bartoi, MG. Screening and Assessment of Co-Occurring Disorders in te Justice System. The Gains Center, 1997.

Peters, RH, Hills, HA. Intervention Strategies for Offenders with Co-Occurring Disorders: What Works? The Gains Center, 1997.

Petracca, Michael "More Women in Prison Because of Drug War", February 2000.

U.S. Department of Justice Programs, "Research on Women and Girls in the Justice System", September 2000

U.S. Department of Justice
National Institute of Corrections

Correctional Health Care:
Women Offenders

A NIC Prisons Division Training Program

01-P602

NATIONAL INSTITUTE OF CORRECTIONS

Morris L. Thigpen, Director
Larry Solomon, Deputy Director

Prisons Division

Susan M. Hunter, Chief

320 First Street, N.W.
Washington, D.C. 20534

Telephone: 800-995-6423, ext 142
FAX: 202-307-3361
e-mail: sshelley@bop.gov

Academy Division

Robert M. Brown, Jr., Chief
800-995-6429, ext 111
rrippetoe@bop.gov

Community Corrections Division

George Keiser, Chief
800-995-6423, ext 135
rtesorc@bop.gov

Jails Division

Virginia Hutchinson, Chief
800-995-6429, ext 140
bmitchell@bop.gov

NATIONAL INSTITUTE OF CORRECTIONS
MISSION

We are a center of correctional learning and experience. We advance and shape effective correctional practice and public policy that respond to the needs of corrections through collaboration and leadership and by providing assistance, information, education, and training.

NIC is fully committed to equal employment opportunity and to ensuring full representation of minorities, women, and disabled persons in the workforce. NIC recognizes the responsibility of every employer to have a workforce that is representative of this nation's diverse population. To this end, NIC urges agencies to provide the maximum feasible opportunity to employees to enhance their skills through on-the-job training, work-study programs, and other training measures so they may perform at their highest potential and advance in accordance with their abilities.

NATIONAL INSTITUTE OF CORRECTIONS
NATIONAL INSTITUTE OF CORRECTIONS PRISONS

Correctional Health Care: Women Offenders
01-P602

Raintree Plaza Hotel & Conference Center — Silverthorne Room
Longmont, Colorado — March 19-22, 2001

TABLE OF CONTENTS

National Institute of Corrections

A Resource for State and Local Corrections

- Training
- Technical Assistance
- Information
- Policy and Program Development
- Cooperative Agreements

5/00

Overview

The National Institute of Corrections is a small agency within the U.S. Department of Justice, Federal Bureau of Prisons. The Institute is headed by a Director appointed by the U.S. Attorney General. A 16-member Advisory Board, also appointed by the Attorney General, was established by the enabling legislation (Public Law 93-415) to provide policy direction to the Institute.

History

In September 1971, a major riot at New York's Attica prison focused national attention on corrections and the practice of imprisonment in the United States. In response to public concern about the handling of the riot by corrections administrators and elected officials, and recognizing the problems in corrections facilities and programs at the state and local levels, Attorney General John A. Mitchell convened a National Conference on Corrections in Williamsburg, Virginia, in December of that year.

Chief Justice Warren E. Burger, in his keynote address at the conference, recommended the establishment of a national training academy for corrections that would:

- Encourage the development of a body of corrections knowledge, coordinate research, conduct executive training programs, and formulate policy recommendations;
- Provide professional training for corrections employees...;
- Provide a forum and exchange for the discussion and evaluation of advanced ideas in corrections;
- Bring about the long-delayed and long-neglected professionalism of the field.

The National Institute of Corrections (NIC) was started in 1974 in response to this recommendation, with training as a primary function. It received its first appropriation in 1977.

Mission and Strategic Outcomes

We are a center of correctional learning and experience. We advance and shape effective correctional practice and public policy that respond to the needs of corrections through collaboration and leadership and by providing assistance, information, education, and training.

The outcomes of NIC's activities contribute significantly to the achievement of state, local, and federal correctional goals and priorities:

- **Effectively managed prisons, jails, and community corrections programs and facilities.** *We will provide services in effective planning, management, and operations strategies that provide constitutional, ethical, humane, safe, and cost-effective prisons, jails, and community corrections programs and facilities.*

- **Enhanced organizational and professional performance in corrections.** *We will provide education and training opportunities in management, leadership, and specialized areas based on value-centered principles and best practices that will continually enhance organizational and professional performance.*

- **Community, staff, and offender safety.** *We will promote correctional practices and procedures that maximize the safety of the community, staff, and offenders; hold offenders accountable; and improve the likelihood of offenders choosing responsible, law-abiding behavior.*

- **Improved correctional practices through the exploration of trends and public policy issues.** *We will promote the exploration of critical issues and shaping public policies that improve the effectiveness, efficiency, and humane quality of practices that impact corrections.*

- **Enhanced NIC services through improved organizational and staff effectiveness.** *We will provide opportunities for organizational and professional growth that enhance the services provided by NIC. We will implement a strategic management process that leads to improved organizational structure, management practices, and program planning that support the mission and vision, consistent with available resources.*

Structure

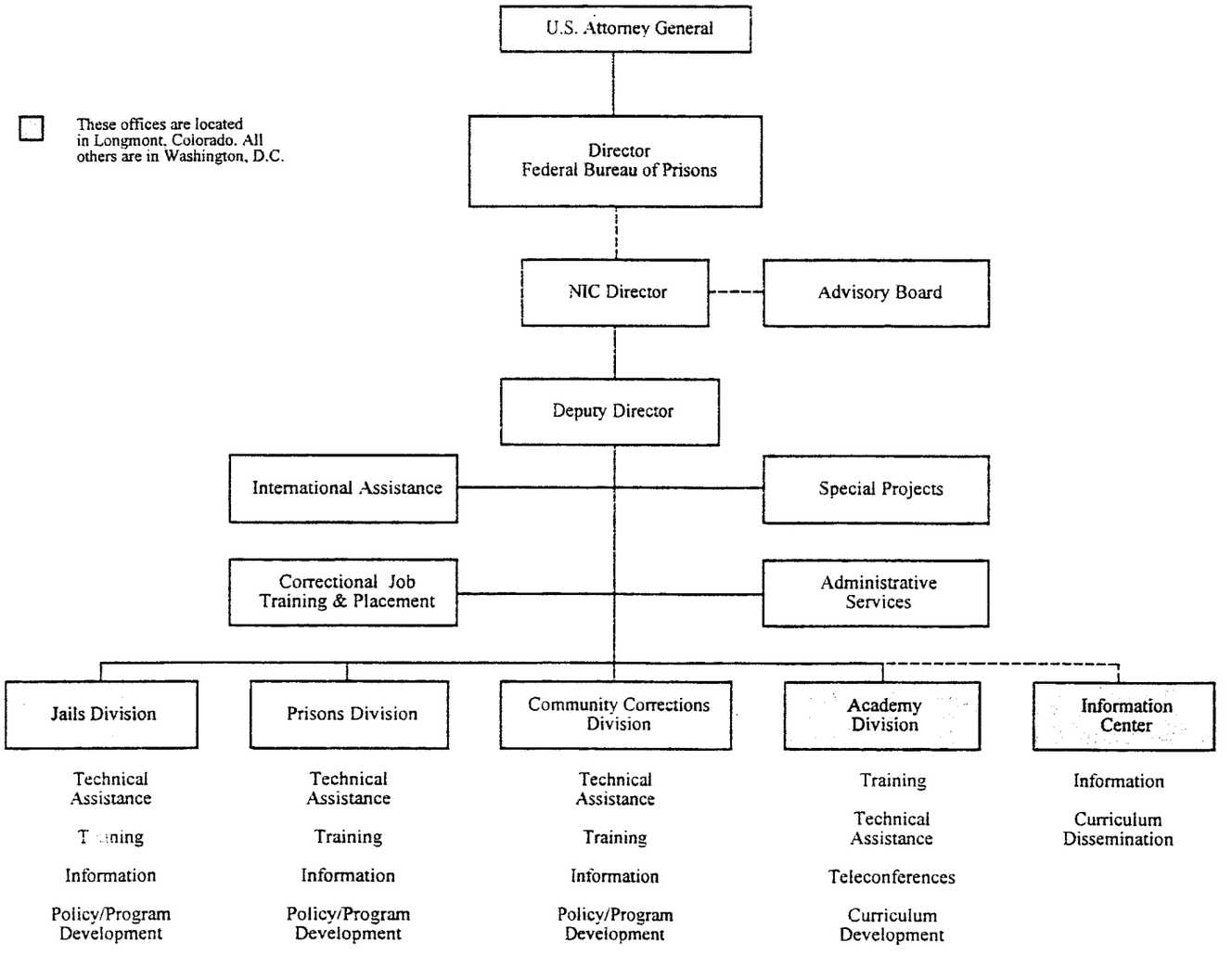
The organizational structure of NIC is one where the primary constituent groups in adult corrections — jails, prisons, and community corrections — are represented and served by an NIC division. All adult corrections agencies are also served by the Academy Division and the NIC Information Center. The Office of International Assistance coordinates assistance requested by foreign corrections agencies. The Office of Correctional

Job Training and Placement works with agencies and organizations nationwide to advance employability and employment of offenders and ex-offenders. The Special Projects Office coordinates NIC's interagency and interdivisional programs and special projects.

NIC's core staff of 51 is augmented by experienced corrections specialists on loan for two-year periods from state and local governments and others assigned from the Federal Bureau of Prisons.

- The **Jails Division** coordinates services to jail systems throughout the country. Its primary constituency consists of more than 3,300 county or regional jails, as well as state-operated jail systems, tribal jails, and police lockups.
- The **Prisons Division** coordinates services to state departments of corrections and prisons. Its constituency includes over 1,400 state prisons, the 50 departments of corrections that oversee them, and the corrections departments and facilities of the District of Columbia and the U.S. commonwealths and territories.
- The **Community Corrections Division** coordinates services for probation and parole agencies, residential facilities, and other community-based programs. Its constituency includes more than 2,500 probation and parole offices, 1,200 community residential facilities, and departments of corrections' community corrections programs.
- The **Academy Division** coordinates most NIC training activities for executives, administrators, and staff

NATIONAL INSTITUTE OF CORRECTIONS ORGANIZATION AND SERVICES



trainers working in state and local prisons, jails, and community corrections. Through interagency agreements, it also provides training and related assistance to practitioners working in juvenile corrections and detention, the federal prison system, and military corrections.

- The **Information Center**, operated by a contractor, serves as the base for information and materials collection and dissemination for NIC and as a national clearinghouse on corrections topics for federal, state, and local practitioners.

Services and Activities

The National Institute of Corrections is a source of assistance for corrections agencies at the state and local levels. Limited assistance is also provided to federal corrections programs. NIC's legislative mandates are to provide training, technical assistance, and information services, and to undertake policy and program development. The Institute manages its programs with cost efficiency and maximized impact as primary goals.

NIC employs a dual strategy of responding to critical needs of corrections agencies and proactively promoting change in the field. Careful planning goes into its annual programming to realize positive long-term results. Programming is driven by actual needs facing state and local corrections administrators, as identified through focus groups, technical assistance requests, and "hearings" held by the Advisory Board to obtain practitioners' views.

The Institute's services focus on a wide range of topics and needs. During fiscal year 1999:

- Technical assistance was provided in response to 394 requests from state and local adult corrections agencies in all 50 states and the District of Columbia, Puerto Rico, American Samoa, Guan, and the Northern Mariana Islands.

- Thirty-nine cooperative agreements were awarded. These awards ranged from $18,000 to %534,823 and supported a variety of projects, including revising the interstate compact for probationer and parolee supervision, assisting the District of Columbia in assessing its pretrial system, and designing intermediate sanctions for female offenders in four jurisdictions.

- 9,281 requests for information from corrections practitioners policymakers, judges, legislators, and others from throughout the U.S. and abroad were filled by the NIC Information Center.

- 38,774 executives, managers, trainers, and specialists working in adult corrections were provided training. Of these, 1,386 participated in training on 33 different subjects at the NIC Academy; 2,365 attended regional or other offsite training; and 10,883 were trained through technical assistance events. In addition, 24,140 people attended informational videoconferences on five corrections topics.

- Through an inter-agency agreement with the Office of Juvenile Justice and Delinquency Prevention, 259 practitioners working in juvenile corrections and detention were provided training and five requests for technical assistance were filled. Also, in conjunction with the Office of Justice Programs" Corrections Program Office, 83 juvenile justice practitioners were trained via three programs on planning new institutions.

- The Office of Justice Programs and Center for Disease Control also transferred funds to NIC through interagency agreements to conduct specific projects.

NIC was authorized to provide technical assistance to foreign governments in October 1991. Since that time, 74 countries received assistance and/or information on corrections issues. NIC provided onsite assistance to the United Kingdom, Jamaica, Panama, Romania, and Poland.

Each summer NIC issues a service plan for the coming fiscal year that describes the services and programs to be provided. Descriptions of training programs and application forms are also included in that document.

For More Information

NIC's service plan and other publications can be downloaded from its website (www.nicic.org/inst). Visit NIC on the Internet, or contact NIC at:

320 First Street, NW
Washington, D.C. 20534
Toll Free 800-995-6423 Fax 202-307-3361
Internet e-mail: btinsley@bop.gov
or
1960 Industrial Circle
Longmont, Colorado 80501
Toll Free 800-995-6429 Fax 303-682-0469

Internet e-mail: rrippetoe@bop.gov

The NIC Information Center can be reached at:

Toll Free 800-877-1461
Fax 303-682-0558

E-mail questions and requests for publications to: asknicic@nicic.org.

More About the NIC Academy

The NIC Academy began operation on October 1, 1981, and provides training primarily for practitioners in state and local adult corrections. By developing and delivering training for prison, jail, and community corrections practitioners, the Academy encourages interaction among corrections agencies, other components of the criminal justice system, public policymakers, and concerned public and private organizations.

The mission of the Academy is to serve as a catalyst through training, technical assistance, and related services to enhance the leadership, professionalism, and effectiveness of corrections personnel in operating safe, efficient, humane, and constitutional systems. The Academy works closely with the other NIC divisions and with the NIC Information Center.

All Academy services are provided free of charge to eligible practitioners in state and local corrections agencies. The Academy also provides services, through interagency agreements, to other federal agencies and practitioners in juvenile justice. Practitioners working in corrections agencies in other countries may be accommodated in training but must pay travel and per diem expenses.

A variety of needs assessment strategies are used to determine the topics for NIC training. They include NIC Advisory Board hearings, focus groups, analyses of requests for technical assistance, and discussions with corrections practitioners.

The Academy provides training services in several ways: 1) training programs at the Academy in Longmont, Colorado, at central locations, or held in partnership with state or local agencies at their training academies or other sites; 2) workshops at national, regional, and state conferences; 3) videoconferences and audioconferences; 4) provision of technical assistance related to training; 5) development of training curriculums; 6) development of DACUM profiles; 7) the Correctional Training Network; and 8) Regionalization. These services are described next.

Training Programs

The majority of Academy funds are dedicated to training programs for corrections administrators, trainers, and specialists. Programs are held in Longmont, at a central location, or onsite in partnership with state or local corrections agencies. Most training programs are 4½ days long. Some programs are followed by technical assistance to participants' agencies.

The Academy contracts with national experts and practitioners to develop and deliver the training programs. Applicants must meet eligibility requirements and have the signed endorsement of their agencies' top administrator to participate in training programs. In most programs, participants develop action plans, which they are expected to implement in their agencies following the training.

Workshops

Half-day to full-day workshops are conducted in conjunction with conferences of national, regional, and state professional associations. These conference workshops provide condensed versions of some of the most requested training programs and opportunities to review new curriculum packages. They take place before, during, or after the conference, and participants are responsible for their own travel and per diem expenses.

Videoconferences, Audioconferences, and Distance Learning Training

As the costs of travel and other expenses associated with face-to-face training escalate, the Academy increasingly uses electronic technologies to provide training. Videoconferences, with one-way video and two-way audio, provide training on current topics to thousands of practitioners throughout the United States. The Academy provides an agenda and handout materials to agencies that register for these 3-hour live interactive videoconferences.

The Academy uses audioconferences for 1- to 2-hour meetings with technical resource providers to plan

training programs or curriculum packages, meetings with Regional Field Coordinators, and follow-up sessions with training program participants.

More extensive training is conducted during distance learning training programs. Trainers are first trained in techniques to using this technology. This is followed by the actual training program consisting of up to 4 days of training which involves using satellite or the Internet four hours each day coupled with four hours each day of onsite activities.

Technical Assistance

The Academy provides direct technical assistance to support the training efforts of state and local corrections agencies, including state departments of corrections, jails, and community corrections agencies. Technical assistance services available from the Academy and from the other NIC divisions are described on page 12.

Development of Training Curriculums

The Academy develops curriculum packages on high-interest topics that include lesson plans, participant materials, and training aids. Some of the packages include slides and videotapes. All of the curriculum packages, as well as the training materials developed for NIC training programs, are available on loan from the NIC Information Center. Many state and local corrections trainers use these materials to train their staff or to augment locally developed training materials.

Development of DACUM Profiles

DACUM is a word derived from Developing A Curriculum that has come to mean a "profile of job duties and tasks" for a specific occupation or position. Among other purposes, DACUM profiles are used as a starting point for developing training curriculums.

The Academy has developed DACUM profiles for key corrections positions, including wardens, community corrections administrators, and corrections education administrators. These and others are available through the NIC Information Center.

Correctional Training Network

The Correctional Training Network (CTN) makes it possible for federal, state, and local corrections agencies to share training materials. The CTN collects and disseminates staff training curriculums and materials developed by the Academy and by state and local agencies. Materials are solicited from all segments of the corrections field and are included in the CTN collection.

Through the CTN collection at the NIC Information Center, corrections trainers have access to instructor guides, lesson plans, student manuals, and training aids (e.g., discussion guides, tests, additional readings, and audiovisuals). The materials can be adapted by state and local agencies for internal training purposes. In some cases, contact information is provided for curriculum developers who have agreed to provide informal telephone assistance to other agencies.

Continued support and contributions of state and local corrections agencies will keep this service viable and valuable. **State and local corrections agencies are strongly encouraged to submit two complete copies of curriculum packages (including overheads, videotapes, etc.) for possible inclusion in the CTN collection.**

To ensure the highest possible quality of materials in the collection, the following should be observed:

- All significant components needed to conduct training (e.g., lesson plans, videotapes, transparencies, exercises, etc.) are included.
- Multiple-part materials include a table of contents or other description of organization.
- Print and audiovisual quality is legible and presentable.
- Content is comprehensive, valid, current, and complete.
- If material is copyrighted, an unlimited copyright release is included.

Technical Assistance Available to State and Local Agencies

A large part of NIC's program consists of providing technical assistance to state and local corrections agencies. The technical assistance program is administered by each of the NIC program

divisions—Jails, Prisons, Community Corrections, and the Academy. NIC offers technical assistance to all adult corrections agencies in the United States and its commonwealths and territories. In some cases, it is also available to professional associations and oversight or advisory groups that are working to improve corrections.

Direct technical assistance will be available to respond to critical needs, problems, and individual requirements of state and local corrections agencies. It responds to the specific needs identified by the requesting agency and is usually provided through onsite assistance. This involves NIC sending an experienced individual(s) to serve in an advisory capacity and/or work with staff of the state or local agency in assessing programs and operations; implementing advanced practices; and improving overall agency management, operations, and programming.

NIC recommends at least three experienced technical assistance providers who are qualified to render the type of assistance needed. Agencies may select one of these persons or may request that assistance be provided by another person who is deemed qualified by NIC to provide the assistance. Occasionally, NIC sponsors visits by an individual or team from a corrections agency to another jurisdiction to observe advanced practices.

Direct technical assistance is usually provided for a period of 3 to 5 days, but for no longer than can be provided for a maximum of $10,000. This amount must cover all expenses related to the technical assistance provider's time, preparation, and travel. For projects that are more complex and require more effort, agencies should contact the appropriate NIC division to discuss possible strategies prior to submitting a request. All onsite technical assistance efforts result in a written report to the recipient agency and NIC, with detailed recommendations for addressing the problem(s) for which assistance was provided.

Procedures for requesting technical assistance follow.

Technical Assistance for Jails

Technical assistance will be provided to local jails and jail-related agencies to improve management, operations, services, and programs. Private agencies providing correctional services under contract to government agencies are eligible for assistance from NIC only if their request is endorsed by the chief executive officer of the government agency to which they provide those services.

Technical assistance available from the Jails Division includes, but is not limited to:

- Policy and procedure development,
- Jail security,
- Legal issues,
- Facility review,
- Standards and accreditation,
- Suicide prevention,
- Medical services,
- Objective jail classification,
- Data management,
- Jail industries,
- Inmate job training and placement.

Technical Assistance for Prisons

Technical assistance will be provided to state departments of corrections and prisons to improve management, operations, personnel practices, and programs. Because of the high demand for technical assistance services, the Prisons Division has established the following priority areas. These priorities do not preclude providing assistance in other areas, however.

Prison Management and Operations

- Classification,
- Supermaximum security facilities,
- Emergency preparedness,
- Privatization,
- Death row management,
- Prison security,
- Health care,
- Prison system master planning,
- Americans with Disabilities Act,
- Women offenders,
- Program and operations audit/evaluation,
- Management information systems,
- Security audits,
- Staffing analysis,
- Victims' services.

Human Resources

- Executive leadership development for women,
- Sexual harassment and sexual misconduct,
- Affirmative action.

Prison Programs
- Substance abuse:
- Parenting;
- Long-term inmates;
- Violent offenders;
- Prison industries;
- Education, literacy, and vocational training;
- Job skills training;
- Sex offenders;
- Mental health;
- Geriatric offenders;
- Pre-release/life skills.

Technical Assistance for Community Corrections

Technical assistance will be provided to state and local probation and parole agencies, residential programs, public and private community corrections agencies, and other community-based corrections programs. In special cases, requests from organizations or associations whose mission is to support and/or assist community corrections agencies will be considered.

Private agencies providing community corrections services (e.g., facility operations, pre-sentence report writing) under contract to government agencies are eligible for assistance from NIC. However, their requests must be endorsed by the administrator of the public corrections agency to which they provide those services (e.g., the chief probation officer, chairperson of the parole board, executive director of the agency, or director of the department of corrections) **or** the elected official accountable for that public agency (e.g., administrative judge or chairperson of the county board).

Requests for assistance should reflect a significant agency problem. Typical areas that could be addressed by technical assistance include, but are not limited to:

Service Delivery Activities
- Supervision strategies;
- Intermediate sanctions;
- Victims' services and programs;
- Caseload management systems;
- Pre-sentence investigations;
- Post-conviction community-based programming;
- Probation and parole decisionmaking;
- Community-based residential programming;
- Supervision and services for women offenders;
- Services for specific offender groups (e.g., sex offenders, substance abusers, high-risk violent offenders);
- Violation and revocation processes and programs;
- Job readiness training, job placement, and job retention services for offenders;
- Community and restorative justice programs;
- Community corrections/community policing partnerships.

Organizational/Environmental Issues
- Organizational development,
- Influencing criminal justice system decisionmaking,
- Officer safety awareness,
- Accountability measures,
- Privatization/contracting for services,
- Improving management practices,
- Community Corrections Act legislation,
- Automation and management information systems,
- Policy development and implementation,
- Marketing effective programming.

Technical Assistance Related to Training

Technical assistance will be provided to state and local jails, prisons, and community corrections agencies to improve the design, delivery, operation, management, and evaluation of their staff training programs. Priority consideration will be given to training that has regional impact or builds intra-/interagency capacity to deliver training.

Typical areas that could be addressed by technical assistance include, but are not limited to:

Identification of Training Needs
- Designing and/or conducting a needs assessment,
- Responding to training mandates,
- Developing the agency's ability to analyze a job.

Strategies for Training Development and Delivery
- Developing a new curriculum,
- Modifying an existing curriculum,
- Developing competency-based training programs,
- Acquiring or maximizing the use of training technologies,
- Designing alternatives to traditional classroom training.

Evaluation of Training Programs
- Evaluating a training program or series,
- Evaluating individual curriculum modules,

Assessing the impact of training on the target population,
Evaluating instructional strategies.

Management of Training Systems
Evaluating the role of training in the organization;
Assessing the use of training staff, resources, and materials;
Developing methods to manage the training budget;
Designing a management information system for training;
Evaluating the current capacity to train.

Training for Trainers: Capacity Building
Building system capacity through training for trainers.
Delivering Academy programs through NIC trainers collaborating with agency trainers. Among the programs available is a 36-hour *Training for Trainers: Foundation Skills* training program, which develops basic training skills of new trainers.

Procedures For Requesting Technical Assistance

There are no deadlines for submitting requests for technical assistance. Since funds are limited, however, it is advisable to apply for assistance soon after a need is identified. Technical assistance requests are considered throughout the year or until funding for the program is depleted. The procedures for requesting technical assistance follow.

The chief executive officer of the agency must sign a letter of request prepared on official stationery that:

Identifies the specific problem(s) for which assistance is sought.
Suggests a plan or specific action(s) to address the problem(s),
Explains why assistance must be obtained at the federal level,
States the anticipated number of days the assistance would be needed,
Identifies an agency contact person for the request.

For technical assistance related to **prisons** or **community corrections**, send the written request to the Technical Assistance Manager of the Prisons Division or the Community Corrections Division at:

National Institute of Corrections
320 First Street, N.W.
Washington, D.C. 20534

For technical assistance related to **jails** or **training activities**, send the written request to the Technical Assistance Manager of the Jails Division or the Academy Division at:

National Institute of Corrections
1960 Industrial Circle
Longmont, Colorado 80501

Review of Technical Assistance Requests

When NIC receives the written request, a staff member will be assigned to review it and will telephone the requesting agency's contact person to discuss the need. If the NIC staff member determines that technical assistance would be appropriate, its delivery will be arranged. In emergency situations, technical assistance can be arranged immediately.

Because NIC resources are limited, each request for technical assistance will be carefully evaluated to determine the best method of meeting the needs of the corrections agency. In reviewing each request, NIC staff will consider:

- Whether the request can be adequately handled by NIC staff or by sending written material from the NIC Information Center,
- Whether state or other resources are available to adequately provide the requested service,
- Whether NIC should retain an experienced individual to work onsite with corrections officials to resolve the specific issue(s) or problem(s).

The criteria that will be used to determine NIC's method of responding to the request for assistance include:

- The costs and time necessary to complete the project;
- The requesting agency's history of prior requests for technical assistance services (e.g., type, number, progress made on implementing recommendations);
- The clarity of the request, including how receiving technical assistance will benefit the corrections agency, staff, and offenders;

- The consistency of the request with the appropriate role of the federal government.

Regionalization

The Academy's Regionalization program supports a network of corrections trainers who provide training opportunities to other trainers and practitioners in their regions. Started in 1990 in response to the field's need to train agency trainers but operate within constrained budgets, the Regionalization effort has steadily grown. Over 4,000 corrections professionals have received training at events sponsored by the Regionalization program, and many thousands of additional staff are estimated to have benefitted.

For the Regionalization program, the Academy has established four regions of the United States: northeast, south, central, west. Each region has 10 volunteer Regional Field Coordinators (RFCs)—two each from prisons, jails, community corrections, juvenile justice agencies, and the Federal Bureau of Prisons—who plan regional meetings and coordinate training networks to share resources and participate in joint training efforts. (See lists of RFCs that follow.)

The Academy provides financial and staff support for activities initiated by the RFCs. Program specialists at the Academy work closely with the RFCs to facilitate the planning and organization of regional training and communication activities. In addition, NIC provides:

- Support for the eight state and local volunteer RFCs from each region to attend an annual planning meeting.

- Financial support and assistance for training programs and other activities to build training capacity within the regions. Activities include curriculum fairs, train-the-trainer workshops, video- and audioconferences, and development of curriculums and videotapes.

There are no registration fees for any Regionalization activity. Agencies are responsible for participants' travel and per diem costs associated with attending the regional training events. The NIC Academy supplies materials, trainers, and, if necessary, meeting facilities.

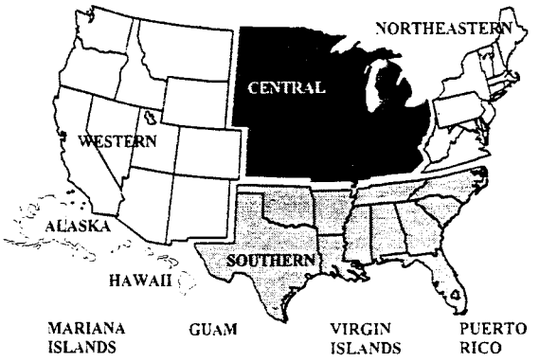
Regional Field Coordinators

RFCs are selected through an application process. Candidates must be employed in a training or training management position in their agencies and must have the endorsement of their agency's chief executive officer to ensure agency support in carrying out their collateral duties as an RFC.

The Academy generally selects only one RFC from a state to serve on its active roster, but will occasionally make an exception if the candidates represent different constituent groups and agencies. RFCs usually serve for 2 years, after which they become part of the RFC alumni network.

Applications are accepted throughout the year, with a closing date each August 1st. To obtain an RFC application or more information on the Regionalization program, contact the Regionalization Manager at the Academy by telephone (800-995-6429) or fax (303-682-0469).

NIC ACADEMY TRAINING REGIONS



Central Region
Lillie Hopkins - NIC Coordinator
800-995-6429 extension 124

Ms. Sue Bradshaw
Employee Development Manager
FCI, P.O. Box 1731
1000 University Drive SW
Waseca, MN, 56093-0741
507-835-8972; e-mail:sbradshaw@bop.gov
C-Year(s) Served: 1999, 2000, 2001, 3rd Year; BOP

Mr. Robert L. Conrad, Training Officer
Ohio Department of Rehabilitation and Correction
Ross Correctional Institution, 16149 State Route 104
Chillicothe, OH, 54601
740-774-7050 x2313, Fax: 740-774-7068;
C-Year(s) Served: 2001, 1st Year; Prisons

Sgt. Brian Fink, Training Supervisor
Will County Sheriff's Department
95 South Chicago Street
Joliet, IL , 60431
815-740-5575, Fax: 815-740-5565;
e-mail: bfink@willcosheriff.org
C-Year(s) Served: 2001, 1st Year; Jail

Ms. Michele C. Foley
Director of Staff Development and Training
Department of Juvenile Justice
1025 Capital Center Drive
Frankfort, KY, 40601-2638
502-573-2738 x292; e-mail: mcfoley@mail.state.ky.us
C-Year(s) Served: 1999, 2000, 2001, 3rd Year; Juvenile

Mr. Dwight L. Graves
Supervisor of Program Development
Indiana Department of Corrections
320 West Washington Street, IGC-South E334
Indianapolis, IN, 46204
317-233-5235; Fax: 317-233-5728;
e-mail: Dgraves@COA.DOC.STATE.IN.US
C-Year(s) Served: 1999, 2000, 2001, 3rd Year; Community Corrections

Ms. Marlene S. Koopman
Training Coordinator
Iowa State Prison
PO Box 316
Ft. Madison, IA 52627
319-372-5432 x285; Fax: 319-372-9087;
e-mail: marlene.koopman@doc1.State.IA. US
C-Year(s) Served: 2000, 2001 2nd Year; Prison

Mr. Larry D. Mitchell
Employee Development Manager
Federal Medical Center
3301 Leestown Road
Lexington, KY, 40511
859-255-6812 x235; Fax: 859-253-8822;
e-mail: lmitchell@bop.gov
C-Year(s) Served: 1999, 2000, 2001, 3rd Year; BOP

Mr. Jay Nelson (Alumni Coordinator)
Correctional Treatment Manager
Mt. Pleasant Correctional Facility
1200 East Washington
Mt. Pleasant, IA 52659
319-385-9511 x2332; Fax: 319-385-8511;
e-mail: jay.nelson@DOC1.state.ia.us

Mr. Tim Tausend, Senior Personnel Officer
North Dakota Youth Correctional Center
701 16th Avenue SW
Mandan, ND, 58554
701-667-1465; Fax: 701-667-1414;
e-mail: tausend@state.nd.us
C-Year(s) Served: 1999, 2000, 2001, 3rd Year; Juvenile

Mr. Keith Williams
Corrections Training Officer
Missouri Department of Corrections, Eastern Region Train Academy
PO Box 365
Park Hills, MO, 63601
314-426-2498; Fax: 314-426-4526 (primary)
573-431-2283; Fax: 573-518-0925 (secondary)
e-mail: kwilliams@mail.doc.state.mo.us
C-Year(s) Served: 2001, 1st Year; Community Corrections

Northeast Region
Mike Dooley - NIC Coordinator
800 -995-6429 extension 132

Mr. Michael J. Bostic
FCI Schuylkill
P.O. Box 700
Minersville, PA, 17954
570-544-7100 x4240; Fax: 717-544-7225;
e-mail: michaelbostic@netscape.net or sch6403@bop.gov
NE-Year(s) Served: 1999, 2000, 2001, 3rd Year; BOP

Mr. Frank Domurad
Director of Staff and Organizational Development
New York City Department of Probation
33 Beaver Street
New York, NY, 10004
212-361-8868, Fax: 212-361-8870;
e-mail: fdomurad@prblan.ci.nyc.ny.us
NE-Year(s) Served: 2000, 2001, 2nd Year; Com Corrections

Mr. Gerald P. Eggleston
Training Manager
Virginia Department of Corrections
Academy for Staff Development
1900 River Road West
Crozier, VA, 23039
804-784-6802; Fax: 804-784-6999;
e-mail: Eggleston GP@vadoc.state.va.us
NE-Year(s) Served: 1999, 2000, 2001, 3rd Year;
Community Corrections

Ms. Launa M. Kowalcyk
Trainer/Supervisor
Central Counties Youth Center
148 Paradise Road
Bellefonte, PA, 16823
814-355-2463 x1; Fax: 814-357-8373;
e-mail: launatk@aol.com
NE-Year(s) Served: 2001, 1st Year; Juvenile

Mr. Barry J. Mulcahy
Academy Administrator
Vermont Department of Corrections
317 Sanatorium Road
Pittsford, VT, 05763
802-483-6228 x27; Fax: 802-483-2343;
e-mail: barrym@doc.state.vt.us
NE-Year(s) Served: 1999, 2000, 2001, 3rd Year; Jail

Ms. Patricia C. Murray
Associate Training Technician
New York State Office of Children and Family Services
Tryon Training Center
881 County Highway 107
Johnstown, NY, 12095
518-762-4681; Fax: 518-762-2119;

NE-Year(s) Served 2000, 2001, 2nd Year; Juvenile

Ms. Evonne R. Nunnally
Employee Development Manager
Federal Correctional Institution, BOP
P.O. Box 1000
Petersburg, VA, 23840
804-733-7881 x411; Fax: 804-863-1541 ;
e-mail: enunnally@bop.gov
NE-Year(s) Served: 1999, 2000, 2001, 3rd Year; BOP

Mr. Chris Smith
Lieutenant/Training Director
Hampton Roads Regional Jail
2690 Elmhurst Lane
Portsmouth, VA, 23701
757-488-7500, Fax: 757-488-9387;
NE-Year(s) Served: 2001, 1st Year, Jails

Mr. George F. Wagner
Warden
Hunterdon County Department of Correction
71 Park Avenue
Flemington, NJ, 08822
908-806-4004, 908-788-1213; Fax: 908-788-1298;
e-mail: WARDEN NJ2@aol.com
NE-Year(s) Served: 2000, 2001, 2nd Year; Jail

Ms. Mary L. Washington
Statewide EAP Director
New York State Division of Parole
314 West 40th Street
New York, New York , 10018
212-239-6379; Fax: 212-239-6372;
e-mail: MaryLMry@aol.com
NE-Year(s) Served: 2001, 1st Year; Community Correcti

SouthernRegion
Leslie LeMaster - NIC Coordinator
800 -995-6429 extension 121

Ms. Mary Gillette
Employee Development Manager
FMC Carswell
PO Box 27066
J Street Building 3000
Fort Worth, TX, 76127
817-782-4390; Fax: 817-782-4394;
e-mail:magillette@bop.gov
S-Year(s) Served: 1st Year; BOP

Mr. Jules T. Franklin
Director of Staff Development
Texas Youth Commission
8004 Cameron Road, Suite C
Austin, TX, 78754
512-340-2740; Fax: 512-340-2702;
e-mail: jules.franklin@tyc.state.tx.us
S-Year(s) Served: 1999, 2000, 2001, 3rd Year; Juvenile

Ms. Melissa Ann Fricker, Training Coordinator
South Carolina Depart. of Probation, Parole, and Pardon Services
PO Box 50666
Columbia, SC , 29250
808-734-9234; Fax: 803-734-9190;
e-mail: MFricker@PPP.state.sc.us
S-Year(s) Served: 2001 1st Year; Community Corrections

Ms. Karen M. Jett
Senior Staff Development/Training Coordinator
Georgia Department of Corrections
1000 Indian Springs Drive
Forsyth, GA, 31029
912-993-4575; Fax: 912-993-4454;
e-mail:jettk00@dcor.state.ga.us
S-Year(s) Served: 2001 1st Year; Prisons

Mr. Daniel W. Lilly, Jr.
Director, Office of Staff Development and Training
North Carolina Department of Correction
2211 Schieffelin Road
Apex, NC, 27502
919-367-7102; Fax: 919-367-7180;
e-mail: ldw01@doc.state.nc.us
S-Year(s) Served: 2001, 1st Year; Prisons

Mr. Bill O'Connell
Senior Management Analyst II
Florida Department of Juvenile Justice
5310 Clay Drive
Lakeland, FL, 33813
863-534-0231; Fax: 863-534-0239;
e-mail: Bill.O'Connell@djj.state.fl.us
S-Year(s) Served: 1999, 2000, 2001, 3rd Year; Juvenile

Mr. John D. Ostrander
Training Director
Dougherty County Sheriff's Office
P.O. Box 549
Albany, GA, 31702
912-430-6514; Fax: 912-430-6562;
e-mail: johnostrander@netscape.net
S-Year(s) Served: 1999, 2000, 2001, 3rd Year; Jails

Ms. Pam Perrin
Employee Development Manager
Federal Correctional Institution
100 Prison Road
Estill, SC, 29918
803-625-4607 x4656; Fax: 803-625-5614;
e-mail: pperrin@bop.gov
S-Year(s) Served: 2000, 2001 2nd Year; BOP

Mr. Michael E. Waters
Director of Training
Alabama Department of Corrections
351 Avenue C
Selma, AL , 36701
334-872-6228; Fax: 334-874-6046;
e-mail: mwaters@doc.state.al.us
S-Year(s) Served: 2000, 2001 2nd Year; Prison

Mr. Dennis White
Major/Academy Director
Jefferson County Sheriff's Department
5030 Hwy 69 South
Beaumont, TX, 77705
409-726-2521; Fax: 409-726-2511
S-Year(s) Served: 2001, 3rd Year; Jails

Western Region
John Eggers - NIC Coordinator
800 -995-6429 extension 152

Mr. Anthony A. Anderman
Program Coordinator, Professional Development Division
Washington State Criminal Justice Training Commission
19010 1st Avenue South, King County
Seattle, WA, 98148
206-835-7356; Fax: 206-439-3752;
e-mail: Aanderman@cjtc.state.wa.us
W-Year(s) Served: 2001, 1st Year; Community Corrections

Ms. Holly Braun
Agency Program Trainer
Human Resource Division, Staff Training and Development
Oregon Department of Corrections
2575 Center Street NE
Salem, OR, 97310
503-378-2842; Fax: 503-378-8681;
e-mail: Holly.BRAUN@State.OR.US
W-Year(s) Served: 1999, 2000, 2001, 3rd Year; Community Corrections

Mr. Gary G. Gilmore
Treatment Services Manager
Wyoming Boys' School
1550 Hwy. 20 South
Worland, WY, 82401
307-347-4969 x290; Fax: 307-347-4869;
e-mail: GGILMO@DFSMAIL.STATE.WY.US
W-Year(s) Served: 1999, 2000, 2001, 3rd Year; Juvenile

Ms. Cherrie L. Greco
Director of Training
Colorado Department of Corrections
P.O. Box 2198
2285 Freemont Drive
Canon City, CO, 81212
719-269-4425; Fax: 719-269-4417;
e-mail:cherrie.greco@state.co.us
W-Year(s) Served: 1999, 2000, 2001, 3rd Year; Prison

Mr. Eddie C. Levins
Corrections Director
Salt River Department of Corrections
10,005 E. Osborn
Scottsdale, AZ; 85256
480-85-8235; Fax: 480-850-8238
W-Year(s) Served: 2001, 1st Year; Jails

Mr. Douglas Lloyd
Training Supervisor
Alaska Department of Corrections
3760 W. Dimond Blvd.
Anchorage, AK, 99515
907-343-6356; Fax: 907-343-6410;
e-mail: Douglas_Lloyd@correct.state.ak.us
W-Year(s) Served: 2000, 2001, 2nd Year; Prison

Ms. Anita Shaw Tymrak
Administrator
Gallatin County Sheriff/Detention Center
611 S 16th
Bozeman, MT 59715
405-582-2131; Fax: 406-582-2138;
e-mail: ashaw@co.gallatin.mt.us (or)
ashawtymrak@hotmail.com
W- Year(s) Served: 2000, 2001, 2nd Year; Jail

Ms. A. Michelle Tonic
Employee Development Manager
FCC Victorville/Activation Office
13777 Air Expressway Blvd.
Victorville, CA, 92394
760-246-2446
e-mail: vim6905@bop.gov
W-Year(s) Served: 1999, 2000, 2001, 3rd Year; BOP

Ms. Beverly Wilder
Department of Juvenile Corrections
Juvenile Corrections Center
P.O. Box 40
St. Anthony, ID, 83445
208-624-3462; Fax: 208-624-3462/4854;
e-mail: bwilder@djc.state.id.us
W-Year(s) Served: 2001, 3rd Year; Juvenile

NIC Corrections Exchange:

A Listserv for People Serious About Corrections

The NIC Corrections Exchange is a communication opportunity for corrections professionals, launched by NIC in 1998. It provides a public, online forum for discussing corrections issues and practices and for exchanging views and information. The Exchange also facilitates communication between the National Institute of Corrections and field practitioners, policy makers, researchers, and others concerned with corrections.

To Join--

- Send email to correx-request@www.nicic.org with the word "subscribe" in your message.
- Or, visit the NIC web site at http://www.nicic.org/lists.htm and click on "NIC open lists" and "NIC Corrections Exchange." Scroll down the entry page to the "join" boxes.

The system will ask you to confirm your email address and will send you user guidelines.

NIC Information Center Web Site--http://www.nicic.org

- Full-text, downloadable NIC publications
- Searchable database of NIC reports and publications
- NIC "What's New" updates
- NetConnections to web links relevant to corrections . . . and more!

NIC Information Center
1860 Industrial Circle, Suite A
Longmont, CO 80501
(800) 877-1461 or (303) 682-0213 -- fax (303) 682-0558
asknicic@nicic.org
http://www.nicic.org

New Communication Technologies at NIC Information Center

Corrections practitioners, policy makers, and researchers now have two new ways to access NIC information and materials.

NIC Information Center Web Site--http://www.nicic.org

- Immediate access to downloadable, full-text NIC publications
- A searchable database of more than 1,200 publications developed by NIC or with NIC funding
- A What's New section, with NIC program and publication announcements
- NetConnections, with Internet links relevant to corrections
- Email links for ordering materials or requesting personal research assistance
- NIC's public listserv, the NIC Corrections Exchange

Fax on Demand:

Call into a menu system at **(303) 678-9049** and select items to be faxed directly to you. Selections are identified by an 8-digit number.

The system provides prominent, shorter publications and the NIC Service Plan. Users can request a list of titles currently on the system, or can view the current list from the Information Center web site at **http://www.nicic.org/faxtitles.htm.**

NIC Information Center

1860 Industrial Circle, Suite A
Longmont, CO 80501
(800) 877-1461 or (303) 682-0213 -- fax (303) 682-0558
asknicic@nicic.org
http://www.nicic.org

U. S. Department of Justice

National Institute of Corrections

1960 Industrial Circle, Suite A
Longmont, Colorado 80501

March 19, 2001

Dear Participant:

Welcome to the National Institute of Corrections Prison Division's training program, **Correctional Health Care: Women Offender**. The number of women incarcerated in adult prisons has more than doubled in the past decade. Although, women offenders comprise fewer than 8 percent of all inmates in state prisons, the phenomenon presents unique challenges to the departments of corrections. Issues such as medical and mental health care, effect the management of these offenders. This program will provide current information and resources regarding correctional health care for women incarcerated in adult institutions, it will also include staffing levels, confidentiality issues focusing on reported sexual misconduct to medical staff, over medication, legal and ethical issues

This will be an active training program. To assist you in this learning experience, we urge you to interact with the faculty and fellow participants and share your expertise and management techniques. It is frequently our experience that participants learn as much from one another, both in and out of the classroom, as they do from the rest of the program.

We are pleased to have your participation and hope that this is a valuable learning experience for you.

Sincerely,

Susan M. Hunter

Susan M. Hunter, Chief
NIC Prisons Division

Acknowledgments

The National Institute of Corrections would like to acknowledge the following individuals for their contributions to this seminar.

Frances Gurnell, Consultant
Training Design and Staff Development
146 Shawn Rd
Chapin, SC 290
Phone: 803 345-6754
email:gurnellfc@gateway.com

Renee Bergeron, Consultant,
Training Design and Staff Development
1615 Catawba St.
Columbia, SC 29205
Phone and Fax: 803-799-9607
E-mail: reneberg@msn.com

Linda Moten, Warden
Gatesville, Unit
Texas Dept. of Criminal Justice
1401 State School Road
Gatesville, Texas 76599
Phone: 254-865-8431

Catherine McVey, Director of Bureau of Health Care Services
Pennsylvania Department of Corrections
Box 598
Camp Hill, PA 17001-0598
Phone: 717-731-7060

Cassandra Newkirk, MD
39 Hendrickson Drive
Belle Meade, NJ 80502
Phone:201-247-0633

Anise Schmidt, Program Director
P.O. Box 915
Gatesville, Texas 76528
Phone: 254-865-9190

Rosemary Jackson, MD
309 Appaloosa Trails
Bahama, NC 27503
Phone:919 471-3906

Training Program Goal

This training will provide current information and resources regarding correctional health care for women offenders incarcerated in adult institutions and assist agencies develop management strategies.

PERFORMANCE OBJECTIVES
PRISON HEALTH CARE: Women Offenders

Seminar Outcomes

After completing this seminar participants will be able to . . .

- describe gender-specific issues of women offenders and the impact of those issues on health, mental health and substance abuse services
- develop strategies to enhance care and services to women offenders
- explain key factors concerning female health, mental health, and substance abuse services
- determine the role of operational infrastructure and case management in the successful coordination and delivery of health care to women offenders

Litigation Issues

- explain factors that influenced the increase in prison litigation cases
- describe the constitutional issues that are addressed in prison litigation
- explain the impact prison litigation has had on the delivery of health care in state prisons and county jails

Health Issues

- list the primary medical conditions that affect all women
- describe barriers to health care for women, both in and outside the prison
- determine strategies to be used by operations and medical staff to improve health care delivery to women in prison
- plan ways to assist in the reduction of health care expenditures

Mental Health Issues

- describe the influences in the lives of women that lead to some psychological difficulties
- list the basic symptoms of the major mental illnesses that are most prevalent among women

who are incarcerated

- determine staff's role in accessibility of mental health care for women

Substance Abuse and Women

- describe the correlation between substance abuse and criminal activity
- explain how women's needs for substance abuse treatment are different from men's
- describe the health risks for women who use alcohol, tobacco and other drugs
- plan ways to overcome barriers to treating women with substance abuse problems
- describe the major components of a therapeutic community

Cooccurring Disorders

- define "cooccurring disorders"
- explain the components of an adequate screening process for identification of women who may have cooccurring disorders
- explain the basic components of treatment programs for cooccurring disorders in women in a correctional setting

Crisis Intervention

- define "crisis intervention"
- list 5 risk factors for suicide within a correctional setting
- explain the essential components of crisis intervention in correctional settings

NATIONAL INSTITUTE OF CORRECTIONS
NATIONAL INSTITUTE OF CORRECTIONS PRISONS

Correctional Health Care: Women Offenders
01-P602

Raintree Plaza Hotel & Conference Center — Silverthorne Room
Longmont, Colorado — March 19-22, 2001

TRAINING PROGRAM STAFF

Betty Gurnell . . .

146 Shawn Road, Chapin, South Carolina 29036; 803-345-6754, Fax: 803-345-6754; E-mail gurnellfc@gateway.net

is currently a consultant specializing in training design and development, program planning, and team facilitation. Betty worked with South Carolina State Government in criminal justice (adult and juvenile) for 30 years primarily in staff development and training. As training coordinator, she was responsible for assessing training needs, developing curriculum, conducting and evaluating training, and developing a cadre of field trainers.

Betty has provided technical assistance to the American Correctional Association, the National Council of Juvenile and Family Court Judges, the National Juvenile Detention Association, the National Institute of Corrections Academy, the American Probation and Parole Association and Michigan State University. She was a Regional Field Coordinator with the NIC's Regionalization Program from 1994-1997. She is a founding and board member of the Juvenile Justice Trainers Association, has been a board member for 16 years and has co-authored two of that Association's publications: *Survival Skills for Supervisors - a self-instructional workbook and Best Practices in Staff Development and Training: Tools and Resources.*

Rosemary Jackson . . .

MD, MPH, FAAFP, 309 Appaloosa Trails, Bahama, NC 27503, (919)560-7600

was first employed as Public Health Nutritionist in Durham County, North Carolina, and later spent two years as a clinical dietitian at Duke University Medical Center. She completed her medical studies at the University of North Carolina Medical School, her residency in Family Practice at the Eastern Virginia Graduate School of Medicine, and her Fellowship in Ob-GYN in Asheville, North Carolina. Her interest in women's health led her to a position as Medical Director of the Prenatal Clinic and Family Planning Clinics for the Durham County Health Department from 1993-96. She has worked in two health departments in North Carolina and was a Primary Care Physician with Kaiser Permanente in Raleigh.

Dr. Jackson served as Medical Director at the North Carolina Correctional Institution for Women in Raleigh from 1997 until December, 2000. She is currently Acting Deputy Medical Director for the North Carolina Department of Corrections. She is Board Certified in Family Medicine and is a member of the Academy. She is a member of the American Correctional Association, the American Correctional Health Services Association, the Society of Correctional Physicians, was a Distinguished Visiting Faculty for Bristol-Myers Squibb, serves on the Correctional Health Advisory Board of Roxanne Laboratories, and is a Credentialed Surveyor for the National Commission on Correctional Health Care, and a member of the Editorial Board for *HIV INSIDE*.

Catherine C. McVey . . .

Director of Health Services, Pennsylvania Department of Corrections, Box 598, Camphill, PA 17001-0598, (717) 731-7031

completed a 25-year career with the Texas Department of Criminal Justice, in Huntsville, Texas, where she held progressively responsible positions in the administration. Positions included the supervision of female offenders as Pre-Release Administrator and Counselor, Administrator of Social Services, Assistant Director Inmate Classification, Assistant Director for Institutional Parole, Assistant Director for the Sex Offender Treatment Program, Pre-Release Programming, Substance Abuse Treatment Program, Faith-Based Pre-Release Program, Youthful Offender Program, Legislative Liaison and Federal Funding Administrator. She concluded her career with the Department as Assistant Director III, with the Programs and Services Division in 1998.

Ms. McVey completed her B.S. Degree in Law Enforcement and Corrections, with distinction, with a minor in correctional administration, at the Pennsylvania State University, State College, Pennsylvania, in 1973. Internships were completed with the Bethlehem Police Department, In Bethlehem, Pennsylvania, and with the Loysville Youth Development Center, with the Department of Public Welfare, in Loysville, Pennsylvania. She went on to complete her M.S. Degree in 1975, in Correctional Administration at the Sam Houston State University, Huntsville, Texas. In 1983, Ms. McVey completed her studies with the University of Houston and received her license as a Professional Counselor through the State Board of Professional Examiners, Austin, Texas.

Ms. McVey retired to her home state of Pennsylvania and accepted the position in 1998 of Director of the Bureau of Health Care Services, with the Pennsylvania Department of Corrections in Harrisburg, PA. In this position she managers offender health care, psychiatric services, and food services for the inmate population of 36,500.

Throughout her career Ms. McVey has worked as a correctional management consultant for numerous correctional programs, has consulted with Her Majesty's Service in Weymouth, England, for youthful offender acre, has been a frequent presenter at conferences, professional training seminars, and before legislative bodies.

Linda M. Moten . . .

Warden, TDCJ-ID Gatesville Unit, 1401 State School Rd, Gatesville, Texas 76599, 254-865-8431

has worked for 25 years with the Texas Department of Criminal Justice-Institutional Division, starting in 1975 as a correctional officer. She has worked in both male and female institutions, with approximately three of the 25 years spent as a Sociologist. She was one of the first female correctional officers to work on a male facility, and the first Afro American female warden in the State of Texas. She has worked with all custody levels of offenders, including death row. She is currently Senior Warden of the Gatesville Unit in Gatesville, Texas, which has a capacity of 2,144 offenders. Her areas of responsibilities include intake and release, substance abuse treatment, boot camp and the mentally retarded offender program.

Ms. Moten received her Bachelor of Science degree from Sam Houston State University, Huntsville, Texas in 1975, and went on to receive 24 hours of Post Graduate work. Ms. Moten has been the recipient of several honors including: Outstanding Woman in Texas Government (which she received twice); Woman of Distinction; Citizen of the Year-Gatesville, Texas; And the Governors Volunteer Service Award for The Texas Department of Criminal Justice Recognized Administrator.

Ms. Moten is also a member of several professional and civic organizations to include: The North American Association of Wardens; Texas Correctional Association; Trustee and Secretary American Correctional Association; Gatesville Independent School District; Board of Directors National Heart Association-Gatesville Chapter; Honorary Member of the Texas Rangers; Gatesville Booster Club; Citizens Against Substance Abuse; Central Texas Juvenile Advisory Board, Sweet Home Baptist Church - Senior Choir Secretary, Vice President of Combined Missionary; Gatesville Public Library; And the Gatesville Exchange Club.

Cassandra F. Newkirk, M.D. . .

Received her undergraduate degree from Duke University and her medical doctor degree from the University of North Carolina. She was Chief Resident in Psychiatry at Emory University Hospital where she completed her residency program. She has had a private practice as well as having had extensive experience working in correctional settings, including working directly with male, female and juvenile offenders in jail and prison settings. She was the Director of Psychiatric Services and Deputy Commissioner for Offender Services for the Georgia Department of Corrections from 1993 until 1995. In these positions she was responsible for the design and implementation of all treatment and rehabilitative programs as well as overseeing the medical component of Mental Health Services. For the last ten years she has served as a mental health expert in several correctional system litigations. She has served as chair of the American Psychiatric Association's Committee on Jails and Prisons and has a special interest in the mental health needs of incarcerated women. Currently she has a full-time practice in correctional and forensic psychiatry.

National Institute of Corrections Staff

Madeline M. Ortiz . . .

Madeline Ortiz is a Correctional Program Specialist in the National Institute of Corrections, Prisons Division in Washington, DC. She is on intergovernmental loan to NIC from the Texas Department of Criminal Justice Institutional Division. In her current capacity, she manages the health care initiative, cooperative agreements, training programs, and short-term technical assistance projects that provide assistance to a number of correctional agencies throughout the country that are evaluating, validating, and their systems. In her recent article in Corrections Today, "Managing the Special Needs Population," she summarized a number of major initiatives related to offenders with special needs and provided an overview of different management techniques.

She has over 21 years of experience in criminal justice beginning her career with the Legal Aid Society Criminal Defense Division, as a Prison Legal Assistant in Rikers Island, New York City Department of Corrections. She was the Administrator of the Substance Abuse Treatment Initiative for the Texas Department of Criminal Justice, and Director of the state's first In-prison Therapeutic Community for Women, a specialized unit that also dealt with with co-occurring disorders, and pregnancy, and Warden of a 500 bed male treatment facility. She has co-authored several publications to include, "The effectiveness of Screening Instruments in Detecting Substance Use Disorders among Prison Inmates," 1996, and "Texas Department of Criminal Justice Substance Abuse Treatment Standards," 1998. Her professional presentations and training include "Criminal Justice Treatment Initiative," 39th Annual Institute of Alcohol and Drug Studies, Austin, Texas, July 1996 "Treatment Resistance," Texas Council on Offenders with Mental Impairments, Austin, Texas, August 1996, "Women in the Criminal Justice System," Central Texas College Second Annual Women's Treatment Issues, Killeen, Texas, August 1996, "Counseling in the Criminal Justice Field," University of Houston Criminal Justice Career Day, Houston, Texas, May 1997, "Diversity of Staff in Substance Abuse Treatment Counseling," Texas Council on Offenders with Mental Impairments, Montgomery, Texas, August 1997, "Special Needs Treatment in the Criminal Justice System," The National Gains Center for People with Co-Occurring Disorders in the Justice System, Tampa, Florida, January 1998, "Treatment Within the Prison Setting," Office of National Drug Control Policy Treatment and Criminal Justice System Conference, Washington, D.C., March 1998, and "Managing Women Offenders," American Correctional Conference, San Antonio, Texas, Summer 2000.

She received her undergraduate degree from the University of Maryland, masters degree from John Jay College of Criminal Justice in Criminal Justice, and Jurist Doctorate from Seton Hall University Law School.

NATIONAL INSTITUTE OF CORRECTIONS
NATIONAL INSTITUTE OF CORRECTIONS PRISONS

Correctional Health Care: Women Offenders
01-P602

Raintree Plaza Hotel & Conference Center — Silverthorne Room
Longmont, Colorado — March 19-22, 2001

AGENDA

Monday, March 19, 2001

6:00 PM	Banquet Welcome/Introductions	Madeline Ortiz

Tuesday, March 20, 2001

8:00 AM	NIC Information Center
8:45 AM	Program Overview
10:00 AM	Management of Female Offenders
11:00 AM	Litigation Issues
12:00 Noon	-LUNCH-
1:00 PM	Overview: Health Issues
2:00 PM	Mental Health Issues
3:15 PM	Group Discussion
4:15 PM	Questions and Answers

Wednesday, March 21, 2001

8:00 AM	Overview Review Questions
9:00 AM	Creating Infra Schedule

10:15 AM	Substance Abuse and Women
11:15 AM	Co-Occuring
12:00 Noon	-LUNCH-
1:00 PM	Panel Discussion: Infectious Diseases
3:15 PM	Crisis Intervention
4:00 PM	Panel Discussion

Thursday, March 22, 2001

8:00 AM	Programming Medical TC's Mental Health Security
10:15 AM	Discharge Planning

Section I
Overview

Prison Health Care
Women Offenders

Introduction and Objectives

Prison Health Care: Women Offenders

Objectives

Enhance Your Knowledge

Heighten your sensitivity

Help you translate knowledge into service delivery strategies

Prison Health Care: Women Offenders

Service Delivery: Science AND Art

SCIENCE - health services based on research, medicine, medical protocol, psychiatry

It's an Art

- To respond to women's unique needs
- To respond to women's vulnerabilities
- To preserve facility security and order while being empathetic and caring
- To respect historic factors which impact women
  - Victimization--sexual, physical, emotional
  - Low socio-economic status
  - Poor choice of partners
  - Stress
  - Parenting responsibilities
  - Drug and alcohol abuse

History of Incarcerated Women's Care

- No focus on gender-specific issues
- Outgrown male institutions "handed down," resulting in
  - Inadequate program space for group counseling
  - No specialized vocational areas
  - Inadequate visitation space for dependent children
  - No specialized medical facilities (ob-gyn)
  - No exercise equipment for women

- 60's and 70's "Same" became "Equal"
  - Uniforms
  - Staff ratio
  - Trades
  - Counseling
  - Medical treatment
- Now "same" means "fair", **Gender-specific**
  - Equal access for full rehabilitative care regardless of requirement
  - Do what it takes to meaningfully and effectively address women's needs

Gender-Specific Services defined

Office of Juvenile Justice and Delinquency Prevention

"Services designed to meet the unique needs of female offenders, value the female perspective, respect and take into account female development, empower girls and young women to reach their full human potential and work to change established attitudes that prevent and discourage girls and women from recognizing their potential."

Need for Integrated Service Delivery

- Often physical/mental health services, education, parole, support services and security manage on parallel, poorly coordinated, poorly communicated tracks
- Incorporated system of case management addresses totality and individuality of the person

Analyze Service Delivery

- Continually analyze through QA, QI, audits and standing service delivery steering committee
- Plan new facilities to address unique needs of women
- Analyze two components of service delivery
  - **Content**
  - **Delivery**

Prison Health Care: Women Offenders

Session Objectives

- Identify distinct health care needs and mental health characteristics that impact the development and provision of services
- Enhance sensitivity for impact of care on the offender's family
- Describe the essential features of adequate infrastructure and effective case management

Session Objectives continued

- Review clinical data concerning women's health care and mental health needs and characteristics
- Describe the role of correctional management and security in collaborating without sacrificing treatment or security.
- Through group exercises, plan to apply this knowledge in correctional practice

Women Offenders: Facts

- 80% have dependent children
- Approximately 23% of incarcerated women, 17% of incarcerated men, have mental health problems
  - Up to 25% of these women, compared to 10-15% of these men, use psychotropic and anti-depressant medications
- Since 1990, number of female defendants convicted of felonies in State courts increased at twice the rate of men

Women Offenders: Facts continued

- 1998 - approximately 951,000 women were in adult criminal justice system (about 1/109 adult women in US)
- 40% of women, 60% of men in State prisons report employment prior to arrest
- From 1976 to 1997, parents and stepparents murdered nearly 11,000 children
  - Mothers and stepmothers committed about 50%
  - 52% of those killed were sons and stepsons

Women Offenders: Facts continued

- 1996 - approximately 45% of women whose parole supervision was ended were returned to prison or absconded


WHAT IMPACTS FEMALE OFFENDER HEALTH?
Lack of Education
Choice of Partners
Post Traumatic Stress
Alcohol and Drug Abuse
Little or no Preventative Health Care
Low Income
Low Self-Esteem
Inadequate Health Coverage
Stress
Victimization
✓Emotional
✓Sexual
✓Physical
Poor Education
Psychosomatic Illness
Isolation From Family

PLANNING FOR ACTION

Program title: _____

From this presentation, what information or ideas about women's health care in prisons were most helpful to you?

How is this information similar to or different from the way you do and view your work with women offenders?

How can you use this information to enhance or change the way you work with women in your facility? What benefits will likely result from these changes (women offenders, staff, institution, community)

What specific steps do you need to take?

What challenges to you foresee in making use of the new information? How will you change these challenges into strengths or opportunities?

Who else needs to know this information? Why? How can you make sure this happens?

What support or resources are needed within and outside your institution to implement change?

Section II
Managing Women Offenders

E.Q.U.I.P.

Enhancing Quality and Understanding for Incarcerated Parents

E.Q.U.I.P

MISSON STATEMENT

To nurture the parent-child relationship of families impacted by parental incarceration

E.Q.U.I P Program Plan

- Incarcerated parent education - trauma of separation of children, family, parents
- Parent education
  - Discipline/nurturing
  - Appropriate parent-child roles
  - Developmental expectations
  - Empathy
- Follow-up and tracking

Eligibility for E.Q.U.I.P

- Minimum custody
- Children under 17
- No minor cases for 3 months
- No major cases for 6 months
- Parole eligible within 18 months
- Cannot be attending college/vocational

Course Topics

E.Q.U.I.P.

- Discipline Strategies
  - time-out
  - praise-reward
  - loss of privilege
  - family rules
- Children's needs, feelings, self-esteem
- Developmental expectations

Course Topics - continued

E.Q.U.I.P.

- Helping children manage own behavior
- Using "I" statements
- Our bodies: nurturing vs scary touch
- Talking to kids/teens about sex

Follow Up and Tracking

E.Q.U.I.P.

- CONTACTS - aftercare and referrals
- TRACKING - review parole success

E.Q.U.I.P. - Key Issues

- Parent-child relationship difficulties and family issues experienced by incarcerated parents increase risk of offender recidivism
- The cycle of second generatin criminal conviction is perpetuated by dysfunctional parenting

E.Q.U.I.P. Budget and Funding

■ Cost per client	$ 585
■ Cost per client with expansion	$ 338
■ Total program cost with expansion	$ 101,456

PLANNING FOR ACTION

Program title: _____

From this presentation, what information or ideas about women's health care in prisons were most helpful to you?

How is this information similar to or different from the way you do and view your work with women offenders?

How can you use this information to enhance or change the way you work with women in your facility? What benefits will likely result from these changes (women offenders, staff, institution, community)

What specific steps do you need to take?

What challenges to you foresee in making use of the new information? How will you change these challenges into strengths or opportunities?

Who else needs to know this information? Why? How can you make sure this happens?

What support or resources are needed within and outside your institution to implement change?

Section III
Litigation Issues

PLANNING FOR ACTION

Program title: _____

From this presentation, what information or ideas about women's health care in prisons were most helpful to you?

How is this information similar to or different from the way you do and view your work with women offenders?

How can you use this information to enhance or change the way you work with women in your facility? What benefits will likely result from these changes (women offenders, staff, institution, community)

What specific steps do you need to take?

What challenges to you foresee in making use of the new information? How will you change these challenges into strengths or opportunities?

Who else needs to know this information? Why? How can you make sure this happens?

What support or resources are needed within and outside your institution to implement change?

Section IV
Health Issues

Women Offenders

Health Issues

Women Offenders - Health Issues

Overview

- Life expectancy
- "Frequent flyers"
- Expenses
- Morbidity and mortality

Women Offenders - Health Issues

Morbidity and Mortality - Details

- Cardiovascular disease
- Cancers
- HIV and STD's
- Violence
- Older women's health
- Disability - effect on household
- Mental illness
- Teen pregnancy

Women Offenders - Health Issues

Unique Issues

- Mandates: constitutional, jurisdictional, institutional
- Security
- Confidentiality
- Consent
- Community support

Women Offenders - Health Issues

Medical Conditions and Treatment . . . and "Operations"

- Diabetes
- Seizures
- Hypertension
- Obesity
- Breast cancer
- Gyn cancers
- Ingrown toenails

Women Offenders - Health Issues

Special conditions continued

- Pregnancy
- Sinusitis/rhinitis
- Back pain
- STD's
- TB/Hepatitis
- HIV/AIDS

Women Offenders - Health Issues

Not-so-unique Issues

- Managed care
- Budget
- Personnel
- Space

Women Offenders - Health Issues

Strategies for Delivering Healthcare

- Communication
- Education
- Multidisciplinary efforts

PLANNING FOR ACTION

Program title: _____

From this presentation, what information or ideas about women's health care in prisons were most helpful to you?

How is this information similar to or different from the way you do and view your work with women offenders?

How can you use this information to enhance or change the way you work with women in your facility? What benefits will likely result from these changes (women offenders, staff, institution, community)

What specific steps do you need to take?

What challenges to you foresee in making use of the new information? How will you change these challenges into strengths or opportunities?

Who else needs to know this information? Why? How can you make sure this happens?

What support or resources are needed within and outside your institution to implement change?

Section V
Mental Health Issues

PLANNING FOR ACTION

Program title: _____

From this presentation, what information or ideas about women's health care in prisons were most helpful to you?

How is this information similar to or different from the way you do and view your work with women offenders?

How can you use this information to enhance or change the way you work with women in your facility? What benefits will likely result from these changes (women offenders, staff, institution, community)

What specific steps do you need to take?

What challenges to you foresee in making use of the new information? How will you change these challenges into strengths or opportunities?

Who else needs to know this information? Why? How can you make sure this happens?

What support or resources are needed within and outside your institution to implement change?

Section VI
Creating Infrastructure

Prison Health Care: Women Offenders

Creating an Infrastructure for Health and Mental Health Service Delivery

Prison Health Care: Women Offenders

Infrastructure and Case Management - - the System's Glue

Infrastructure - The organizational culture, the coordination of functions, and the establishment of necessary position, all integrated with and through a commonality of mission.

Case Management - The oversight and guidance provided to individuals; theories within an infrastructure that embrace inmate rehabilitation

Prison Health Care: Women Offenders

Infrastructure and Case Management

- Appropriate staff-to-inmate ratio
- Specialized staff training
- Policies and procedure
- Communication structure that is followed
- Interdisciplinary teamwork
- Clear understanding of mission

Prison Health Care: Women Offenders

Phases of Treatment Delivery of Service Infrastructure

- Intake
- During incarceration
- Reintegration

Requires ongoing coordination between health, mental health, security, classification and parole

Prison Health Care: Women Offenders

Infrastructure

Integrated

and

Integral

Prison Health Care: Women Offenders

"Gender-Specific" Health and Mental Health Services

- Program content *and* methodology
- Communication that encourages women's response to services
  - Encourage independence (self-care, self-meds, responsibility for behavior)
  - Increase interaction
  - Reinforce desired behavior
  - Listen
  - Show empathy
  - Be fair, firm, friendly and consistent
  - Avoid authoritarian control

Prison Health Care: Women Offenders

- All facility operations must support mental health services
  - Counseling
  - Interaction with children
  - Family visitation
  - Self-esteem strategies
  - Crisis intervention
- Non-clinical staff must support health activities
  - Medication compliance
  - Therapeutic diets
  - Smoking cessation
  - Nutrition
  - Exercise

Prison Health Care: Women Offenders

Unique Issues for Women Offenders
Different, not **Difficult**

- Separation from children (80% have dependent children)
- Child placement and care
- Depression and anxiety
- Complicated reintegration issues

Prison Health Care: Women Offenders

Phases of Case Management

- Phase One - Intake
  - Gathering and using intake information
  - Clinical staff interpret and translate for non-clinical use and making assignments
    - Bed
    - Housing
    - Facility
    - Job
    - Vocation

Prison Health Care: Women Offenders

Phases of Case Management

- Phase two - During Incarceration
  - Ongoing communication of women's health and mental health status
  - Communications - Inter and Intra-facility
  - Significant impact by non-clinical staff (health protection, disease prevention and health education

Prison Health Care: Women Offenders

Phases of Case Management

- Phase three - Reintegration
  - Inmate health education specific to release
  - Establish/enhance inmate's ability to care for herself
  - Plan for continuity of care
    - Consistent and timely notification of release date
    - Coordinate with Classification Case Management
    - Interdisciplinary Treatment Team planning
    - Reintegration counseling to include family issues (child custody, parenting, fundamental support, health care/mental health issues) and impact on family

Prison Health Care: Women Offenders

Release Planning

- Mechanics of release
- Emotional preparedness for release

PLANNING FOR ACTION

Program title: _____

From this presentation, what information or ideas about women's health care in prisons were most helpful to you?

How is this information similar to or different from the way you do and view your work with women offenders?

How can you use this information to enhance or change the way you work with women in your facility? What benefits will likely result from these changes (women offenders, staff, institution, community)

What specific steps do you need to take?

What challenges to you foresee in making use of the new information? How will you change these challenges into strengths or opportunities?

Who else needs to know this information? Why? How can you make sure this happens?

What support or resources are needed within and outside your institution to implement change?

Section VIII
Co-Occurring

PLANNING FOR ACTION

Program title: _____

From this presentation, what information or ideas about women's health care in prisons were most helpful to you?

How is this information similar to or different from the way you do and view your work with women offenders?

How can you use this information to enhance or change the way you work with women in your facility? What benefits will likely result from these changes (women offenders, staff, institution, community)

What specific steps do you need to take?

What challenges to you foresee in making use of the new information? How will you change these challenges into strengths or opportunities?

Who else needs to know this information? Why? How can you make sure this happens?

What support or resources are needed within and outside your institution to implement change?

Section VII
Substance Abuse and Women

Prison Health Care: Women Offenders

Substance Abuse and Women

Prison Health Care: Women Offenders

Substance Abuse in Prison Population

- 80% of prison population use alcohol and other drugs
- 41% of first offenders have history of substance abuse
- 81% of those with five convictions have history of substance abuse

Prison Health Care: Women Offenders

"Typical" Incarcerated Woman

- Ethnic minority
- Young
- Low socio-economic status
- Single mother
- Non-violent crime
- ***Substance abuse problems***

Prison Health Care: Women Offenders

Women are more likely than men to . . .

Use heroin and cocaine
Begin to drink at older age
Consume smaller amounts of alcohol
Drink less often and binge less
Drink alone
Drinking triggered by event

Be divorced by spouse due to alcoholism
Become alcoholic with smaller amounts
Experience greater social pressure
Health problems occur sooner

Prison Health Care: Women Offenders

Health Risks for Women who Drink Alcohol

- Higher rates of breast cancer, liver disease and osteoporosis
- Menstrual disorders
- PMS
- Impaired childbearing
- Heavy, irregular periods
- Unplanned pregnancy
- Sexually transmitted disease, including AIDS

Prison Health Care: Women Offenders

Alcoholic Women and Treatment

Women come to treatment . . .

- **At about the same age as men**
- **Due to health or relationship problems**

Prison Health Care: Women Offenders

Women Seeking Treatment

- Start in non-substance abuse setting
- Substance abuse issues often overlooked due to other common disorders: sexual abuse, violence, eating disorders, etc.
- Have more anxiety and depression than men
- Low self esteem coincides with substance abuse

Prison Health Care: Women Offenders

Obstacles for Women Entering Treatment

- Primary caregiver of children at home
- Limited access to treatment programs
- Pregnancy

Prison Health Care: Women Offenders

Substance Abuse Treatment Needs to Address

- Coping skills
- Life situations that led to substance abuse
- Assertiveness skills
- Family, marital, parent counseling
- Recovery for sexual or physical abuse
- Help to achieve economic self-sufficiency

Prison Health Care: Women Offenders

Therapeutic Community Treatment

- ★ Proven effective for men and women
- ★ Based on idea that substance abuse is disorder of whole person
- ★ Seeks to improve interpersonal skills and coping strategies
- ★ Rituals and ceremonies mark rehabilitative progress

Prison Health Care: Women Offenders

Therapeutic Community Lifestyle

Drug Abstinence

Elimination of criminal behavior

Development of employable skills

Acquisition of postive attitudes, values and behaviors that reflect honesty, responsibility, non-violence and self-reliance.

Prison Health Care: Women Offenders

Therapeutic Community - Categories of Activity

Primary Objective: foster personal growth and change

- ✔ Behavior management
- ✔ Emotional and psychological
- ✔ Intellectual and spiritual
- ✔ Vocational/survival
- ✔ Combination of counseling, group therapy and peer pressure

Prison Health Care: Women Offenders

Therapeutic Community Environment

- Family environment that stresses
  - Honesty
  - Trust
  - Self-help
  - Strict discipline
  - Seriousness of work at hand
- Clients assigned to jobs within communal structure
- Clients expected to take responsibility for cleanliness and appropriate behavior

Prison Health Care: Women Offenders

Therapeutic Community Model for Women

- Staff members serve as **role models**
- Community must promote **safe environment**
- Group activities and treatment must be **gender-sensitive**
- Programming must be **gender specific**
- Staff must coordinate with **social welfare agencies**

Prison Health Care: Women Offenders

Therapeutic Community - Staffing

- Staff needs training and education in
  - Women's health care issues
  - Women's street experiences - prostitution, predatory crime, drug networks, violent relationships
  - Women who use drugs and their relationship with their children
  - Parenting, child abuse and sexual abuse issues

Prison Health Care: Women Offenders

Therapeutic Community - Safe Environment

- Treatment providers promote safe environment for women to engage in and process treatment
  - Program policies encourage supportive treatment environment
  - Avoid inappropriate use of punishment or coercion

Prison Health Care: Women Offenders

Therapeutic Community - Gender Sensitive, Gender Specific

- Teach women to bond and develop sense of trust
- Develop relationship skills
- Recognize women's addiction experiences differ from men's
- Develop parenting skills
- Increase contact with children
- Address appropriate use of free/leisure time

PLANNING FOR ACTION

Program title: _____

From this presentation, what information or ideas about women's health care in prisons were most helpful to you?

How is this information similar to or different from the way you do and view your work with women offenders?

How can you use this information to enhance or change the way you work with women in your facility? What benefits will likely result from these changes (women offenders, staff, institution, community)

What specific steps do you need to take?

What challenges to you foresee in making use of the new information? How will you change these challenges into strengths or opportunities?

Who else needs to know this information? Why? How can you make sure this happens?

What support or resources are needed within and outside your institution to implement change?

Section IX
Infectious Diseases

PLANNING FOR ACTION

Program title: _____

From this presentation, what information or ideas about women's health care in prisons were most helpful to you?

How is this information similar to or different from the way you do and view your work with women offenders?

How can you use this information to enhance or change the way you work with women in your facility? What benefits will likely result from these changes (women offenders, staff, institution, community)

What specific steps do you need to take?

What challenges to you foresee in making use of the new information? How will you change these challenges into strengths or opportunities?

Who else needs to know this information? Why? How can you make sure this happens?

What support or resources are needed within and outside your institution to implement change?

Final Action Plans

Daily Action Planning

Action steps	Target dates	Persons responsible	Resources needed	Desired outcome	Challenges	Opportunities

- **Action Steps** needed
- **Target Dates** the steps will be accomplished
- **Persons Responsible** (who will be responsible for each action step)
- **Resources** needed (financial, human etc.)
- **Desired Outcome** (the end result or product you anticipate after completing the task)
- **Challenges** you anticipate
- **Opportunities** you plan to meet these challenges

Daily Action Planning

Action steps	Target dates	Persons responsible	Resources needed	Desired outcome	Challenges	Opportunities

- **Action Steps** needed
- **Target Dates** the steps will be accomplished
- **Persons Responsible** (who will be responsible for each action step)
- **Resources** needed (financial, human etc.)
- **Desired Outcome** (the end result or product you anticipate after completing the task)
- **Challenges** you anticipate
- **Opportunities** you plan to meet these challenges

Daily Action Planning

Action steps	Target dates	Persons responsible	Resources needed	Desired outcome	Challenges	Opportunities

- **Action Steps** needed
- **Target Dates** the steps will be accomplished
- **Persons Responsible** (who will be responsible for each action step)
- **Resources** needed (financial, human etc.)
- **Desired Outcome** (the end result or product you anticipate after completing the task)
- **Challenges** you anticipate
- **Opportunities** you plan to meet these challenges

Daily Action Planning

Action steps	Target dates	Persons responsible	Resources needed	Desired outcome	Challenges	Opportunities

- **Action Steps** needed
- **Target Dates** the steps will be accomplished
- **Persons Responsible** (who will be responsible for each action step)
- **Resources** needed (financial, human etc.)
- **Desired Outcome** (the end result or product you anticipate after completing the task)
- **Challenges** you anticipate
- **Opportunities** you plan to meet these challenges

Daily Action Planning

Action steps	Target dates	Persons responsible	Resources needed	Desired outcome	Challenges	Opportunities

- **Action Steps** needed
- **Target Dates** the steps will be accomplished
- **Persons Responsible** (who will be responsible for each action step)
- **Resources** needed (financial, human etc.)
- **Desired Outcome** (the end result or product you anticipate after completing the task)
- **Challenges** you anticipate
- **Opportunities** you plan to meet these challenges

Section X
Crisis Intervention

PLANNING FOR ACTION

Program title: _____

From this presentation, what information or ideas about women's health care in prisons were most helpful to you?

How is this information similar to or different from the way you do and view your work with women offenders?

How can you use this information to enhance or change the way you work with women in your facility? What benefits will likely result from these changes (women offenders, staff, institution, community)

What specific steps do you need to take?

What challenges to you foresee in making use of the new information? How will you change these challenges into strengths or opportunities?

Who else needs to know this information? Why? How can you make sure this happens?

What support or resources are needed within and outside your institution to implement change?

Supplemental

REFERENCES

AIDS Counseling on Education (ACE). Breaking the Walls of Silence – AIDS and Women in a New York State Maximum-Security Prison. The Overlook Press, 1998.

Anderson, Jean M. D., et al. A Guide to the Clinical Care of Women with HIV. U. S. Government Printing Office, 2000.

Corrections Connection Staff. "Correctional Health Care Year End Review 2000." http://www.corrections.com/healthnetwork/healthnews.html.

Fag, Meghan. "Female Inmates: Not Better or Worse, Just Different" in The Corrections Connection Network. http://www.corrections.com/news/feature/index.html.

Greenfield, Lawrence and Snell, Tracy L. "Women Offenders". Bureau of Justice Statistics Special Report. December 1999, NCJ 175688.

Health and Human Services. "Health, United States, 1995 with Special Profile of Women's Health", 1995.

Health and Human Services Administration (HRSA). "Health Issues Impacting Women" in HRSA Agenda for Women's Health. http://www.hrsa.dhhs.gov/Women's Health/ Agenda_A.htm.

HIV Inside. Quarterly Newsletter for Correctional Professionals produced by World Health CME.

National Commission on Correctional Health Care. 2000 Conference Proceedings. St. Louis Missouri, September 2000.

National Commission on Correctional Health Care Position Statements. "Women's Health Care in Correctional Settings." Adopted September 1994.

National Institute of Corrections. "Current Issues in the Operations of Women's Prisons". U. S. Department of Justice, September 1998.

Neff, Guy, M.D. and Schiff, Eugene, M.D. "Chronic Hepatitis C: Populations at Risk and Treatment Strategies" in Hospital Medicine, September 1999.

Ortiz, Madeline M. "Managing Special Populations" in Corrections Today, December 2000.

Puisis, Michael, D. O. editor. Chapters 16 and 17 Women's Health Care in "Clinical in Correctional Medicine. Times Mosby, 1998.

Ross, Phyllis Harrison and Laurence, James E. "Health Care for Women Offenders" in Corrections Today, December 1998.

Stephan, James J. State Prison Expenditures, 1996. U. S. Department of Justice. August 1999, NCJ 17221.

Bibliography

American Correctional Association, Female Offenders, Meeting Needs of a Neglected Population 1993

Anno, B. Jaye, National Institute of Justice, Prison Health Care: Guidelines for the Management of an Adequate Delivery System, March 1991

DeBell, Joan, "The Female Offender: Different Not Difficult", Correctional Compass, May/June 2000

Edited, Fletcher, Beverly R. Shaver, Linda Dixon, and Moon, Dreama G., Women Prisoners: A Forgotten Population, Praeger Pub., 1993

GAO, Federal Prisons, Containing Health Care Costs for an Increasing Inmate Population, April 2000

Greenfield, Lawrence A. and Snell, Tracy L., "Women Offenders," Bureau of Justice Statistics Special Report, December 1999

Lamb-Mechanick, and Nelson, Julianne, Prison Health Care Survey, An Analysis of Factors Influencing Per Capita Costs, February 2000

Maruschak, Laura M. and Beck, Allen J. "Medical Problems of Inmates, 1997", Bureau of Justice Statistics Special Report, January 2001.

Morash, Merry, Bynum, Timothy S. and Koons, Barbara A. – "Women Offenders: Programming Needs and Promising Approaches", National Institute of Justice, August 1998

Ortiz, Madeline M., "Managing Special Populations," Corrections Magazine, Vol. 62 No. 7, December 2000

Phillips, Richard and Roberts, John W., Correctional Administration, Aspen Publication, 2000

Women, Girls and Criminal Justice, Vol. 2., No. 1, Dec/Jan 2001

U.S. Department of Justice Programs, "Research on Women and Girls in the Justice System", September 2000

Vera Institute of Justice, "Why Planning for Release Matters"

(Bibliography.1.20.01)

Substance Abuse and Women
Bibliography

Califano, Joseph A. "A Punishment - Only Prison Policy", February 21, 1998.

Clark, Wetley H., Ph.D. "Therapeutic communities and High Functioning", Summer 1999.

Davis, Kimberly, "The Shocking Plight of Black Women", Ebony, June 2000.

DeLeon, George, Ph.D. "Therapeutic communities for Addictions: A Theoretical Framework", The International Journal of Addictions, 1995.

Estronaut, "Women and Substance Abuse", GenneX Helathcare Technologies, Inc., 1999.

Henderson, Dorothy, "Gender-Appropriate mental health Services for Incarcerated Women: Issues and Challenges", Famiily and Community Health, October 1998.

Lockwood, Dorothy, Ph.D. M; McCorkel, Jill, MA; Inciardi, James A., Ph.D. "Developing Comprehensive Prison Based Therapeutic Community Treatment for Women", Drugs and Society, 1998.

National Institute on Drug Abuse, "Assessing Drug Abuse Within and Across Communities."

National Institutes of Health, "Economic Costs of Alcohol and Drug Abuse Estimated at $246 Billion in the United States", May1998.

Otterbein, T. "Posit Statement: Drug-Alcohol Treatment", December1995.

Petracca, Michael "More Women in Prison Because of Drug War", February 2000.