Health Care for Women Inmates: Issues, Perceptions and Policy Considerations

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Abstract

Rapidly increasing numbers of women incarcerated in the United States have created an overwhelming need for appropriate health services for these inmates despite limited resources. This article outlines the key health care issues associated with women inmates. We begin by examining the challenges posed by this population of inmates. Additionally, we investigate the provision of health care to these women and then evaluate the perceptions of that care from the perspective of the women and their care providers. We conclude with a discussion of policy-relevant considerations and suggest that realism should be the underlying premise of any health-related policy for women inmates. Specifically, we suggest that education and the treatment of communicable diseases become the most targeted health-related goals for women inmates, as it is inevitable that most of these women will eventually be released.

Keywords: women inmates, correctional health care, women's prisons

Introduction

The number of women inmates in the United States has grown dramatically in recent years (Unless otherwise specified, all references to inmates are to women inmates). Of the almost 1.4 million inmates incarcerated in state and federal prisons at midyear 2004, 103,310 were women (Harrison & Beck, 2005). This represents roughly a three percent increase in their numbers since mid-year 2003 (Harrison & Beck, 2005). In 2004 some 1,213,300 women were under supervision of criminal justice authorities (Glaze & Palla, 2004; Harrison & Beck, 2005). Most of these women — approximately 85 percent— were being supervised as probationers or parolees, while the others were incarcerated in prisons or jails. Provision of health care for this population has been insufficient according to scholars (Belknap, 1997; Ross & Lawrence, 1998). In this article, we first examine the challenges this population presents to correctional administrators. This is followed by a discussion of the perceptions these women and their care providers—both medical and custodial—have regarding the health care delivered in prisons. The article concludes with a discussion of related policy issues. We argue that the provision of care for inmates must be realistic in what it can accomplish and that given the limited means available for their care, education and treatment of communicable diseases should be the priorities in addressing their needs.

Health Needs of Women Inmates: Health Problems of Incarcerated Women

Marquart, Merianos, Hebert, and Carroll (1997, p. 186) suggest that the medical problems of incarcerated people be seen within the combined context of an inmate's life prior to and during incarceration, which they call a "life course perspective." Many of the health problems inmates experience in prison are often the result of factors — such as socio-economic status and lifestyle — that affect their wellbeing before incarceration. In writing about inmates, Ross and Lawrence (1998, p. 128) note, "Their health problems and needs do not arise in prison; rather, the women bring their health care problems to prison."

The health difficulties of inmates have long been a daunting challenge. Nineteenth-century inmates in the prisons of the American West, for

example, often entered these facilities with chronic health problems and bodies scarred by evidence of rough lives (Butler, 1997). Some had substance abuse problems and/or sexually transmitted diseases (STDs) that were often in advanced stages. Tuberculosis (TB) was also a considerable problem among prisoners confined in dank, unhygienic conditions and weakened by inadequate diets. Existing physical and emotional problems were aggravated by being incarcerated in prisons unsuited for women.

With the exception of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), many of the health challenges faced by contemporary women — before and during their incarceration — are similar to those of their 19th century predecessors. According to Belknap (2001), incarcerated women have more challenging health issues than other women, due most likely to their increased exposure to poverty, insufficient nutrition, as well as substance abuse histories and a lack of knowledge about health generally. Another significant factor is that few inmates had access to health care prior to their incarceration (Kane & DiBartolo, 2002). This can be attributed to not being insured or coming from "medically underserved areas" (Marquart, Merianos, Cuvelier & Carroll, 1996, p. 334). This translates into their having had little or no preventive care, and for those who are ill, having received care later in the course of an illness (if care had been received at all). As a result, many women bring untreated health problems with them to correctional facilities, including STDs, high blood pressure, asthma, and diabetes (Maeve, 1999).

Women also bring unique health issues to correctional health care, such as a need for gynecological and obstetrical services. In 1998, for example, five percent of women admitted to state prisons and six percent of women admitted to jails were pregnant at that time (Greenfeld & Snell, 1999). Many of these pregnancies may be high risk if the mother has a history of substance abuse and/or sexually transmitted diseases (Hufft, Fawkes, & Lawson, 1993). The latest estimates indicate that approximately three-quarters of women in prisons are mothers (Center for Children of Incarcerated Parents, 2001; Snell & Morton, 1994).

Abuse histories present another gender-specific health challenge. Far more women than men inmates report having been physically or sexually abused at some time in their lives — 55.3 percent of women in jails (compared to 13.4 percent of men — see James, 2004) and 57 percent of women in state prisons (compared to 16 percent of men) (Harlow, 1999). Some women may have permanent injuries as a result of their abuse (Richie, 1996). Abuse is a factor that may also contribute to mental health and substance abuse difficulties, both factors themselves linked to having negative effects on women's overall health (Reed & Mowbray, 1999). Among state prison inmates in 1998, for example, 24 percent of women were identified as mentally ill, and a large percentage of these women — 78 percent—had been abused at some time before their admission (Ditton, 1999). Because a number of incarcerated women are African-American — approximately 37 percent of women in jails or prisons at midyear 2004 (Harrison & Beck, 2005) — they can bring health issues to correctional facilities which either occur more frequently or exclusively among this population, such as diabetes, hypertension, and sickle-cell anemia (Acoca, 1998).

Some of the women's poor health conditions are related to their life circumstances prior to being incarcerated. Inmates, both women and men, were more likely to have medical problems if they had been homeless or unemployed prior to their arrest (Maruschak & Beck, 2001). In a study of incarcerated parents, 18 percent of mothers reported having been homeless in the year before admission to state prisons (compared to eight percent of fathers) and 50 percent of mothers in state prisons were unemployed in the month before their arrest (compared to 27 percent of fathers) (Mumola, 2000).

Problems with drug and alcohol use are notable among inmates. Fifty-four percent of women in state prisons surveyed in 1991 had used drugs in the month prior their arrests (Snell & Morton, 1994). Among these women, 65 percent reported

regular drug use and 41 percent reported using drugs daily. Nearly 54 percent of women in state prisons in 1998 reported having been under the influence of drugs and/or alcohol at the time of their offense (Greenfeld & Snell, 1999). Table 1 below provides specifics about the substances that inmates reported having used in the 1997 Survey of Inmates. Unsurprisingly, drug and alcohol abuse are harmful to women's overall health (Reed & Mowbray, 1999), and some practices are more so than others. Among inmates those who had used needles to inject drugs or were alcohol dependent, health problems were more common (Maruschak & Beck, 2001). One-third of inmates studied by Snell and Morton (1994) had used injected illegal drugs, and an estimated 18 percent had shared needles. These women drank less frequently than their male counterparts. However, as Reed and Mowbray (1999) note, because women metabolize alcohol differently than men, they can develop more serious health problems despite less consumption.

Table 1
Drug/Alcohol Use and Mental/Medical Health Issues as Reported by Women Inmates, 1997 (N= 3,796)

Variable	Percentages
Drug and Alcohol Use	
Ever Used:	
Alcohol (more than 12 drinks, lifetime)	76.2
Heroin	23.2
Other opiates	12.2
Methamphetamines (ice/crank)	19.5
Other amphetamines (speed)	19.8
Methaqualone (Quaaludes)	12.8
Barbituates (downers)	14.9
Tranquilizers (valium)	19.3
Crack cocaine	39.5
Other cocaine	44.2
PCP	12.4
LSD (other hallucinogens)	18.1
Marijuana/hashish	63.1
Any other drugs	1.3
Ever sniffed or inhaled to get high	11.0
Mental and Medical Health Issues	
Have a limiting condition (i.e., disability)	24.1
Difficulty seeing	8.7
Difficulty hearing	6.1
Learning disability	7.7
Speech disability	2.8
Physical disability	13.3
Mental/emotional condition	14.2

Women intravenous (IV) drug users are also more likely to engage in risky sexual behaviors — such as having multiple partners, unprotected intercourse, and exchanging sex for money or drugs — which put them at increased risk for STDs/HIV and gynecological problems that include pelvic inflammatory disease and cervical cancer (Shearer, 2003). A study of women in a Texas correctional facility illustrates this point: 40 percent of women in the study self-reported

having had an STD and 47 percent reported engaging in HIV risk behaviors (Marquart, Brewer, Mullings, and Crouch, 1999). Other health problems experienced by women with substance abuse issues include hepatitis, cirrhosis, higher risk for bone fracture, and anemia (Reed & Mowbray, 1999). Certain STDs—such as genital herpes and syphilis—make individuals more vulnerable to HIV infection (Marquart et al., 1999). HIV and tuberculosis are significant problems as well. Among state prisoners, three percent of inmates were HIV positive in 2002 (compared to 1.9 percent of male inmates) (Maruschak, 2004). In some states, however, this percentage was considerably higher, chiefly in New York (13.6 percent) and Maryland (12.1 percent). Wilcock, Hammett, Widom, and Epstein (1996) report that as many as 27 percent of female inmates in 1994 through 1995 had positive tuberculosis skin tests at intake (the mean was 6.7 percent). Although some of the correctional facilities they surveyed provided the number of male inmates who were both HIV positive and had positive TB skin tests, these facilities were largely unable to report this information for female inmates. However, AIDS mortality rates have decreased over time (see Maruschak, 2004).

Table 2 presents the self-reported demographic and legal characteristics of inmates in the most recent Survey of Inmates in State and Federal Correctional Facilities, 1997 (U.S. Department of Justice, 2000). These inmates were between 15 and 75 years of age, pretty equally divided among blacks and whites, and roughly 17 percent reported Hispanic heritage. Additionally, approximately one-third reported having either a high-school diploma or GED while a little more than half reported being employed prior to their prison admission. More than one-third of these women also reported receiving public assistance or welfare prior to admission while 12 percent reported being homeless, living on the streets, or living in a shelter. Although 43 percent reported never having been married, 20 percent were married and the remaining 37 percent were separated, divorced, or widowed. Additionally, almost 80 percent of the inmates reported having children. Approximately one-quarter of the inmates reported a history of physical and sexual abuse while 42 percent reported only physical abuse and more than one-third reported being sexually abused.

Roughly 40 percent of the inmates surveyed while incarcerated were first-time offenders while almost 60 percent were recidivists. More than one-third of these women reported being previously incarcerated. Many of these women were reluctant (or refused) to speak about their offenses; however, approximately one-third of women reported that they were under the influence (of drugs and/or alcohol) at the time of their offense. One-quarter of women reported drinking alcohol at the time of the offense while one-quarter reported committing the offense in order to get money for drugs. Almost one-third of the women reported that their offense was a drug-related offense, 16 percent stated that they had committed a violent offense, and 18 percent reported having engaged in a property-related offense. Finally, more than 80 percent of these inmates stated that they had pled guilty to the offense for which they were currently serving time. These women illustrate a series of life course characteristics which makes them much more susceptible to poor health—including unmet medical needs, drug/alcohol use, and mental health issues—that have the potential to be treated, or exacerbated, by incarceration.

The range of self-reported health problems for many inmates is considerable. Treatment for these issues operates against a background of legal and penal concerns, which are discussed in the following section.

Table 2
Self-Reported Characteristics of Female State and Federal Inmates, 1997 (N= 3,796)

Variable	Percentages
Demographics	
Age range	(15 – 75 years old)
White	47.8
Black	46.3
Hispanic (including white/black)	16.9
High-school diploma/GED	34.6
GED earned in prison	15.8
Employed at time of admission	53.6
Homeless, on streets, in shelter at time of admission	12.2
Receiving public assistance/welfare at admission	34.6
Marital/Family Status	
Single (never married)	43.2
Married	20.3
Separated	10.1
Divorced	20.5
Widowed	5.7
Has children	79.5
Abuse History	
Ever physically abused	42.3
Ever sexually abused	34.8
Ever physically and sexually abused	24.6
Offending Status/Criminal History	
First-time offender (total)	41.2
Violent offense (first-timer)	13.0
Drug offense (first-timer)	13.7
Other offense (first-timer)	14.5
Repeat offender (any priors)	58.5
Previously incarcerated	36.6
Offense/Case Characteristics	
Committed offense under the influence	34.0
Drinking at the time of the offense	25.3
Committed offense to get money for drugs	25.9
Violent offense*	15.5
Drug offense*	33.2
Property offense*	17.6
Pled guilty	83.2

* Most of the women did not provide this information. Thus, the percentages do not total 100. Data Source: Survey of Inmates in State and Federal Correctional Facilities, 1997.

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Underlying Concerns Regarding Women's Health Care in Prison Legally Required Standard for Medical Care in Correctional Facilities

The United State Supreme Court's decision in *Estelle v. Gamble* (1976) is central to evaluating legal requirements for the medical treatment of incarcerated individuals. Because the decision turns on considerations of the 8th Amendment's prohibition of cruel and unusual punishments, *Estelle* and its progeny directly affect those who have been convicted of crimes. It indirectly affects those awaiting trial, who although incapable of being punished, may still be subjected to certain deprivations so long as they do not rise to the level of punishment. Precisely what this class of inmates is entitled to is unclear, but must at least satisfy what is required by the 8th Amendment (see Parker forthcoming).

According to the Court, the government has an obligation to provide medical care to inmates and accordingly, *Estelle* (1976, p. 104) holds that "deliberate indifference" on the part of correctional officials with regard to an inmate's "serious medical needs" is impermissible. Indifference could manifest itself in denying or delaying care or the interference with treatment. However, the Court was clear in limiting what might be considered deliberate indifference, specifically excluding negligence and medical malpractice.

Subsequent Supreme Court decisions have refined what must be demonstrated to establish that correctional officials have been deliberately indifferent to an inmate's health care needs. Chief among them is *Farmer v. Brennan* (1994, p. 837); here, the Court stated that a plaintiff must show that an official "knows of and disregards an excessive risk to inmate health or safety." This requires a showing of a corrections official's "state of mind" (Robbins, 1999, p. 221).

Theoretical Views of the Role of Correctional Facilities

Correctional facilities have been described as the "social safety net of last resort" (Ross & Lawrence, 1998, p. 128) and also as institutions that implement penal harm. These seemingly contradictory descriptions can be seen as complementary, however, when corrections is understood both as a means of managing "disruptive and unsightly members of the underclass" and as "an emergency service net for those who are in the most desperate straits" (Feeley & Simon, 1992, p. 468). Familiarity with both concepts is critical to an understanding of the health care expected by and delivered to women in correctional facilities.

Correctional Facilities as Devices of Penal Harm and Penal Harm Medicine

An emerging trend in corrections is that of "new penology," which focuses on "techniques to identify, classify, and manage" offenders rather than explain their behavior or address their rehabilitation (Feeley & Simon, 1992, p. 452). It is described as being more concerned with actuarial aspects of penology and how to manage efficiently the probabilities that different risks present. Marquart et al. (1999) have suggested that health risk be considered amid other criteria used for evaluating offender risk — some groups may present more of a health

risk than a criminal risk and that this consideration will affect their management within the criminal justice system. Another concept emerging from discussions of the new penology is that of penal harm, in which punishment is a tool for harming offenders — harm justified because it is offenders being affected and harm that is easier to justify in the atmosphere of "depersonalized efficiency" which critics attribute to the new penology's emphasis on management and probability (Cullen, 1995, p. 339). Penal harm concepts have come to affect the health care provided in some correctional facilities, such as when medical care is withheld or delayed or used to humiliate inmates (Vaughn & Smith, 1999). According to Vaughn and Smith (1999, p. 217), it is the "collective demonization" of the inmates that permits medical care providers to violate their ethical obligations. Vaughn (1999) has also argued that the treatment capabilities of medical care professionals in some correctional systems have been excessively confused with custodial concerns, as when the Federal Bureau of Prisons provides basic correctional training to its medical staff without any distinction between their role and that of other correctional officers. Medical care as a device of harm within correctional facilities is not new (Butler, 1997). *Estelle v. Gamble* ameliorated the situation in 1976 by mandating a minimum level of medical care below which facilities could not fall. However, medicine remains a tool for deliberate harm in some facilities. Schlanger (2003) for instance, reported that issues of medical care are the number one cause of litigation in jails or prisons.

Sometimes the harm that results from medical care is at the hands of the medical care providers themselves. However, placing excessive blame on this group is inappropriate and misleading. Penal harm medicine also occurs at the hands of correctional officers when they undertake tasks intended for medical professionals (Vaughn & Collins, 2004). Penal harm may also be the result of correctional facility policies (for example, those addressing security concerns), such as when officials override the suggestions and needs of medical personnel (Ammar & Erez, 2000). Penal harm medicine may be a consequence of a correctional system's decision to provide treatment in a managed care model, in which cost-savings measures may compromise inmate care (Robbins, 1999). Ross and Lawrence (1998, p. 128) argue that poor quality health care for these women is not the fault of staff, but rather "a manifestation of pervasive and insidious attitudes, behaviors and beliefs which influence government policy." Thus, not all penal harm medicine can be attributed to medical care providers themselves.

How widespread the practice of penal harm medicine may be is not clear. Maeve and Vaughn (2001, p. 58) report that "penal harm medicine and nursing have become so routinized, mundane, and banal that they pass for standard operating procedure." However, their research has often focused on single facilities (Maeve, 1999; Vaughn & Smith, 1999) or judicial decisions (e.g., Dabney & Vaughn, 2000; Vaughn & Collins, 2004) which, by their adversarial nature, cannot reflect the full range of medical care provided in correctional facilities. On one hand, studies relying on judicial decisions obviously would not reflect provision of good medical care. On the other, they may underrepresent instances of poor medical care, owing to a number of factors including the limits federal legislation has placed on inmate lawsuits (Schlanger, 2003) or the fact that inmates may be less likely to bring lawsuits challenging the conditions of their incarceration (Aylward & Thomas, 1984).

Other sources indicate that penal harm medicine is not typical of all institutions. Ammar and Erez (2000) describe medical care providers who are very concerned about the women they care for in the Ohio prison system. Prison nursery programs that address the needs of pregnant and post-partum women are examples of thoughtful care within the correctional context (Fearn & Parker, 2004). In *Todaro v. Ward* (1977, pp. 1159-1160), the first case to address the health care of inmates specifically, the presiding judge, even while finding deliberate indifference, nevertheless complimented the Bedford Hills prison medical staff for their "concern…with the well-being of the inmates they served."

Correctional Facilities as Social Safety Net

Individuals from several disciplines — law (Friedman, 2004; Nordberg, 2002; Stratton, 2004), medicine and social science (Berkman, 1995; Munetz & Teller, 2004; Ross & Lawrence, 1998), and journalism (Bernstein, 1999; Butterfield, 1992) — have discussed the role of prisons and jails as social safety nets, especially with regard to the mentally ill and homeless. Some observers relate this aspect of corrections to an increased willingness to spend tax dollars on incarcerating people, rather than providing them with adequate social services that might prevent their incarceration (Butterfield, 1992). Friedman (2004), for example, contrasts the social safety nets of other Western democracies, especially in their provision of health care, with the United States' preference for criminal justice solutions to long-standing social problems such as concentrated poverty or addictions. According to one physician, "It is fatuous for politicians or social planners to deny the relationship between rising unemployment, deepening poverty, and the parallel growth in the prison population" (Berkman, 1995, p. 1617).

In correctional facilities, people in need of limited social services can receive shelter, food, and medical care that would either not be available to them or that is available only in very poor quality (Butterfield, 1992). Some social services — such as subsidized housing, treatment, and mental health treatment — have long waitlists that also put them out of immediate reach (Nordberg, 2002). Mentally ill individuals appear to have difficulty accessing certain resources in their communities, even where referrals and guidance have been provided prior to release (Bernstein, 1999). Marquart et al.'s (1997) notion that jails are sometimes the sole resource for a dealing with a community's mentally ill is confirmed by a state supreme court justice, who has described correctional facilities as the "de facto mental health system of our day" (Stratton, 2004).

These views of correctional facilities as safety nets, however, largely disregard the particular circumstances of inmates. Essentially, it is a view of prisons and jails that works for men in a way that it cannot for women. Information about the socio-economic difficulties of inmates discussed above clearly demonstrates their need for social services. Incarceration can also provide relief to these women from poverty and violence (Bradley & Davino, 2002), yet with regard to health care, what is available to inmates is very limited, as discussed below. Furthermore, jails and prisons functioning as safety nets provides little for these women in their roles as mothers and nothing for the children they leave behind while incarcerated. In short, correctional facilities may be literally safer for women facing lives of violence, as has been claimed by some observers (Acoca, 1998; Bradley & Davino, 2002). But to claim that they provide social safety nets for women to the same degree as they might for men is inaccurate. This is especially true with regard to health care, when "some correctional systems... justify their often inadequate women's health care services by comparing them to the nonexistent care the women were receiving on the street" (Acoca, 1998. p. 61).

In the end, the influence of the correctional facility on the overall health of an inmate is unclear. In their survey of free-world care versus that provided in prisons, Marquart et al. (1996, p. 345) tentatively suggest that "most inmates experience no change in their health status during incarceration." The care they receive within a facility is better than they would have otherwise received, but the potential of this care to remedy their health problems is negated by the depth of their existing problems prior to admission. Vaughn and Smith (1999), however, dispute this view arguing that it disregards the effect of penal harm medicine on an inmate's health. (Marquart and other colleagues (1997) do account for prison conditions in their evaluations.) Maeve (1999, p. 66), likewise, with regard to inmates, argues that inmates become "less healthy" in prison (see Murphy, 2003, for a discussion of rationed health care within the Bureau of Prisons). However, because Marquart et al. (1996) did not consider the health care of women inmates specifically, their findings may not be generalizable regarding this particular inmate population.

Health Care Received by Women Inmates

This section addresses the health care received by inmates. First, we examine challenges that exist to providing care to these women; this is followed by a discussion of what women and corrections officials report with regard to the health care that has been provided.

Challenges to Providing Medical Care to Women Inmates

The fact that women constitute a small portion of the correctional population has been used to justify a lack of adequate programming and treatment for them (Belknap, 2001). This is especially true with regard to their health care. Overall, scholars report that effective health care for inmates is insufficient, particularly in preventive care (Belknap, 1997). Ross and Lawrence (1998, p. 126) attribute the inability to provide sufficient health care to inmates to a "systematic denial to women of parity of services readily and regularly available to incarcerated men."

The workload of medical care providers in correctional facilities is considerable. Maeve (1999, p. 51) notes that "health care for women in prison is largely an effort to 'catch up' in that considerable effort is most often necessary to raise women's health status to legally mandated, acceptable levels." Given the extent of problems many of these women have, catching up constitutes a massive undertaking. In addition to providing health care to a "very needy" population, the isolation and security concerns within prisons and jails makes inmates entirely dependent on care providers, which is especially cumbersome with inmates suffering from chronic conditions. For example, care providers must devote time simply to distributing medications to affected inmates, who would not require this outside the institutionalization context (Marquart et al., 1997), or providing other routine treatment. Care providers may also need to evaluate the well-being of inmates who are not ill, such as those confined to segregation or placed in restraints (Ammar & Erez, 2000).

Aggravating the workload for medical care providers in correctional facilities is the insufficiency of staffing and provision of resources for women's correctional health care. Women inmates in state and federal prisons reported having medical problems after being admitted in higher percentages than men — 23 percent of women in state prisons compared to 16 percent of men and 25 percent of women in federal prison compared to 15 percent of men (Maruschak & Beck, 2001). Because the health care provided in women's prisons and jails is often based on what is needed and provided in men's correctional facilities (Ross & Lawrence, 1998), the estimate of staffing levels on the part of correctional officials can be inaccurate. A nurse reported this problem within Ohio's women's facilities, commenting that, "Staffing of the women prisons follows the male mode: 300 men to three nurses. But women in prison go to doctors two and a half times the rate of men. Women have problems that men do not have...." (Ammar & Erez, 2000, p. 20). A similar problem has been reported in California's women's correctional system, where resource needs are determined "using a healthy, young male as its model prisoner" (Hill, 2002, p. 232). The resulting lack of adequate staffing resources often translates into delayed care for the women who have difficulty being seen by a medical doctor, such as those studied by Belknap (1997) and Dobash, Dobash, and Gutteridge (1986). Problems of higher rates of utilization of health services by female inmates as well as difficulty in seeing doctors have been reported in Lindquist & Lindquist's (1999) study of men and women's use of health services in jails.

Acoca (1998) has noted the challenge of attracting medical professionals to work in correctional facilities, where the pay may be lower and the location of the facility may be undesirable — many prisons are located in rural areas where it is often difficult to attract professionals. In addition to the challenges of working in correctional facilities, medical professionals may find other aspects of the job undesirable. In Ammar and Erez's (2000) study, nurses working in Ohio's women's prisons, faced the prospect of forced or mandatory overtime in the event that another nurse was unable to relieve them, sometimes requiring the duty nurse to cancel personal plans.

Furthermore, there appears to be a considerable stigma for individuals providing health care within correctional facilities. Dabney and Vaughn (2000, pp. 153-154) report that physicians who work in correctional health care are perceived by their peers as "inept," and all medical professionals in this area are generally regarded as "less qualified." On occasion, these negative perceptions of the qualifications and ability of the professionals employed by correctional facilities are accurate (Acoca, 1998; Dabney & Vaughn, 2000). Combined, these factors make the prospect of working as a medical care provider within a correctional facility for women highly undesirable.

Another challenge for medical care providers — one that is apparently experienced by many physicians — is the co-occurrence of health problems with mental health and/or substance abuse issues. According to Reed and Mowbray's (1999, p. 74) study of non-correctional medical care, women with these combined mental health and substance abuse issues sometimes receive incomplete care from general practitioners "because they tend to ignore physical health problems once an individual has this label." Additionally, substance abuse can mask symptoms and its related problems can occasionally be difficult to distinguish from neurological problems. This confusion may occur in correctional health care as well and impede care for inmates, a number of whom enter prison with mental health difficulties and substance abuse problems, as discussed above. A woman in Young's (2000) study reported that her medical care provider dismissed her request for further examination by stating she felt the patient's problem was imaginary. Reed and Mowbray (1999) also report a problem with negative gender stereotypes among some health care providers such as perceptions linking women with hypochondriasis or a failure of these practitioners to understand differences in the way women's health could be affected by substance abuse. Similar perceptions may be held by correctional medical providers.

Provision of Care to Women Inmates

This section presents data that reflect the care and treatment that women report receiving in correctional facilities and the care and treatment that corrections officials report that their facilities provide.

Care Reported by Women

Table 1 presents information, as reported by prison inmates (U.S. Department of Justice, 2000), regarding their drug/alcohol use and their mental and medical health issues. This table illustrates just how pervasive drug and alcohol use is among this sample of inmates. More than three-quarters of these women reported using alcohol while reports of the use of other drugs (from heroin to marijuana) ranged from 1.3 percent ("other" drugs) to 63.1 percent (marijuana/hashish). Additionally, almost one-quarter of these women reported having some kind of limiting disability ranging from difficulty seeing (8.7 percent) to mental/emotional conditions (14.2 percent).

Treatment and services available, as reported by these women, are presented in Table 3. More than 40 percent of the women surveyed reported treatment for drug/alcohol abuse at some point in their lives. Almost 31 percent stated they had received treatment while incarcerated; however, only 15 percent reported receiving any treatment since their current prison admission. Approximately 61 percent of inmates reported that the staff had checked for illness, injury, and intoxication at admission — 92 percent reported receiving a medical exam of some kind at admission. Especially important to women's health issues, 87 percent reported receiving a pelvic exam while 85 percent stated they had been asked questions about their health and medical history.

Table 3
Treatment/Services and Programming Provided as
Reported by Women Inmates, 1997 (N= 3,796)

	Percentages
Treatment/Services	
Staff check for illness, injury, intoxication (admission)	60.6
Medical exam (admission)	92.4
Pelvic exam	87.1
Ask questions about health/medical history	84.7
Ask if thought about/attempted suicide	82.8
Tested for tuberculosis (TB)	95.4
Positive results	8.3
Negative results	86.0
Blank/unknown/refused	5.7
At admission/in Prison	
Tested for HIV virus (admission)	72.7
Positive result (last test)	1.9
Negative result (last test)	66.1
Injured at admission	20.9
Any other medical problems	38.7
Emotional/mental problem	31.6
Received overnight program admittance	12.9
Received counseling/therapy	30.9
Received other mental health services	5.1
Received medication	21.8
Programming	
Ever been in a job training program	29.6
Currently in vocational program	11.9
Ever been in other educational program	37.6
College-level classes	9.7
Participated in:	
Religious study group	39.9
Other religious activities	44.2
Prisoner assistance groups	8.9
Other prisoner personal improvement groups	18.6
Life skills classes	22.2
Drug/alcohol groups	42.5
Ethnic, racial groups	3.4
Pre-release programs	13.5
Outside community programs	4.2
Arts/crafts programs	16.8
Treatment History	
EVER treated for drug/alcohol use	41.0
ANY treatment while incarcerated (ever)	30.8
ANY treatment since admitted to prison (currently)	15.0

Data Source: Survey of Inmates in State and Federal Correctional Facilities, 1997

With regard to medical testing, 95 percent of women reported being tested, at admission, for tuberculosis (TB) and 73 percent reported being tested for HIV. Approximately eight percent of women received positive TB skin test results while only 1.9 percent reported that their most recent HIV test was positive. However, 21 percent reported being injured at admission and almost 39 percent reported that they had other medical problems. Additionally, emotional/ mental problems were reported by almost one-third of the inmates and approximately 31 percent stated that they received some sort of counseling or therapy. Twenty-two percent of the women reported receiving medication for this problem, while 13 percent reported overnight programming and five percent received "other" mental health services. These inmates also reported participation in a wide variety of programming during incarceration. These included, for example, religious study groups (39.9 percent), prisoner assistance groups (8.9 percent), life skills classes (22.2 percent), and drug/alcohol groups (42.5 percent) as well as others (e.g., arts/crafts programs, pre-release programs, community-based programs). Altogether, these results indicate that many women are receiving at least some basic level of medical and mental health testing and services along with opportunities to participate in activities related to improving their chances for success upon reentry in their communities (e.g., life skills, job training).

Care reported by corrections officials

Using data provided by the Census of State and Federal Adult Correctional Facilities, 2000 (U.S. Department of Justice, 2004), Table 4 presents information, from corrections officials/ administrators in facilities incarcerating women offenders, regarding correctional policy and procedures related to the medical treatment and services provided to inmates. Table 5 presents information, from the same respondents regarding mental health services, education programming, prevention services, and other substance abuse programming. Briefly, corrections officials report a broad range of services that are available to inmates; however, the processes through which inmates must go to attain these services remain unclear. Likewise, prior research has demonstrated that there is sometimes a disconnect between the services or programs that are said to exist and those that are actually available (Murphy, 2003).

Corrections officials also reported having various medical health services, including testing for serious and communicable diseases. Approximately 63 percent of facilities test inmates for Hepatitis C; 47 percent vaccinate inmates against Hepatitis B; 68 percent test inmates for HIV; and 62 percent screen inmates for TB. However, very few of the officials reported that their policy mandates that all inmates receive these tests or services. Most corrections officials report policies for testing and vaccinating inmates that pertain to high-risk groups, inmate requests, clinical indication, or when treatment is recommended by a physician.

Corrections officials also reported regarding mental/emotional health services. Sixty percent of officials reported having specific policies regarding the intake of mental-disordered inmates. More than 50 percent reported use of psychiatric evaluations and assessments while more than 66 percent reported the use of psychotropic medications. Additionally, some officials reported the availability of 24-hour mental health care (40.8 percent), therapy/counseling (59.2 percent), and assistance to inmates to obtain community mental health services (62.6 percent). However, 7.6 percent of corrections officials reported that there were no mental health services available/provided. More than 80 percent of officials reported having specific policies regarding suicide prevention. Services available/provided include assessment at intake (66.8 percent), counseling/psychiatric services (58.9 percent), and monitoring of high-risk inmates (36.6 percent).

Table 4
Medical Treatment and Services Provided as Reported by Corrections Officials in Facilities With Female Inmates, 2000 (N= 380)

Variable	Percentages
Test for Hepatitis C Virus	62.9
All inmates (at some time)	6.3
At admission (all inmates)	.2
High-risk groups	17.1
At inmate request	31.1
Clinical indication	44.2
Facilities containing inmates with positive tests	25.8
Treatment for Hepatitis C positive inmates	57.1
Treatment for ALL Hepatitis C positive inmates	11.6
Only inmates at risk for cirrhosis	22.1
Only when treatment is recommended	28.2
Hepatitis B Vaccine	47.1
All inmates (at some time)	7.6
Only inmates with STDs	1.1
Only young inmates (18 years and younger)	3.7
At inmate request	12.6
High-risk inmates	23.9
Test for HIV Virus	68.2
All inmates (at some time)	7.4
All convicted inmates at admission	13.7
All convicted inmates at release	3.2
Random sample	0.8
High-risk groups	15.5
At inmate request	52.6
Court order	26.6
Involvement in incident	27.4
Clinical indication	41.6
Facilities containing HIV-positive inmates	27.4
Facilities containing inmates with lesser forms of HIV	12.4
Facilities containing inmates with AIDS	16.6
Facilities containing lesser forms, HIV+, and AIDS	32.9
Screen Inmates for Tuberculosis (TB) at Admission	61.6
No TB screening policy	20.5
Annual screening for inmates	62.1
Screen HIV-positive inmates	41.8
Screen inmates with no vaccination history	29.5
Screen inmates with possible exposure	61.1
At inmate request	33.7
At inmate release	0.8
Facilities with inmates suspected of TB	11.6
Facilities with inmates with positive TB skin test	38.9
Facilities with confirmed TB-positive inmates	5.4

Data Source: Census of State and Federal Adult Correctional Facilities, 2000.

Table 5
Additional Treatment and Services Provided, as Reported by Corrections Officials in Facilities With Female Inmates, 2000 (N= 380).

Variable	Percentages
Mental Health Services/Treatment	
Policy regarding intake for mental disordered-inmates	60.0
Psychiatric evaluations/assessments	52.6
24-hour mental health care	40.8
Therapy/counseling	59.2
Psychotropic medications	66.6
Assistance obtaining community services	62.6
No mental health services	7.6
Education Programs	
Basic adult education (ABE)	62.9
GED	68.2
Special education (inmates with disabilities)	33.2
Vocational training	44.5
College courses	27.6
Study release courses	21.3
No education programs	12.6
Counseling/Special Programs	
Drug dependency	88.2
Alcohol dependency	85.3
Psychological issues	57.6
HIV/AIDS issues	55.5
Employment	68.7
Life skills	75.8
Parenting/child rearing	61.1
Other (religious, cognitive, domestic violence)	25.0
No counseling/special programs	1.3
Suicide Prevention Services	
Specific policy procedures	83.4
Assessment at intake	66.8
Staff training	33.2
Inmate counseling/psychiatric services	58.9
Monitoring high-risk inmates	36.6

Data Source: Census of State and Federal Adult Correctional Facilities, 2000.

Lastly, corrections officials reported on the availability of a wide range of education and counseling/special programs. Basic adult education, GED programs, and vocational training were among the most available education programs (62.9, 68.2, and 44.5 percent, respectively). Almost 13 percent of the corrections officials reported that there were no education programs in their facility. Regarding counseling and special programs, drug and alcohol dependency, employment, and life skills were the most widely available options for inmates within these facilities. However, only 1.3 percent of the corrections officials reported that there were no counseling/special programs available.

Perceptions of Health Care

How inmates and their care providers perceive the health care in correctional facilities is invaluable in the areas of disagreement it reveals between these stakeholders. Each group has different perceptions of what is possible and what each is expected to contribute to the effort. Examining the concerns of each group is highly valuable for the purposes of illustrating how disagreement arises with regard to this sensitive issue. Understanding the respective positions of each group may be useful for preventing some conflict over health care.

Some caution must be used when reporting outcomes of studies that examine the perspectives of inmates or their caretakers regarding the care received and provided. Many of these studies focus on a single facility or system making some of their findings hard to generalize (Ammar & Erez, 2000; Belknap, 1997; Kane & DiBartolo, 2002; Lindquist & Lindquist, 1999; Maeve, 1999; Vaughn & Smith, 1999) and some have small sample sizes (Kane & DiBartolo, 2002; Maeve, 1999; Mahan, 1984; Young, 2000). Some of the studies may focus only on the perspectives of a single group, leaving out the views of others who may have alternative explanations. Furthermore, each group may have its own biases that color their statements—such as wardens who want to conceal limitations within their correctional program or prisoners who may be motivated by either ill will or unrealistic expectations regarding health care treatment.

Perceptions Held by Inmates

Increasingly, scholars studying corrections are seeking to include the narratives of female inmates, whose voices had long been disregarded (Young, 2000). The purpose is to validate the experiences of these women, as well as to provide insight into problems in correctional health care.

Some inmates have articulated the view that "prison was their 'big chance' to get healthy," in light of their prior lack of access to this resource (Maeve, 1999, p. 62). Medical care in corrections may also be perceived by inmates as a defense against the hostile nature of prisons and jails (Mahan, 1984). This optimism, however, can be dashed by the realities of what is possible within correctional health care systems, where limitations include not only scarce resources, but also concerns for safety and the need to maintain boundaries between the care providers and the women they treat (Ammar & Erez, 2000).

Women prison inmates studied by Young (2000) — whose findings echo similar observations made by Dobash et al. (1986) — generally held negative views of the health care they received while incarcerated. Although these perceptions were somewhat mitigated by instances of care they perceived as empathetic and adequate, the overall consensus was one of treatment that was nonempathetic — characterized by disregard for the patients and an abrupt manner in personnel — and inadequate — characterized by care that was considered incomplete, unresponsive, delayed, or misdirected. With regard to adequacy, some women sought a different type of medication than was prescribed, perceived that they had been misdiagnosed, or that care was delayed beyond reasonable lengths of time. Complaints about nonempathetic care were found among all the women studied. Of greatest concern to the women Young (2000, p. 228) interviewed was the sense that the prisoners had been "lumped together" by care providers whose perceptions appeared to include specific stereotypes about the prisoners, such as their being unworthy of good-quality care, drug-seekers, responsible for their own health problems, and so forth.

Another problem reported in studies of inmates' perceptions of their health care indicates a view that medical providers are apathetic toward the needs of inmates (Belknap, 1997; Dobash et al., 1986; Maeve, 1999; Mahan, 1984; Young, 2000). This view is exemplified by one prisoner's sense that "They don't seem to care what happens to you. They just do what they have to do.... If it's not the right time, right day, if it's not convenient or whatever, you could suffer and die and it wouldn't really matter" (Mahan, 1984, p. 375).

Perceptions Held by Medical Care Providers

Many of the reported negative perceptions held by medical care providers in correctional facilities are derived from studies that seem to reflect assumptions of scholars rather than the actual feelings of the care providers themselves. As admitted by Dabney and Vaughn (2000, p. 178), "we know very little about the men and women who work in this field."

Providing care in women's correctional facilities has an air of chaos about it. As one nurse stated, "Health delivery here is like the emergency room. Everything is noisy, done in a hurry and everyone is overworked" (Ammar & Erez, 2000, p. 20). The challenges of correctional health care create cynicism on the part of some treatment staff. An example of this is the response of one care provider to an inmate's sinus problems, in which the provider commented that "if you were on the street you'd be smoking rocks or shoving cocaine up your nose . . ." (Maeve, 1999: 63). Dabney and Vaughn (2000) attribute some of these negative perceptions of inmates to penal policies that dehumanize inmates and make them seem unworthy of care. Maeve (1999: 63) reports the frustration of medical care providers to being overwhelmed by sick call requests from women at the prison, described as being "preoccupied" with their bodies and some of whose complaints were "elusive" and incapable of being ascertained. Additionally, care providers feel it is important to "remember that [inmates] are here for a reason," no matter how concerned they are for their patients (Ammar & Erez, 2000, p. 23). Ross and Lawrence (1998, p. 128) caution, however, medical care providers in correctional facilities to "adopt a less judgmental approach to their patients."

Not all care providers share these stereotypes and are instead genuinely concerned about the women for whom they provide care. This is a notion explored by Ammar and Erez's (2000) research and is a factor that distinguishes their study of health care in Ohio's women's prisons from other studies that feature the voices of those involved in correctional life. Care providers interviewed by Ammar and Erez (2000) expressed pride in their work and indicated that the difficulties were outweighed by the benefits of being able to see marked improvement in the women they treated. Additionally, some of the care providers noted their feelings that women were more amenable to being rehabilitated — physically and otherwise — than men.

A recurring theme in this research is one of having to balance empathy with distance and professionalism with compassion. Some of the caution that care providers deploy is motivated by concerns about hostile responses from inmates who do not succeed in getting what they want. One nurse commented that, upon refusing the request of an inmate, the inmate became abusive and went "out of her way to try to make the medical staff and medical service here look terrible" (Ammar & Erez, 2000, p. 23). Other concerns reported focused on not being manipulated by inmates, who might be seeking medical attention for drugs or simply to break up the monotony of life in a correctional facility, avoid work, and the like (Lindquist & Lindquist, 1999; Marquart et al., 1996).

Resolving the Conflicting Perceptions Held by Inmates and Medical Care Providers

Conflicts that exist between the perceptions of inmates and their care providers include differing definitions of and expectations regarding health as well as who is responsible for achieving health. Whereas society generally, and by extension care providers in correctional facilities, sees health care as being a matter of "personal responsibility," Maeve (1999) argues that women prisoners often see their health care as being in the hands of providers. Thus, inmates are expected by providers to participate in the joint venture that is "health," although this appears unclear to the women.

In addition to not clearly understanding their role in health promotion, inmates often face challenges that prevent them from taking an active role in achieving improved health. In large measure this is due to the "dependence demanded by the nature of prison" (Maeve, 1999, p. 66). Often, health care is subordinated to institutional needs, creating tensions between medical care providers and other corrections officials. According to one physician, front-line

corrections officers believe that "the medical needs are not as important as safety" (Ammar & Erez, 2000, p. 24). On one end of the spectrum, this can include an inability to engage in self-care for minor problems such as headaches or menstrual cramps (Acoca, 1998). Other women, who may be aware of how to treat their medical conditions, may have less discretion in the treatment options for addressing their particular needs. For example, diabetic women in the facility studied by Maeve (1999) had no ability to calibrate their insulin doses to correspond with their dietary intake. At the opposing end of the spectrum are situations, such as that described by Ammar and Erez (2000), in which a doctor's efforts to get a woman with serious heart problems transported to an outside specialist were thwarted by a corrections officer's unwillingness to drive the woman to the cardiologist because of fog. This then may result in a perception that women are not sufficiently compliant with regard to taking responsibility for their health, despite the fact that "substantive health care is available within an environment capable of enforcing expected health care behaviors" (Maeve, 1999, p. 51).

A delay in the medical care received is also a considerable complaint of inmates, one which often combines with their perceptions of inadequate care. For example, women in Young's (2000) study reported lengthy gaps between reporting a condition and receiving the proper care for that problem. According to one woman, "Somebody can be almost dying or whatever in here, and they just take their time about things" (Young, 2000, p. 226). Once care is provided, it is also perceived as inadequate (Belknap, 1997; Young, 2000). From the perspective of medical care providers, however, staffing levels are often a factor in this delay. The resources for providing specific services may also be limited, which necessitates transporting women to outside care providers—a cumbersome task laden with red tape.

Medical care providers and the inmates they treat place different weight on empathy. Women in Young's (2000) study placed a priority on empathetic care, valuing some level of personal interest on the part of providers caring for them as well as respect and a willingness to listen. Accordingly, "[e]mpathetic treatment requires being aware of and understanding the needs, feelings, and views of others" (Young, 2000: 228). However, as discussed above, medical professionals construe the level of empathy they demonstrate within the context of having to balance that emotion with distancing themselves from inmates (Ammar & Erez, 2000). Medical professionals articulate a need to "protect" themselves, maintaining distinct boundaries between the professional and personal aspects of the care provided, as well as having concerns about the personal safety of the care providers. This arises from concerns about the risk of violence, as well as from concerns about being manipulated and deceived by inmates. In addition to using manipulation and/or deception, inmates might also malinger — intentionally feigning or exaggerating physical or psychological symptoms for person gain (see Allen & Bosta, 1981; American Psychiatric Association, 2000; Sykes, 1958). Although these behaviors may take many forms — and are attempted for many reasons (e.g., to increase goods and services, avoid work, gain autonomy or safety, see Sykes, 1958) — once an inmate has been recognized as a malingerer, staff are more likely to "dismiss legitimate…requests for help" (American Psychiatric Association, 2000). On the other hand, are those malingering inmates who are never identified and are "automatically" provided treatment for whatever symptoms or ailments they report (American Psychiatric Association, 2000).

Prison inmates often try to manipulate prison staff, and it has long been recognized that they have much to gain and little to lose in these attempts (see Allen & Bosta, 1981). For example, Lindquist and Lindquist (1999) describe several motivations for seeking medical attention that have no basis in actual need, including obtaining drugs. These prescriptions could be for personal use or, as Ammar and Erez (2000, p. 24) note, as coveted commodities in "inmates' informal market system." This assertion can be contrasted with that of an inmate in Mahan's (1984) study, who felt that it was easier to get illegal drugs within the prison than to get legally prescribed medications. Maeve (1999) reports an interesting cycle of

skepticism and exaggeration demonstrated by staff and inmates in the facility she studied. Because care was often delayed in the prison, some inmates exaggerated their symptoms to receive more expedient care. Such observations confirm the notions of the medical care providers that they were being manipulated and increased their resistance to being duped. Maeve (1999), however, argued that actual instances of manipulation among prisoners were rare. Skepticism may also be necessary to providing appropriate health care itself. Kane and DiBartolo (2002) found, on occasion, a problem among false reporting by some jail inmates of health conditions they did not have, or a failure to admit candidly those behaviors that might put them at risk for particular illnesses. This required, then, that assertions made by inmates be substantiated by appropriate testing. As a result, some level of skepticism on the part of medical care providers within correctional facilities is clearly warranted.

Policy Considerations Regarding Health Care for Women Inmates

Problems

One significant consideration with regard to inmates is that the socioeconomic and other challenges faced prior to incarceration are also faced by women in similar straits who are not offenders, and thus, are unable to benefit from the health care — even that which is minimal — within correctional facilities. More consideration should be given, then, to provision of health care services that would benefit all women in need, not merely devoting that benefit to women who offend. In this way, the social safety net of last resort need not be correctional facilities.

Ultimately, policymakers who determine what activities to criminalize must be realistic about the cost of their decisions (e.g., three strikes laws, the "War on Drugs"). Outlawing specific behaviors and "get tough on crime" mentalities have long-term costs beyond building cells for inmates (for example see Bush-Baskette, 2000; Tonry, 1995). Health care for inmates is among these costs, one that can be particularly high given that some populations are going to place greater financial demands on a correctional health care system, even for basic care alone. As noted by Marquart et al. (1996, p. 352), "Incarcerating more women, coupled with their unique health demands, will be a costly crime control policy." Moreover, the costs of health care increase threefold as inmates age (see Aday, 2003). As an alternative, legislators and corrections officials might be better served by learning about women at risk of falling into the criminal justice system and creating interventions that would be more cost-effective than correctional supervision (Fearn & Parker, 2004).

Correctional administrators need to consider how their policies can affect the health care for inmates, both those which are specific to care itself and those which affect that care indirectly. This includes distinguishing between offering treatment and programming and being capable of providing that to all inmates who require care. As our data indicate, there appears to be a discrepancy between the types of services corrections officials report exist, and what inmates actually receive.

Opportunities

Incarceration can provide an opportunity to improve health for people "whose risk factors and infection prevalence rates far exceed those of other populations" (Glaser & Greifinger, 1993, p. 139). It is an opportunity that can help inmates. It is also one that can help others who may be affected by the health problems of inmates—unfortunately, release from a correctional facility is no guarantee that an individual will cease engaging in risky behaviors that can expose others in the community. Addressing these problems — especially through education and treatment of particular health conditions — in correctional facilities may be an important preventive measure for all.

Educating inmates about their health while they are incarcerated is an investment that empowers these women and may reduce the burdens they present to health care systems, both in correctional facilities and in the community for those who are released. Given the lack of education that many of these women have about health issues (Ammar & Erez, 2000; Maeve, 1999), providing them with information about a

variety of health issues — such as basic preventive care, family planning, disease prevention, and the like — has the potential to make a constructive difference in their lives. Ross and Lawrence (1998) suggest helping inmates to develop skills and esteem that would enable them to avoid risky behaviors. They also suggest that educating women about navigating the health care system, encouraging the development of positive attitudes toward wellness, and providing direction and referrals for women facing release with regard to post-incarceration health care options such as Medicaid.

Because female inmates tend to serve shorter sentences, it is of particular importance that specific health issues be tackled while they are incarcerated. This is very applicable to women in jails, which tend to house pretrial detainees and inmates with sentences of a year or less. In California, for instance, the average jail stay in 2004 was approximately 20 days, and many inmates make bail in a day or two (California Board of Corrections, 2005). This creates a debate about how much health care should be delivered to these short-term populations, and whether the jail is the most appropriate place for public health interventions (see Leach, 2004).

Glaser and Greifinger (1993, p. 143) recommend devoting attention to communicable disease, in the form of treatment and prevention, an effort which can "yield broad social benefits." The time to identify these problems is at intake, when screenings for STDs, HIV, and certain chronic health problems can be done (Kane & DiBartolo, 2002; Lindquist & Lindquist, 1999). Identifying tuberculosis and hepatitis exposure is also necessary (Glaser & Greifinger, 1993). Intake procedures may identify diseases in their early, more treatable stages, which can be addressed more cost effectively than when such issues have advanced (Acoca, 1998). Finally, pregnancy screenings should be performed at intake as well. This early identification allows pregnant inmates to begin receiving appropriate prenatal care, including special diets. It also alerts medical care providers to foreseeable complications that might arise with the pregnancy or birth (Parker, forthcoming).

While adequate and quality healthcare in correctional facilities faces many challenging obstacles, a few promising programs have been developed and implemented in prisons/jails across the country in the past decade, especially those focused on inmates with mental illnesses (Hills, Siegfried, & Ickowitz, 2004). Maryland, Oregon, and Texas have established programs, identified by the National Institute of Corrections as successful, that seek to enhance the treatment and services provided to offenders. Maryland's Community Criminal Justice Treatment Program, Oregon's Department of Corrections' Mental Health Program, and the Texas Department of Criminal Justice's Correctional Health Care/Mental Health Services Program all include comprehensive screenings for mental illness and substance use as well as ongoing therapy, medication, progress evaluations, and individualized and group counseling (Hills et al., 2004). Additionally, Maryland's program is currently provided solely to women and has plans to offer additional services to pregnant and postpartum inmates. Finally, these programs also have been deemed as successful — or at least promising — in that they view treatment as an ongoing process, thus providing aftercare and transition services to inmates leaving the facilities (Hills et al., 2004).

Given the issues discussed throughout this paper, it is important to reiterate the complexity of the factors that underlie the issue of providing adequate and appropriate mental and medical health care to female inmates. The provision of care for these inmates must be realistic in what it can accomplish and that, given the scarce resources and limited means available for their care, education and the treatment of communicable diseases should be the main priorities. It is inevitable that many of these inmates will eventually be released from prison. Educating these women regarding signs, symptoms, and prevention and treating any serious, debilitating, and transmittable diseases that they have are issues that must be at the forefront of any conceivable health care policy for women in prison.

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