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Malign Neglect or Benign Respect: Women's Health Care in a Carceral Setting¹

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A central tenet of feminist criminological scholarship is the examination of women's experiences with crime and incarceration through their own narratives. Through semi-structured interviews with thirty jailed women, this article examines carceral conditions through the critical lens of the female inmate. Highlighted in this article is the availability and quality of health care in a detention center in Arizona. The findings indicate a contentious duality, exposing both heinous neglect and benign solicitude in the care delivered to jailed women. This duality is situated within the dismal health care system available to indigent women in the region.

KEYWORDS. Women, gender, jail, incarceration, health care, medical care, mental health

INTRODUCTION

Correctional reform throughout the last century has served to entrench the imprisonment philosophy in American consciousness (Davis, 1998). Under a “get tough on crime” ideology and equality rubric, the trend over the last few decades has been to make female institutions more similar in structure, security, and operation to male institutions so as to facilitate gender equity within the criminal justice system. This phenomenon, appropriately termed “equality with a vengeance” by feminist scholars (Chesney-Lind, 1997, p. 152), has had devastating consequences for women and girls. Rather than improve both men's and women's correctional facilities in equitable fashion, the trend toward equality has worsened the carceral experiences of female offenders (Daly & Chesney-Lind, 1988). While women have faced harsher sentences and increased correctional security, scarce, marginalized and gendered educational and vocational training programs have remained largely unchanged, as have the available medical and mental health care services (Davis, 1998).

These changes come at a time when the female incarceration rate is burgeoning; women now make up over 11% of the U.S. jail population and consistently experience higher yearly incarceration rate increases than men (Greenfield & Snell, 1999; Stephan, 2001). It is within this context that we examine programming and services available to jailed women in terms of medical and mental health care. We aim to contribute to the feminist literature on women, crime, and correctional practice as the majority of research has focused on prison as the long-term, totalizing correctional institution. Jails and detention centers have remained a more neglected location of the social control of women. While a few studies have specifically discussed

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women's experiences in jail, more common approaches seem to be to either assume the experiences of imprisoned women mirror those of jailed women, or to simply call for further research on women in jail (Barry, 2001; Leh, 1999; Macher & Goosby, 2000; Resnik & Shaw, 1981; Sigurdson, 2000). Only a handful of studies have devoted explicit attention and/or analyses to women's jails or detention centers. For instance, El Bassel, Ivanhoff, Schilling, Gilbert, Borne, and Chen (1995), as well as Baxter (1991), considered HIV infection and prevention in jail settings. Veysey (1998) discussed the complexity of addressing the mental health needs of jailed women, while Teplin, Abram and McClelland (1997) undertook a large survey regarding the mental health needs and services available to female detainees. Additionally, Beltrami, Cohen, Hamrick, and Farley (1997) completed a large survey regarding the rates of syphilis in male and female jail arrestees, and an early study by Shaw, Browne, and Meyer (1981) examined sexism in health care delivery to female jail inmates.

The relative dearth of literature in this area is unfortunate given that more women actually pass through jail and detention centers than through prisons (Greenfeld & Snell, 1999). Of course, some do not merely "pass" through these facilities, but rather spend years in jail awaiting sentencing, or through repetitive incarcerations for petty offenses or probation violations. Since jails are intended to provide short-term intervention, punishment for misdemeanants, and holding cells for felonious offenders, most neither develop serious programs nor receive the external scrutiny which sometimes exists for prisons.

HEALTH RELATED NEEDS OF JAILED WOMEN

Many women who are incarcerated have been seriously victimized prior to their arrests; the best estimates are that at least half of all female jail inmates suffer physical or sexual abuse prior to incarceration (Browne, Miller & Maguin, 1999; Harlow, 1998; 1999; Wan, 2001). Battering by an intimate partner(s) appears to be particularly common (American Correctional Association [ACA], 1990; Gilfus, 1992; Richie, 1996; Wan, 2001). Thus, women may likely enter jail having been recently assaulted physically or sexually, which may necessitate medical attention as well as counseling and support services (Shaw, 1992). Prior victimization may also be correlated with various self-destructive coping mechanisms such as substance abuse, psychological and psychiatric disorders such as Post-Traumatic Stress Disorder, and suicidal tendencies, which complicate service delivery in the carceral setting (Veysey, 1998). In addition, many need protection from further abuse upon leaving jail, which may not be readily available. Regardless of a woman's experiences prior to incarceration, the stress of being imprisoned adversely affects health as inmates struggle to negotiate legal, familial, and financial problems (Shaw, 1981).

Beyond physical and psychological injuries induced by violent victimization, incarcerated women suffer from a myriad of health problems (Barry, 2001; Ingram-Fogel, 1991; Maeve, 1999). These range from sexually transmitted diseases (Beltrami et al., 1997; Simbulan, Aguilar, Flanigan & Cu-Uvin, 2001), HIV/AIDS transmission (El Bassel et al., 1995; Farley et al., 2000; Maeve, 1999; Mullings, Marquart & Brewer, 2000), and breast cancer (Williams, Mahoney & Williams, 1998) to alcohol and/or drug addictions (Birecree, Bloom, Leverette & Williams, 1994; Chesney-Lind, Harris & deGroot, 1998) and mental illness (Birecree et al., 1994). Of particular concern today is the prevalence of Hepatitis C among inmates, which has been

described as an epidemic with more than 18% of this virus' carriers passing through jails and prisons annually (Abramsky, 2002). Overall, incarcerated women experience higher rates of serious and chronic physical and mental illness than the general population (Maeve & Vaughn, 2001). Sixty percent of incarcerated women report at least one significant medical problem (Young, 1998), 60-70% have a substance abuse problem (Regier et al., 1990), and 70-80% of female jail inmates suffer from at least one lifetime psychiatric disorder (Teplin, Abram & McClelland, 1996).

HEALTH CARE FOR JAILED WOMEN

Incarcerated women frequently need and use available medical services within the carceral environment (Ingram-Fogel, 1991; Maeve & Vaughn, 2001; Young, 1998). Unfortunately, few initial or routine assessments of women's health-related needs occur. It seems assessments of jailed women are more likely to occur intermittently depending on the observations of individual inmates made by various correctional and medical staff (Gorsuch, 1998; U.S. General Accounting Office [GAO], 1999; Veysey, 1998). Perhaps not surprisingly then, the need for services far exceeds the resources for providing them (Teplin et al., 1997). Access to the most basic medical services is often problematic, the care received is frequently inadequate, and medical personnel who treat female inmates continually do so without empathy and as if their patients are undeserving of attention (Belknap, 1996; Young, 2000). Long waiting lists usually exist for high-demand services such as substance abuse treatment (GAO, 1999). Moreover, research has found that women of color are less likely to use available medical services and to perceive their treatment by medical personnel as less favorable than do white women (Young, 1999). Aside from issues of access, research has substantiated the need for greater diversification of substance abuse treatment beyond AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) (Shaw, 1992).

Only 53% of jails provide gynecological and obstetrical services, while 59% provide prenatal and postpartum services (ACA, 1990). Pregnant women may fare worse than those needing other health services because so few inmates are pregnant and/or actually give birth while in jail (ACA, 1990; Greenfeld & Snell, 1999). In addition, many pregnant women fear the conditions under which they will give birth, as most correctional facilities do not adequately provide care for inmates in medical emergencies such as labor. Just over half of all jails and prisons for women have medical staff on site 24 hours a day. In emergencies, less than 20% routinely call paramedics while only 32% of jails provide transportation to a hospital (ACA, 1990).

Approximately 30% of women's jails do not provide any type of psychiatric care (ACA, 1990). Those that do provide psychiatric care limit treatment to the use of psychotropic drugs more often than is the case in men's facilities (Morash, Haarr & Rucker, 1994; Ross, 1998). A study of 1,272 jailed women found that less than 24% of inmates received the mental health services they needed while incarcerated (Teplin et al., 1997). This figure supports data from the National Institute of Justice, which indicates that only about 20% of women receive mental health services after admission to jail (Harlow, 1998). The services that are available, while often ill-equipped

and under-funded, are usually reserved for the most seriously ill. Those with moderate mental disorders are not likely to receive any services whatsoever (Steadman, Holohean & Dvoskin, 1991; Teplin et al., 1997). Untreated ailments contribute to incidents of self-injury, such as mutilation and suicide (Haywood, Kravitz, Goldman & Freeman, 2000; Pollock-Byrne, 1990; Shaw, 1992; Sigurdson, 2000).

At the same time, however, some inmates express gratitude for what little health care services they receive, as few obtain proper health care while not incarcerated (Staton, Leukefeld & Logan, 2001; Young, 2000). This is indicative of the environment in which many women live prior to their incarceration. Women have reported that victimization, drug use, and living in rural areas are factors which prohibit their access to proper health care (Staton et al., 2001). It has also been argued that while the need for greater health care programming is obvious, society's continued disregard of the needs of female inmates reflects the antipathy toward providing health care for poor women generally (Smith & Dailard, 1994). As the poverty rate has increased for single women and their children, welfare and health care subsidies have been slashed substantially over the last decade (Mink, 1999). Additionally, mental health services for the chronically and severely mentally ill have all but disappeared for the poor and underinsured (Sigurdson, 2000). In recent years, studies have suggested that jails are becoming primary health care providers for the poor, homeless, and mentally ill (Ditton, 1999; Fuller, 1995; Sigurdson, 2000). Indeed, because so many women live in poverty with little or no health insurance prior to their incarceration, most enter jail or prison with some sort of medical or dental need that has not been adequately treated (Barry, 2001).

METHODS

The data on which we rely come from our transcribed interviews with 30 women incarcerated at a detention center in Arizona during the spring of 2000. We originally approached these interviews with the goal of obtaining information about incarcerated women's experiences with violence. However, because of the qualitative, semi-structured format of our interviews, we encouraged women to talk further about various experiences as they were mentioned. Health care was among the prominent themes noted through this approach. Indeed, 63% of the women addressed their concerns regarding their experiences or observations of mental and physical health care during the interviews. Additionally, it is likely that some of the other women in our sample had experiences with health care services which were not discussed during their interviews. Because we did not systematically inquire about health care, but rather observed the emergence of such concerns as a theme throughout several of the interviews, it is possible that a higher percentage of women had experiences with the health care services. For those who did discuss health care, no means of verification or validation outside of their recollections were available at the time of our research. However, we did compare individual women's accounts of common events and found that they were often consistent with one another. Thus, we were able to increase the reliability of the data in this way.

This research is further hindered by its lack of generalizability. We could not determine whether the experiences recounted at Southwest Detention Center³ were typical of all the women incarcerated there, nor could we conclude that the observations contained here are typical of other Arizona facilities or facilities in other states. However, such is not the goal of qualitative research. Our data provided a deeply rich, detailed, descriptive, and diverse set of narratives that would not have been possible through alternative means of data collection (Kvale, 1996; Lofland & Lofland, 1995). These data are intended to supplement the small body of literature explicitly focused on jailed women's experiences. Our research follows the tradition within feminist epistemology of emphasizing the epistemic privilege, or the specific vantage point, of the subjects (Collins, 1989; Elliot, 1994; Hartsock, 1987; Narayan, 1988; Smith, 1987). This approach assumes that members of marginalized groups can offer meaningful accounts of the ways in which the world is organized according to the oppressions they experience. Thus, in turning to the vantage points of jailed women, we may better understand the ways in which correctional policy and practice impact inmates. Such a methodology has become prominent in qualitative feminist research on women and crime (see, as examples, Arnold, 1990; Gilfus, 1992; Richie, 1996).

Funding for this project was obtained from the Center for Urban Inquiry at Arizona State University, which provided \$10-20 stipends to each of the women. The ability to earn such money by participating in a research study proved to be a strong incentive for the inmates who said they would use the funds to purchase such basic supplies as hair shampoo, hair conditioner, tampons, stamps, paper and pencils, soda, and candy bars. Some planned to save their funds so that they could purchase a bus token and food upon their release. A few mentioned that they were going to try to share their funds with other women who had not gotten a chance to participate in our study and who had no outside sources of funding.

While regimentation of secured correctional facilities makes entry of outsiders cumbersome, the cooperation of the administrators and correctional staff at Southwest Detention Center facilitated our presence in the facility. Prior to our visit, correctional officers explained the research to the women and asked all volunteers to sign up on a list, which the administrators approved and provided to us upon our arrival. Approximately 65 women's names appeared on this list. The women were not screened by us, or to our knowledge, by correctional staff, prior to their participation. We had no pre-established criteria for selecting participants beyond that they be willing volunteers. Our goal was simply to interview as many women as we could who wanted to talk to us. With the amount of funding we obtained for stipends, and the availability of individuals at the time we conducted interviews, 30 women actually participated in this project. Several of the women who had volunteered were not available at the time of our interviews. Some were working, sleeping, visiting with guests, or at court while we were at the facility, while others had been released, transferred, or placed on lockdown.

³ To further protect the confidentiality of our interviewees and the facility in which this research was conducted, we utilize the pseudonym "Southwest Detention Center" throughout this article.

The correctional staff were very accommodating and assisted us with finding private spaces in which we could separately conduct individual interviews without interference. Before beginning each interview, we explained the purposes of the research to the women and asked each participant to sign an informed consent form. Upon their permission, we audiotaped the interviews and later transcribed them. To respect the women's concerns with regard to the privacy of particular events in their lives, we conducted some portions of interviews "off-the-record" by turning off the recording equipment and promising the women that such information would not become part of our research. The participants were also given great latitude in how long they wanted to speak to us. Subsequently, the interviews lasted from thirty minutes to three and a half hours. We asked them to provide their own pseudonyms, which we used to identify their transcripts and all quotes included here. As a final effort to respect the women's privacy, we provided our addresses and telephone numbers as well as an addressed, postage-paid envelope with which they could contact us after the interviews to clarify or request additional editing of the events they had shared during the interviews. We also offered to send each woman her transcript and any written materials resulting from the research. Additionally, arrangements were made with a local domestic violence shelter to provide counseling services for any woman who experienced emotional distress as a consequence of the interview process.

PROFILE OF PARTICIPANTS AND FACILITY

The sample of women was diverse in terms of age and race/ethnicity, but quite homogeneous in terms of class. The women ranged from 21 to 50 years of age, with an average age of 34 years. There were 15 white women (50%), seven Black women (23%), three Latinas (10%), two American Indian women (7%) identifying as Tohono O'odham and Pima, and three women who identified as biracial (African American/ white, Latina/white, and American Indian-Cherokee/white). This distribution was roughly comparable to the proportions of women in each racial/ethnic group in the jail at the time of our interviews in which 53% were white, 24% Latina, 13% Black, 9% American Indian. This racial and ethnic distribution of Southwest Detention Center inmates mirrored national jail data in that African American and American Indian women were vastly overrepresented (Davis, 1998; Greenfeld & Snell, 1999; Richie, 2001), although Latinas were underrepresented. In the general population for the county in which this research was conducted, 69% of women were white, 23% were Latina, 3% were Black, and 3% were American Indian, according to that county's health department statistics.⁴ Almost all of the women had low or no incomes prior to incarceration, although a few women indicated that they were "middle class." One woman's description of her circumstances, however, which included being one of three children of a single mother whose only income was from waitressing, suggested that her definition of middle class did not include the level of privilege generally associated with that designation.

⁴ These statistics were obtained through public records accessible over the World Wide Web. A direct citation is not provided here as doing so would compromise the confidentiality of the participants and the facility in which this research was conducted.

These 30 women were among the approximately 200 women incarcerated at Southwest Detention Center at the time of our research.⁵ In total, roughly 1,500 men, women, and juveniles were incarcerated at the facility during any given day in 2000. Thus, women encompassed an estimated 13% of the overall inmate population. They were housed in a podular-designed “new generation” jail that afforded direct contact with and supervision by correctional staff.

The women we interviewed came from one of three pods with differing security levels. The highest security pod was the admissions unit, which housed women for 24 to 72 hours for observation and assessment. Within this unit women were given time to “detox” from any drugs or alcohol they may have had in their systems prior to admittance and were also observed for suicidal tendencies. Some were transferred from this unit to a medical or psychiatric unit depending on their conditions; however, most were transferred directly to a second unit regardless of their circumstances. Beyond an initial assessment aimed at addressing serious medical conditions, psychiatric disorders, or security risks, any particular needs the women exhibited were handled on a case-by-case basis by correctional staff, counselors, treatment providers, and medical personnel in all of the units.

The second pod was also a higher security unit; however, women were allowed more freedom of movement than in the admissions unit. This unit was also a temporary facility (most women spent fewer than 30 days in it), which housed women awaiting trial or sentencing. The third unit from which we obtained interviews was a longer term, lower security facility for sentenced women. The inmates in this area were either serving their sentences or awaiting transfer to prison or a treatment facility. About half of the women had obtained work furlough from this unit as well.

FINDINGS

The sentiments expressed by the women we interviewed largely echo prior research on health care in carceral settings and are best understood within the context of the overarching social conditions that influence the services and assistance poor and marginalized women receive. Arizona’s approach to providing health care for low-income people is called the Arizona Health Care Cost Containment System (AHCCCS). It is extremely difficult to qualify for benefits under this program and those who are able to enroll in the system receive an average of only \$1,670 per year in care services, compared to the national average of \$1,874 (Caiazza, 2000). Hence, an overarching theme in the interviews was the seemingly conflictual feelings of carceral health care being dismal and inadequate, while simultaneously better than what could often be obtained on “the outside.” The following excerpts, organized by general categories, provide an array of the feelings and experiences noted by the women we interviewed.

Preventative, Maintenance, and Emergency Care

⁵ Inmates were admitted and released from the facility throughout the day, thus population counts changed frequently.

Southwest Detention Center did provide a range of basic routine, preventative, and maintenance health care options, which were provided without any out-of-pocket expense for the inmates. Some women recognized this and made ample use of the opportunity to obtain some basic routine and preventative medical care. As Boo, a 27-year-old Latina woman incarcerated for prostitution and unpaid fines, explained:

In here they'll do AIDS tests, TB tests for skin diseases, pregnancy tests . . . all that stuff. I tell these girls, "This shit's for free. They're paying \$35,000 per year for each person. Now go over there and get that shit for free." Whether it's a urine infection, an itch, a little bug bite, it's free.

Such sentiments are illustrative of the abysmal health care available to poor and indigent women in Arizona. For Boo, even carceral health care was better than she would have typically obtained on the outside. Others disagreed, however, and found the health care and the health care providers inadequate. Alicia, a 21-year-old bi-racial (Black/white) woman incarcerated for a probation violation for drug sales, summed up many women's feelings, "They don't have any good medical personnel here. They're just like holier than you." More specifically, Tamara, a 32-year-old white woman incarcerated on a probation violation, addressed a concern over the available dentistry services:

My teeth are all messed up. I went to go get them worked on because I have teeth growing up inside my mouth, like my canines or something. I don't know how to explain it they're coming out and they're pushing my front teeth out. I don't want to do anything here because all they do is pull them.

Alicia expressed sentiments regarding the treatment for and prevention of head lice:

In here they basically want you to find the [lice] bug before they treat you. If you're itching your scalp, why should you have to wait to be treated until you find the bug? And those bugs are so small, how are you going to find it anyway? And then they only treat the person that has it they don't treat everybody in here. Just like if somebody in your home has it you treat your whole house, spray your beds. They just make that person strip their bed and the lice will be on the floor and the bed and it's just going to be the whole cycle again.

When treatments were administered for head lice further problems occurred. As Crystal, a 24-year-old white woman incarcerated for D.U.I. (driving under the influence), explained:

This lady had lice in here and she got medicine in her eyes. They didn't do anything for her. . . . Her eyes were the color of blood and she couldn't see. They would not take her in medical. I couldn't believe it. You only get one pair of eyes. You'll never be able to get that sight back again if she lost her sight. It makes me sick. I know here in jail we're being punished but it doesn't mean that.

In at least one situation, an infection resulting from a minor injury that had gone untreated posed a much graver health concern for an inmate:

Right now something just happened. My bunkie right next to me . . . before she got in here she'd gotten into a fight with somebody and kicked a glass door. She has this big cut on the bottom of

her foot that still has glass in it. You can literally see it. She went and told them “I need to see medical.” So she went and saw medical. Medical didn’t give her Neosporin. They didn’t give her peroxide or alcohol or anything to put on this cut. . . . Her foot is sore. She said, “I think it’s infected.” I’m like “Yeah, I think it’s infected too.” She’s gone as far as to tell the surgeon that her foot is infected and she needs to see somebody. She jumped off her bed probably ten minutes before they called me out and her foot like bursts open and all this puss and blood just splatter everywhere. [Anne, 21, white, incarcerated for transporting drugs]

Even more serious diseases for which maintenance care ought to have been provided did not seem to merit increased medical concern:

There’s a lady next to me who has Hepatitis C from doing so many drugs. She has a really rare blood disease. Her liver is all messed up. You can tell just by the color of her. She’s like yellow and green. She keeps telling them . . . she’s put in like seven medical slips, she’s put in grievances, she’s talked with the sergeant. You know, “I need to go somewhere.” She can’t pee. She hasn’t peed in two weeks. She hasn’t gone to the bathroom. . . . They’re not doing anything. [Anne]

As some of the above excerpts indicate, beyond some basic, yet mostly marginal and inadequate, medical care, a frequently cited challenge was negotiating access to medical personnel. Simply having a medical condition did not guarantee that the correctional officers would make any sort of treatment available. As Alicia commented, “They feel like you have to be absolutely dying to go to the doctor.” The inmates’ dependence on correctional staff was well illustrated in a number of testimonials regarding medication. As Tamara explained, following proper procedures for obtaining over-the-counter medication did not necessarily result in the receipt of such medication:

You have to fill out a medical slip and you give it to them [correctional officers]. Usually by the time you’re feeling better, they’ll try to give you something for it. I got a cold and it took I think four days to get something to clear my nose up, my sinuses up.

Anne expressed similar frustration over her attempts to receive pain-relievers:

For a Tylenol it’s like you’re asking for a shot of morphine or something. They just have no compassion for anybody. They treat us all like we’re murderers. And, granted, we’re all wearing the same color . . . but you can be at least a little bit understanding. . . .

Even in more serious cases involving chronic illnesses and medical emergencies, inmates complained of inattentiveness on the part of correctional officers. As Brina, a 27-year-old white woman incarcerated for embezzlement, stated, “I fell and twisted my ankle. It was black and blue and swollen. It took three and a half days to get emergency X-rays. That’s how the system works here.” In many instances, the tendency of staff to disregard immediate medical needs contributed to more serious maladies for the women involved. Karen, a white 47-year-old woman awaiting trial for murder, expressed concern over the treatment of diabetes based on her experience in nursing:

The diabetics are treated the worst because diabetic people are pretty well in control of their situation except they're brittle and you come in here and you're not allowed to have anything except food in your locker. I think diabetic people should be able to keep a little candy on them, because they know when their blood sugar is falling. We've had a few deaths in here just since I've been here of women who are diabetic who crash and die before they get help. . . . They don't take the situation real seriously like they should. I think they've kind of covered up a couple of the deaths that have happened in here recently, you know, blaming it on the drugs . . . when in reality when you take a diabetic and throw them in a cell and lock them down without any resources or anything . . . if they're to drop off into a coma, chances are they're going to die.

Anne, whose bunkmate's foot had ruptured due to infection, went on to describe the ordeal involved with accessing medical care for what had turned into a medical emergency:

The C.O. doesn't even come in. He's like, "Well, tell her to come out here." I went and got her and she like hobbled out. She shows him her foot, and her foot is like bleeding. He goes "Ooh." You could hear him. And you would think that they would call medical immediately because she's bleeding. "No, just wait until the nurse comes tonight at 7:00."

Anne was also privy to another medical emergency which may have been avoided had an inmate's medical requests been honored:

There was another girl in here about two weeks ago whose appendix burst. All night long she was crying and complaining to them, "My stomach hurts. My stomach hurts. I need to go to the infirmary. I need to see somebody." And they're just like "Eh, you're just whining 'cuz you ate too much or you're not eating enough or you're just nervous or whah, whah, whah." All night long, almost 12 hours, she cries and complains and yells at the main officer. They almost walked her down to H, like in solitary, because she wouldn't give up on how bad her stomach hurt. Morning comes around and one of the C.O.s that she knows from the outside . . . says, "I'll take you to the infirmary." She gets to the infirmary and they're like "Oh my gosh, your appendix burst!" They took her to the hospital. She was gone for two weeks . . . they just totally neglect people in here.

Given these conditions, many women expressed concern over the spread of disease within the jail. As Linda, a 35-year-old Black woman incarcerated for a parole violation, remarked, "It's like people been making me sick in here. I haven't been feeling too well." Similar concerns were shared with regard to more serious diseases, particularly hepatitis and HIV/AIDS. Anne expressed her concern over the predicament of her bunkmate:

It made me mad. I mean there's just like blood everywhere and I'm freaking out. That scares me, especially nowadays. I'm not saying that she has AIDS, but still there's that possibility. She could not know that she has AIDS. Even though I'm not in her cubicle, I'm right next door. Even though she didn't have a roommate I mean, still, she's bleeding. Get somebody in here. They hadn't even put a band-aid on her foot yet. She's walking around in a bloody sock. That's just not right to me. That's just not right at all.

A contentious duality exists between the availability of certain medical services, which were inaccessible outside of jail, and the overriding feeling that such services were inadequate and administered in unempathetic ways. The minimal and often times inaccessible provisions for

medical care to low income and incarcerated women, even for serious, chronic, and sometimes life-threatening ailments, demonstrates the difficulty marginalized women face in maintaining their health.

Pregnancy

Only one woman in our sample was pregnant at the time of the interviews; however, she along with others who knew expectant mothers serving time at Southwest Detention Center, were forthcoming with regard to the challenges, as well as some benefits, of being pregnant while in jail. Boo had been incarcerated on many occasions and had three children placed with relatives. She was five months into her pregnancy at the time of the interview. Boo felt that her incarceration was helpful because it forced her to stay away from drugs and enabled her to receive prenatal care and nutrition, which she would not have otherwise obtained:

I'm pregnant so this is my chance to get off of drugs. I'm kind of thankful for it, but then again, you know, who wants to get locked away? But it's nice, though. I mean, to me this is my home away from home, 'cause I don't have nobody on the outside. So, it's kind of hard for me, but then at the same time, I like it in here 'cause I get that special attention that I crave . . . I get taken care of in here very well. They give us three pregnancy bags a day, which contain two cartons of milk, two orange juices, and two fruits and you get three pills three times a day during breakfast, lunch, and dinner. If I get a little thirsty in between our lock downs, they let me get up and go get a juice, or eat one of my apples real quick. They're real considerate about things like that.

However, Boo admitted that being pregnant in jail resulted in increased surveillance and intervention by state authorities. She described the scrutiny she was under by child protective services due to her incarceration:

I'm a ward of the county, the state, for being locked up. They automatically get involved 'cause I have a baby . . . to see where I'm going to be staying and stuff like that. If the baby would be born on drugs the baby would be taken away from me that day and I would be put in jail for child abuse . . . abusing your child before it's even born . . . they can take your baby right on the spot and then you go to jail.

While the threat of intervention by child protective services was stressful in itself, even without CPS involvement women were unable to stay with their newborns for very long. This was not unique to Southwest Detention Center, however, as has been documented in prior studies (Owen, 1998; Ross, 1998). According to Tamara, it was fairly common to observe inmates leave the facility to deliver their babies and return a short time later without them:

There's one lady who had a baby in here. . . . They took her to go have the baby and then she came back. There's another pregnant girl in here right now and then there was one that came in and left. That lady was gone only about two days.

There was no indication that despite the circumstances, any celebration or support was offered to the women who had experienced what is for so many a momentous and life-altering event. In fact, Karen described an incident in which a pregnant inmate had been placed on lockdown in the

medical unit until she was ready to give birth. Staff were so slow to respond to her cries of pain that she nearly delivered twins without any medical assistance:

There was a girl that was locked up in the medical unit . . . you're not there because you're getting extra care. You're locked there because you're on the medical unit and you're locked there so they don't get a lawsuit or something. This girl went into labor and she was so scared and she screamed and cried and nobody came. Finally several of us started screaming and screaming and screaming until somebody responded because she was getting ready to deliver her babies, her twins, all alone.

Women requiring postpartum care fared worse and their physical problems were compounded by grief over immediate separation from their infants. Lisa, a 26-year-old Latina incarcerated for a probation violation, spent two days in the hospital after giving birth, then was placed in jail where she received no postpartum care and was required to work:

I wasn't even supposed to work, and they keep working me, but I don't argue with them 'cause they get mad. My doctor told me six weeks not to work, and I been bleedin' like a lot cause I had my baby and I been getting real bad headaches, like spinnin', and they got us workin' downtown, moppin' parking lots. We were there for four and a half hours today, moppin'. My back was hurtin'.

Hence, while some basic prenatal care was made available for pregnant women who would probably not otherwise have obtained proper medical attention, it was not without the cost of added state surveillance. Additionally, adequate care and support for those in labor and postpartum seemed to be a neglected aspect of the medical services.

Substance Abuse Treatment

Unlike the mostly negative comments offered with regard to medical care for physical conditions, the women's reactions to available substance abuse treatment in Southwest Detention Center were much more positive. Access to programs such as AA (Alcoholics Anonymous), NA (Narcotics Anonymous), and CA (Cocaine Anonymous) were open and did not appear to be impeded by correctional staff. In fact, the inmates were strongly encouraged to partake in such services, so much so that even those without an addiction were told by staff that they would benefit from the treatment. Overwhelmingly, however, most of the women (77%) we interviewed openly admitted to drug and alcohol addictions and actively sought treatment. Almost all of these women had committed crimes related to drugs or alcohol as well.

In particular, Marie, a white 27-year-old woman incarcerated for prostitution, which supported her crack and heroin addictions, found that the effectiveness of these services were enhanced because they took place inside the jail:

I'm taking advantage of the programs in here. I go to AA and NA . . . I like the AA meetings because they helped me when I got off drugs the first time. But in here, it's a lot different. The people in the circle are here. It's better. There are some hardcore addicts in here. They have hit rock bottom and they've hit rock bottom bein' here. So it's a lot more intense from the start.

On the other hand, women expressed concern that the self-help programs neither confronted the long-standing, serious problems which contributed to their drug use, such as abuse and mental illness, nor the drug-using milieu which awaited them upon release. The availability of long-term residential programming was severely limited, and some women were waiting in jail to gain access to a bed. Like physical health care, residential substance abuse treatment programs are available only to the wealthy and the court mandated.

T.T., a white 39-year-old woman, expressed gratitude for being able to access substance abuse treatment while incarcerated. While she had been sober for three and a half years and living in a residential treatment center prior to her incarceration, she was arrested for aggravated D.U.I. after causing an automobile accident. She explained that the incident occurred shortly after she had learned that the state was going to sever her parental rights to her children. Her narrative exemplified the complexity of many of the women's stories, which along with substance abuse, often included a history of domestic violence:

Due to my drinking, I lost my children last year . . . they've been sentenced to adoption. I have four younger and one older that they couldn't touch because he's 22. . . . Yeah, so from here I'm awaiting a bed space for residential treatment to continue not drinking. I've done pretty good now, 90 days so far. And usually your first 30 are your hardest days. I quit for three years, three and a half years . . . since 1995 . . . and then when they said severance and adoption, I slightly fell off the wagon. . . . They just brought up so many different things . . . they said we caused problems for the kids because of our arguments and our fighting and this and that. They bring up so many different things. . . .

Substance abuse, particularly illicit drugs, were also correlated with the dangers of homelessness. In fact, some women suggested that the conditions in which they were living were so desperate that having the opportunity to obtain substance abuse treatment in jail provided a much needed respite. As Linda remarked:

People on the streets, they say "Oh God, I can't take it no more," and then they come to jail and they wonder why they in jail. . . . Not always but most of the time I think jail is a safe haven for those who are about to kill themselves without even realizing it.

One woman even admitted to purposely failing a urine-analysis test in hopes of obtaining treatment:

When I wrote the judge I told him I dropped [tested positive] on purpose hoping to get help and I didn't. He said right there, six months in county jail or until rehab comes and gets me. He knows this is what I want. It's really what I want. I'm tired of this life I have. I really am. Being broke all the time . . . it gets old. I used to have nice things but once I started doing that crack, I lost everything. That crack is nothin' to mess with. I don't want to do it no more. That's why I say this is a blessing in disguise for me. [Gillian, 36, white, incarcerated for a probation violation involving drugs]

Indeed, for poor women desperate for help, arrest and a judge's mandate may be the only opportunity to obtain treatment. As T. T. stated, "When a judge requires a treatment center, the state does cover it." While not all went to such intentional lengths to access treatment, many still

hoped to continue with it once released if they could find a program that would accept them. Peaches, a 32-year-old Black woman incarcerated for prostitution, was very upfront about her need for continued treatment, and her alternatives if she did not receive it:

I'm hoping this is it for me. I feel like it is. I'm ready to go to a long-term treatment program because I know my crack addiction has taken a toll on me. I'm too old to be goin' through this again and again. I'm ready for it all to end. That's why I made the decision to go to treatment. Do my six months here and then go to long-term treatment . . . I'm hoping I don't have to go to the street. I'm hoping that I can go straight from here to treatment. I know if I don't I'll start usin' again. That's how strong my addiction problem is. . . . Matter of fact, I think it is the only option for me . . . if I chose drugs, that's death. I don't want to die doin' drugs.

Peaches' sentiments were indicative of the critical importance of long-term substance abuse treatment for some women. Since so many women come to jail or prison with substance abuse problems, frequently connected to the crime for which they are incarcerated, it is essential that treatment be made available which is specific to their needs (Henderson, 1998; Regier et al., 1990). However, it seemed that correctional staff and administrators assumed that all inmates could benefit from such services. Some women expressed concern that because of the lack of counseling services, all inmates were expected to attend and benefit from substance abuse programs even if these services did not fit their individual circumstances. Lonna, a white 31-year-old woman incarcerated for a probation violation involving welfare fraud, commented on this "one size fits all" approach:

Mostly everybody is in here because of drugs. I experimented in high school and stuff like that, but it's not an issue for me. I don't do drugs anymore. I hate to sit here and say "I don't do drugs" because everybody looks at you like, "Yeah, right. Everybody does them." I just can't see myself going to AA and CA but they just told me I have to. I have just totally different problems.

Thus, it would seem that diversification of substance abuse treatment would be beneficial for jail inmates, as would increased programming to address a variety of needs, such as support services for abuse and mental health treatment, which may be related to women's use of drugs as a form of self-medication or emotional escape (Shaw, 1992; Wan, 2001).

Psychological and Psychiatric Counseling

One way in which programming was diversified somewhat within Southwest Detention Center was through the use of counseling programs. The need was great for this type of service, as Angel, a 41-year-old Black woman awaiting sentencing for writing fraudulent checks, explained:

I see so many girls in here that don't need to be in prison. They need to be intensively in some sort of therapy. They've been so severely abused that their personality is just splintered . . . they don't even know who they are. They're just, they're not in touch with who they are. They're just shells of people. They need to be put back together before they can begin to be expected to understand any kind of responsibility or consequences.

Many women remarked that they had met with very understanding counselors and that efforts were made to address their common concerns, including violence in their homes and separation

from their children. The most prominent counseling service available was a program called PEP. PEP offered a range of supportive and self-awareness services, including domestic violence counseling, anger management, and support groups. The women reported watching videos during PEP, which they believed helped them to think through their own lives and circumstances within a supportive environment. Brina described some of the activities in PEP:

It's anger management. It's counseling, group counseling. They showed that movie about Tina Turner's life and the violence, *What's Love Got to Do With It*. Tomorrow, we're going to watch the second half of the movie *Isaiah*, which hits home for me because of losing my baby. I didn't necessary put her in a trashcan but the consequences are still the same. I think it is a good movie to show. It brings hope to the women in here who have maybe not put their children in a garbage can but have lost them to circumstances. It gives you hope that you can straighten yourself out. You can get everything rearranged and on the right track.

Several others commented on how helpful they found this more general form of counseling and support networking to be. For many, having the opportunity to participate in such a program was a unique experience, one which was not available to them outside of jail. As Lonna remarked, "While I'm here, I'm not going to make it a waste of time. I'm going to do what I can to get ahead."

Indeed, the women seemed to need and want as much of this type of supportive counseling as possible. Some who were relatively new to the facility or had not yet made use of the available services commented that participating in our study had been helpful. As Sherrie, a white 40-year-old woman awaiting sentencing for prostitution, remarked, "Yeah, I've got to get some of this stuff out. You know, you people are the first people I've talked to . . . I've told nobody any of this, you know, and it's hard." Sherrie continued to express her worry that if she did not start dealing with her emotions and anxiety properly, she would become seriously ill:

. . . and even right now it's just the bare surface, you know? If I start talking, I'm going to be like Humpty Dumpty. I'm going to fall and you ain't going to find all of those pieces. That's what I'm afraid of, that I'll lose it completely mentally, you know? It's going to take a lot.

Such concerns were coupled with the worries of what types of treatment would be available for more serious forms of mental illnesses both in and outside of the jail. Unfortunately, services for more severe mental problems that required extensive treatment and/or psychotropic drugs seemed to be lacking, similar to the way in which treatment for physical ailments was insufficient. Some women reported severe mental disorders that had gone untreated:

I'm manic-depressive. I need to be on meds. I've been in denial of that. Maybe I've been self-medicating with cocaine because it made me feel good. I was like, "I have energy. I can clean. I'm not depressed. I don't sleep all day." [Orca, 31, white, incarcerated for a probation violation involving drugs]

Another woman explained what she had heard about inmates who needed medication:

People have these medications in their purse. They come in here and they're telling the guards, "Hey, I need my medication. I'm supposed to take my medication." They give them the

runaround. They have to call the doctor and they have to get it okayed even though you have the prescription in your purse. The pills have your name on them. It doesn't matter. The guards don't okay them until the doctor says so. My attorney was telling me about this guy who was in here and needed his psych meds and it had been like 13, 12 days. It got to that point and he flipped out and physically assaulted a guard. They wanted to charge him with another charge when it's their fault he didn't get his psych meds. If he would have had his psych meds, he never would have flipped out. . . . For people with multiple personalities or other psychological problems, they won't give them their medicine, sometimes for the entire time they're in here. That's dangerous. They're in general population. [Brina]

It appeared as if the only time inmates were successful in receiving attention for their mental problems was after they threatened to commit suicide. As Orca explained, the institution's response to a suicide threat involved putting an inmate on "suicide watch," which was not helpful and, in fact, appeared to be abusive:

When I came here it was the second time I thought about suicide. Oh wow, after four days I was ready to just, "That's it, I'm hanging it up, I'm punching out." Then I heard about their suicide watch. "Nope, nope, I'm happier than a pig in shit." They chain you naked to a . . . [long pause as begins to cry]. Let's put it this way, I did it once and I won't tell anybody in here that I'm sad again. I won't cry in front of nobody because then they start watching you. Then they take you and put you in a holding cell that's smaller than this. There's a bunk in there and they chain you to it. They take away your clothes and your blanket, everything [crying harder]. You have nothing. You can't even get over to the toilet. If you have to go to the bathroom, you do it right there. I was on suicide watch for 48 hours. If I wasn't suicidal, that'll drive you to it.

Despite such drastic efforts to prevent women from hurting themselves, it appeared as if several women still successfully found ways to hurt and kill themselves. Even more telling, the inmates who described such incidents were adamant that most of the suicide victims had not come to the facility with serious or chronic mental illnesses, but rather had digressed mentally through the course of their stay. As Anne explained:

Three months ago a girl committed suicide in here . . . she hung herself with a sheet. She didn't come in here psycho or schizo. She didn't need to be put in the mental ward. She wasn't on any medication. She must have just been really depressed about . . . I think she got sentenced to prison for like two years or something. She took a sheet and went to the shower and hung herself from the stall.

Counseling and support are essential in jail settings and ought not be reserved only for the most serious and recognized ailments, as seemed to be the case for the woman Anne described (Steadman et al., 1991; Teplin et al., 1997). Rather than taking drastic preventative measures, as in the case of Orca, widely available support groups and individual therapy could do much to reduce the self-destructive ways in which inmates may deal with their stress and anxiety. As Boo explained, inmates try to help each other in order to prevent suicide attempts:

We clown a lot. We make each other laugh and stuff. Otherwise we'd be sitting in our rooms and we'd go crazy. That's why a lot of people do the things they do. I've seen a couple people hang themselves in here. I've seen people go crazy.

Angel took an even more pro-active approach to helping some of the other inmates because she saw the need for additional support services:

I've done a lot since I've been here. I taught a class . . . the counselor here is really, really good and she lets us do what we want to do in the group so now since I've taught the class, a couple of the other girls are putting together exercises and they're going to also get up and teach the class. You need to have something to do in here and there's not enough programs here.

Because of a counselor who was open to innovative programming, many of the women at Southwest Detention Center received support and counseling that they probably never would have otherwise received. As is the case with physical health care, mental health care is almost nonexistent for indigent women in Arizona. The state has been under federal court order since 1972 to provide adequate mental health services, but the various governors and legislatures have failed to provide the necessary funding.

CONCLUSION

The purpose of this article is to contribute to the small yet growing body of literature related specifically to female jail inmates. The value of this work may be found in what it contributes to our understanding of women's carceral experiences, the need for heightened and specific programming for female inmates in prisons as well as in jails, and the larger discussion of correctional philosophy and practice. While many topics could have been addressed in this regard (e.g., women's contacts with dependent children, carceral support groups, vocational training, religious freedom), we centered our attention here on jailed women's experiences with health care. It is within these types of services that the contentious duality between genuine care and concern and obvious disregard and disrespect is most obvious.

What we observed through our conversations with the women were the ways in which the culture and environment of the carceral setting mirror and exaggerate the deprivations and abuse which are part of so many women's lives outside of jail. As a location of the most extreme and explicit forms of social control, the experiences of women in jail may be best understood within the contexts of social marginalization, disempowerment, and oppression. Until greater attention is given to improving the economic and social positioning of the poorest women, as well as eradicating the sexist and racist social structures which contribute to their lot, improved jail programming will do little more than temporarily serve the most obvious and immediate needs of female inmates.

It is our hope that these findings are as helpful to others working in the correctional arena as they have been for us in our individual and collective attempts to facilitate greater discussion and action toward improving the current carceral conditions for women and men. Our most useful lessons may be learned from those on the inside. Women incarcerated at Southwest Detention Center described numerous ways in which they actively resisted their environments and supported one another. Many examples of humanitarianism and compassion may be taken from these women who under the most coercive of conditions, continue to speak up, act out, and

protect one another as best they can. Indeed, while many were thankful for the services they received, all were fully aware of how much more they deserved.

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