Access to Community Healthcare for Youth in the Juvenile Justice System: Initial Lessons From the Massachusetts Health Passport Project

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This article examines one aspect of women’s imprisonment that historically has received much scholarly attention, yet remains somewhat unclear: homosexuality. (For a comprehensive discussion of the history of lesbian activity in prison, see Freedman, 1996; Hensley, Tewksbury, and Koscheski, 2002.)

Studies indicate that few women who participate in same-sex relationships while in prison identified themselves as lesbians prior to incarceration, though statistics concerning the sexual orientation of women prior to incarceration are difficult to obtain. Indeed, none of the studies reviewed in this article included such information. Roughly 20% of incarcerated women are married and about 30% are separated or divorced. (Greenfeld and Snell, 1999.) Prior to incarceration, about 20% of women inmates resided with their spouses and children and an additional 19% lived with their spouses or boyfriends. (Owen and Bloom, 1995.)

Homosexuality in a women’s prison often is viewed as situational and largely attributed to the lack of male partners and other environmental factors. For example, early studies viewed same-sex relationships as a means of coping with the stresses and deprivations of the prison environment. (Gagnon and Simon, 1968; Ward and Kassebaum, 1964.) Indeed, prison life is stressful and maintaining a relationship with a spouse or significant other on the outside is difficult. According to Hairston, “Couples are usually denied sexual intimacy and are unable to engage in day-to-day interactions, experiences, and sharing that sustain marital and other intimate relationships.” (Hairston, 2003, at 270.) Most researchers suggest that women inmates for whom lesbian experiences are new will revert to heterosexual relationships after they are released. (Pollock, 2002; Watterson, 1996.)

More recent studies (e.g., Hensley et al., 2002; Watterson, 1996) suggest, however, that the issue of sexual identity among women who participate in same-sex relationships may be more complicated than previously believed. Interviews with prisoners provide at least some evidence that women may continue homosexual behavior upon release. (Watterson, 1996.) As Propper concludes, “Although inmates emphasize the temporary nature of their participation, what happens in reality is often different from what they expect.” (Propper, 1982, at 179.)

This paper will explore the nature of homosexual relationships in women’s prisons more fully, drawing from the research pertaining to imprisoned women’s sexuality and interviews with inmates concerning their attitudes toward and participation in this behavior. The intent

“Who Am I Now?”
Exploring Same-Sex Experiences Between Women in an Ohio Prison
by Theresa A. Severance, Ph.D.

This article examines one aspect of women’s imprisonment that historically has received much scholarly attention, yet remains somewhat unclear: homosexuality. (For a comprehensive discussion of the history of lesbian activity in prison, see Freedman, 1996; Hensley, Tewksbury, and Koscheski, 2002.)

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girls and boys in the juvenile justice system are experiencing gender-specific health challenges and therefore should have gender-responsive health interventions. (Acoca, 2000; Covington, 2007; Cauffman et al., 2007.) As they enter adolescence, boys' and girls' health needs increasingly diverge. This has been particularly well documented in relation to mental health and is true for girls and boys in the juvenile justice system. (Timmons-Mitchell et al., 1997; Cauffman et al., 2007.) As one example, whereas both adolescent girls and boys who enter the juvenile justice system appear more likely than teenagers in the general population to have engaged in early sexual activity, and both genders are more likely to become “teen parents,” young women experience more serious reproductive health issues, including elevated rates of many STDs, and, of course, only they become pregnant with all the attendant risks. (C. Gallagher, A. Dobrin, and A. Douds, 2007.) Many of the reproductive health issues facing these girls are highly correlated with sexual risk behaviors, substance abuse, school truancy, family violence, and trauma, including histories of sexual abuse, which are not addressed in the juvenile justice system. (S. Covington, 2007; P.J. Kelly et al., 2007.) Conversely, males are still at greater risk of violent death, especially correlated with handgun ownership and violence.

Mental Health Needs by Gender

The mental health needs of young men and women in the justice system have received recent attention. In her 2002 study, Teplin found that nearly two-thirds of males and three-quarters of females in the Cook County Juvenile Detention Center met criteria for two or more psychiatric disorders, primarily depression and anxiety disorders. (Teplin et al., 2002.) Mental health issues are linked to high rates of childhood trauma, family chaos, and residential instability. In her 2007 study, comparing mental health by gender across matched groups of community and detained youth, Cauffman found that detained girls externalize their problems as well. She found that detained girls are twice as likely as boys to behave in an angry and irritable manner and just as likely as boys to have problems with alcohol or drug use. (Cauffman et al., 2007.) In these girls, mental health issues (like physical health issues) are linked to high rates of childhood trauma, family chaos, and residential instability. The lack of family and community connection that drives so many youth into the juvenile justice system is also a central feature of the juvenile justice system itself.

Mental health issues are linked to high rates of childhood trauma, family chaos, and residential instability.
Honolulu’s Girls Court: Lessons Learned From a Process Evaluation
by Lisa Pasko, Ph.D., and Meda Chesney-Lind, Ph.D.

In Hawaii, girls comprise over 40% of all juvenile arrests, compared to only 29% nationally. While most of these arrests can be attributed to status offenses, girls also account for nearly a third of “other assaults” and “offenses against the family,” respectively, and 39% of juveniles arrested for drug possession. (Crime Prevention and Justice Assistance Division, Profile of the Female Juvenile Offender, 2006.) Girls also represent two-fifths of youth referred to family court, nearly one-third of all youth adjudicated as delinquent, two-fifths of juveniles on probation, over half of juveniles on protective supervision (for status offenses), and, on any given day, between 15% and 20% of the Hawaii Youth Correctional Facility population. (Crime Prevention and Justice Assistance Division, supra.) Because of these trends, the First Circuit Court (which serves the island of Oahu where Honolulu is located) initiated a specialized Girls Court—a laboratory to develop “gender specific” programming and address the special needs of adolescent girls in the judicial system. This essay describes the fundamentals of Girls Court, results from a two-year evaluation, and lessons learned in developing girl-sensitive programming.

Girls Court Program

Girls Court began in the fall of 2004 with a cohort of 10 adjudicated girls (all of whom were on probation or protective supervision), six probation officers who “volunteered” to be part of the program, and a part-time project coordinator. Generally the program works as follows: The girls attend hearings every five weeks for 12 months, where they appear with their parent(s) before the same “Girls Court” judge. With the prosecutor, their public defender, the probation officers, and the rest of their cohort looking on, the girls explain their behavior, problems, and accomplishments during the previous five weeks to the judge. They receive praise (personal congratulations from the judge, applause from onlookers) for their successes as well as consequences for their infractions (written assignments, apologies, enhanced curfews, extended protective supervision/probation, out of home placements, etc.). In addition to the hearings and throughout every month, the girls attend activities that include, but are not limited to, HIV/STD education, community service projects (such as cleaning and grooming dogs at a facility that trains the animals for the visually impaired and collecting money for Hawaii Food Bank), family events, and, in the beginning, Ocean Café (life skills training). During the girls’ post-court hearing activities, parents attend their own quasi-therapeutic group designed to address family problems and healthy parent-daughter relationships.

Starting with the second cohort (11 girls), the girls also attend group and individual therapy with the Girls Court’s therapist who specializes in girl-sensitive approaches. The girls do “Girl Circle” monthly; the format includes each girl taking turns talking and listening to one another respectfully about their respective concerns and interests at that moment in their lives. In a safe environment, the girls use role playing, drama, journaling, poetry, dance, drawing, collage, and other activities as a means of self expression. Staff (including the probation officers) introduce gender-specific topics which relate to the girls’ lives, such as being a girl, trusting themselves and friendships, developing healthy body images, setting goals, understanding healthy sexuality, understanding addiction, and learning skills to make good life decisions. In addition, girls who have histories of sexual abuse also receive group and individual therapy that address trauma issues. By the end of the cohort two, Girls Court staff included of a full-time project coordinator, two probation officers whose caseloads consist of only girls from the program, a part-time psychiatrist, and several volunteers who conduct the activities.

Evaluation Method

During the first year of Girls Court, the authors conducted a process evaluation of the problems and benefits emerging from the laboratory. Collecting and updating the girls’ arrest information, the authors also performed in-depth interviews with the probation officers, their supervisor, and the judge; a focus group with the girls; a focus group with the parents; and observations of the planning meetings as well as the court hearings. With the second cohort, the authors repeated this approach while also creating a comparison group of similarly situated female juvenile offenders who were not part of the program. The control group matched the cohort in terms of demographic characteristics, histories of abuse and neglect, drug addiction, family dynamics, and, for the most part, offense backgrounds. One key difference between the comparison group and the Girls Court cohort was that the comparison group did have one participant who had a child, while the second cohort of Girls Court included no girls with children. Additionally, the comparison group girls had more reports of violence and aggression, as evidenced by their arrests for assault and family abuse. While the comparison group was not a precise match to the Girls Court group, they did have one overall significant commonality: The majority of girls in the comparison group as well as Girls Court group had been chronic runaways, in and out of detention multiple times, with commitment to the correctional facility a distinct possibility in the future. All together, the comparison group had a history of 35 detention admits and 69 runaway arrests, spending nearly a year-and-a-half detained and over two years on the run. The cohort group had 115 runaway arrests and the same number of detentions, with total time spent in detention being roughly the same. Before Girls Court, the cohort group had collectively been on the run for 402 days.

Participants

In addition to these characteristics, the following was common to the first cohort

See GIRLS COURT, next page
and second cohort as well as the comparison group:

- Strained parental relationships;
- Lack of vocational goals;
- History of chronic status offending.

**“My self-esteem went way up and I set my standards way higher and I just wanted to move on.”**

particularly running away (80% of girls);
- History of psychological disorders and suicidal ideation (70%), with over half of the girls reporting past or recent suicide attempts;
- Academic failure (all girls);
- History of abuse, with roughly half having a history of sexual abuse;
- Reports of some type of drug abuse or experimentation (90%), with over three-fourths reporting crystal methamphetamine abuse;
- Unhealthy relationships with boyfriends/older men; and
- Negative peer group associations (all).

Nearly 90% were girls of color. In addition, if the girls did not have at least one parent/guardian active in their lives, they were ineligible for Girls Court. What is also important to note is that no solidified, formal selection criteria were stated in the planning stages; the volunteer probation officers (followed by the two dedicated ones) suggested girls for the program based on their high-risk behaviors and/or chronic runaway/detainments. At the end of the second cohort, Girls Court staff was in the process of incorporating formal eligibility and assessment tools.

**Positive Results**

In the 11 months following their participation in the program, arrests per first cohort participant decreased 79%. The data also indicate that the number of runaways dropped by 88%. Probation officers reported overall better school attendance and less drug and alcohol use. Similar success was reported during the second round. A comparison of the participant girls’ arrest and detention records during the first six months of Girls Court showed a two-thirds decrease in their arrests; runaway length time decreased by over 80%. In addition, detention admissions were cut by nearly four-fifths. In comparison, the control group girls’ arrests increased by 180%, with runaway arrests increasing by 350%. Detention admissions went up 100%; one girl was committed to the youth correctional facility as well. Runaway length time did decrease with the control group by 75%, however, and one girl was taken off probation because of her good performance. One caveat to the control/cohort comparison is that each group had a reduction by one girl in the final analysis. One girl designated to be part of Girls Court ran within the first weeks of the program and therefore was not given any services in order to be used in the comparison. One girl in the control group aged out of the system three months shy of the end of Girls Court; likewise, she was also removed.

**Marked Benefits, Positive Aspects.**

While these percentage improvements may not be surprising given the small number of girls in the program and in the control group, the interviews, focus groups, and observation data showed other marked benefits and positive aspects to the program. The first cohort of girls said that the main positive aspects for them included:

- Feeling connected to girls who had similar experiences;
- Getting off drugs;
- Staying away from unhealthy relationships;
- Feeling happier; and
- Appreciating that the court “might finally be on [their] side” instead of “always favoring the boys.”

One participant explained, “My self-esteem went way up and I set my standards way higher and I just wanted to move on.”

The second cohort of girls offered, if anything, even stronger comments on the positive aspects of the program. They also agreed that Girls Court helped them feel connected to girls who understood their experiences and a judge who believed in their success. For example:

“We don’t have to have that good girl look all the time. We can just be ourselves.” Another explained:

And, you know, like they keep saying “you’re a bright girl” and they keep saying that. I see a future now. I always knew I had a future and because of Girls Court, I feel a lot more positive.

Indeed, Girls Court became a mix of informal and formal social control that kept them from reoffending. As observed during a group session, one participant encouraged another cohort girl “not to run [from her new placement], Just don’t run. Give it a few weeks. Just try.” Other girls also responded about how running was not a good coping mechanism for her, because of consequences such as detention and because “judge, she’ll find out.” After three weeks, the participant said that if it were not for Girls Court, she would have run from her placement.

**Helped to See Future.** Some girls discussed how Girls Court “saved them” and helped them “to see a future.” One participant explained:

I have maybe something like 30 something arrests. My last judge told me the next time I get arrested, they’re going to hold me and send me to [correctional facility]...It (Girls Court) completely changed everything around.

All girls felt that Girls Court helped them to reconnect with school, which was key to investing in a future. As one girl stated:

Like there’s so much positive things. I was like a year behind in school, I’m like three credits away from getting caught up and graduating next year. I got a job. They just do so much encouraging things.

Other girls felt that Girls Court opened up experiences they would have never had:

So even with me, like, with me, like sometimes like I really like to write so they got me a scholarship from the [Honolulu] Advertiser and they sent me to a Pen Women thing. I got to meet an author, Maxine Hong Kingston. And I ate lunch with her. It was awesome. And then went to different conventions, writing conventions and stuff. Sometimes if you

See GIRLS COURT, page 94
Working With Incarcerated Mothers and Their Children

by Dee Ann Newell, M.A.

New York City, 1971

The first formerly incarcerated mothers I ever met were Naomi and Leuka, survivors of the Holocaust who had relocated to Washington Heights, an upper Manhattan neighborhood near the Cloisters. It was the summer of 1971, and Washington Heights was predominantly a German-Jewish community, home to many immigrants who had been traumatized by World War II and by their captivity in German concentration camps.

In the summer and fall of 1971, I was a research intern at Columbia University, where a double-blind study of the efficacy of lithium bicarbonate in the treatment of depressive and manic-depressive disorders was being conducted. Both Naomi and Leuka were participants, and because I knew a little German, I was designated to provide some social services to the two women.

This idea that I might provide any truly meaningful assistance to these women as they woke day after day to memories and trauma that confounded even the most perceptive aspects of my imagination, seemed both absurd and impossible. At the time, I was pregnant with my first child, I was only 25, and I was living on the edge of Washington Heights with my husband, a psychiatric resident. My education, it seemed, had trained me to process my patients’ experiences, and then to counsel and provide appropriate services, but I was left to wonder if my training, like my address, left me simply on the edge of this simultaneously collective and private trauma.

As our days together went by, I was profoundly moved by these two women, also mothers, who were now childless and without family. I thought often of the peculiar mark, though I was left to wonder how my connection to these two women would play itself out in my own adult life. Certainly I would never meet any other women who, denied dignity and humane treatment, would continue to value life.

New York City to Little Rock

In the early 1990s, I moved from New York City back to Little Rock, my hometown. In 1993, I volunteered to teach parenting classes to incarcerated women in Arkansas’ state prison for women, the McPherson Unit of the Arkansas Department of Correction, located in Newport. In 1998, I was asked by Warden James Cooksey to develop a prenatal and postpartum class for the increasing number of pregnant women in the prison, whereupon I requested the inclusion of men who had delivered within the last year. From 1998 until 2004, I participated in the Family Matters Program, a community of pregnant and post-delivery incarcerated women for an hour-and-a-half each week, 50 weeks a year.

We shared everything except the truly impressive portions of carbohydrates and grease that were delivered on plastic trays during our lunchtime class. The laughter and humor that the incarcerated women shared regarding the food was endearing, but the food was maddeningly unhealthy, especially given their pregnant condition. Equally frustrating was the fact that some of the pregnant mothers who had just entered the prison did not receive any prenatal vitamins for weeks or months. Most startling was the absence of a folic acid supplement, which is critically important for the health of both the mother and her child. As most of the women suffered from addiction, an illness that necessarily distracts one from attending to one’s own wellness, they had not been receiving prenatal services prior to their arrest. This delay in receipt of either vitamins or folic acid, compounded by the dangerous physical effects of the mother’s trauma upon incarceration, often worked to harm the unborn child.

Accommodations Withheld. Many of the prison’s policies appeared to purposefully withhold any pregnancy-specific accommodations until the last possible moment, and often this was too late to have any real effect on the health or comfort of either the mother or the child. For example, the policy of the prison was not to provide an extra one-inch sleeping pad until the last trimester, and often these were not forthcoming. Sleeping on a one-inch pad was difficult and painful for most of the pregnant women. Sometimes other women in the barracks would give up their only pad to the pregnant women.

I heard many stories of how the other women would protect their pregnant prison mates.

As the first members began to deliver their babies, they were, in many cases, appearing back in my prenatal class only two or three hours after their deliveries. Cramping, exhausted, hormonally zigzagging, and in great despair after being separated from their newborns, they still came to the class. Not surprisingly, they required immediate emotional and physical comfort, including massages, and desperately sought opportunities to describe their experiences. What they shared was difficult to hear and had little in common with my own childbirth experiences, or those I had witnessed years before as a Lamaze instructor.

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Sentenced to Hostile Childbirth. Here, in the first world at the end of the 20th century, were women who were forbidden any free movement during labor. Instead, they were handcuffed by one wrist and the opposite ankle was shackled. Iron tools of restriction, restraint, and oppression did not belong in anyone’s childbirth experience. Although attachment theory is not solely concerned with the immediate contact at birth, most mothers have vivid recollections of the first time they hold their newborns, nursing them, checking out all of their parts and features. When incarcerated, some states do not allow any contact between mothers and their infants after delivery; other states permit some time together, but mothers are usually restrained, either by the wrist or the ankle, or in two-point restraints.

After years of listening to my students’ painful recollections of this process, it was clear that none were allowed any semblance of a positive, meaningful birth experience. Instead, their childbirths wounded them, deepening their feelings of stigma and shame. Many of the mothers expressed a sense of being further devalued, and felt their babies had been devalued as well. Among the many questions raised here is one that addresses the philosophical and pragmatic goals that necessarily direct the course of legal decision-making. When we ask judges to weigh in during the sentencing stage of a case, what exactly are we asking of them? More to the point, are the sentencing judges also sentencing these women to a traumatic, hostile childbirth, one that can only negatively effect the health and well being of both mother and child? When a person is incarcerated do they deserve to lose all possession of the humanity, health, and dignity demanded by most of us at this stage in our civilization? And should those losses reverberate into the next generation?

Edith: A Story of Birth in Prison

What should have been the happiest day of my life was the worst.

-Otha, the first woman in the class to give birth, recalling the day of her delivery

How will I tell my child about his birth? Should I tell her I was in prison when she was born and had to go right back there? I did not get to nurse her. Do I tell her I took many deep breaths so I would know her smell? How was my baby ever to know me? Can I ever be a good mother with this hanging over us? These are questions I have heard repeated by every mother who has returned to the prison and our prenatal and postpartum class after childbirth. I am still in contact with many of these mothers, and, again and again, the same concerns persist.

Loss of First Child. Edith, a young, petite white woman, thin with brownish hair and hazel eyes, more reminiscent of a college freshman than a prisoner, was having her second baby while serving time in the state’s only women’s prison, a minimum- to maximum-security facility, for writing a hot check in the neighborhood of $4,000. It was her first offense, not simply her first felony. Her criminal judge, who also served as both the juvenile and family court judge for the county, sentenced her to 13 months “to make an example.” She had a 12-month old son and no family members to call upon, save the baby’s paternal grandparents. The judge denied her any visitation whatsoever with her baby, with the exception of so-called “phone visits.” Each collect call she made to the paternal grandparents was denied. She knew she had lost her son. The grandparents eventually acquired permanent guardianship over the child from the same judge, who again prohibited any visitation between the mother and the toddler. But for Edith, who was all the while pregnant with her second child, the struggle had just begun.

Edith was a small woman, seemingly carrying a smallish baby. She listened and learned all that she could from her childbirth education class. She had no family and was hoping that a church group would care for her baby until she was out. One day, I came to class to find her missing; she had gone into labor the evening before. Around 1:30 p.m., before our class had even ended, Edith returned. Just three hours earlier, at 10:30 that morning, she had given birth to a baby boy weighing over nine pounds. I was appalled, quite physically taken aback, not only by the fact of her being rushed back from the hospital, but by her shocking appearance.

She was ashen and cold, shaking as though she had just returned from a long journey. Her arm hurt, sometimes tingling, sometimes swelling up. A bandage covered where the IV had been. Her arm was missed by the hand that had been cuffed. She learned she had torn her rotator cuff in the left shoulder, which corresponded to the hand that had been cuffed. She recalled how she shook with cold, and remembered that all she had wanted during labor was to move around. But she had not been permitted to get up. Her arm hurt, sometimes tingling, sometimes cramping. She kept asking to have her arm released. The doctor and other medical staff also asked, but nothing changed until she had already entered the final stage of labor and delivery.

See INCARCERATED MOTHERS, page 96
Worth Reading  
by Russ Immarigeon

Value-Centered Circles

Building a Home for the Heart: Using Metaphors in Value-Centered Circles

by Patricia Thalhuber and Susan Thompson

In this welcome addition to the literature on “sentencing circles” and their offshoots, restorative justice practitioners Patricia Thalhuber and Susan Thompson report on their practice of using metaphors in value-centered circles they conducted over the course of the past decade at the Volunteers of America Regional Corrections Center, a women’s prison located in Roseville, MN. Building a Home for the Heart, which also serves as one of the metaphors explored in this practice-oriented volume, consists of two major parts.

In the first part, “Using Metaphors to Explore Values in Circles,” Thalhuber and Thompson offer concise and compelling reasons for the use of circles, and of restorative justice generally. (Author’s Note: Readers unfamiliar with the background, history, and roots of sentencing circles should consult the groundbreaking volume, Value-Centered Circles: From Crime to Community (Living Justice Press, 2003, $15.00), cowritten by Kay Pranis, Barry Stuart, and Barry Wedge.) I was especially struck by the authors’ challenging of contemporary punitive practices. Also helpful is their summary of the principles on which value-centered circles are based.

In the second section, “Sample Circle Formats,” the authors more explicitly examine a set of values, such as humility, patience, respect, and integrity, which were identified by the Roseville women. More specifically, Thalhuber and Thompson explore the women’s values through dialogue and images that focus on seasonal (and, indeed, monthly) changes that find metaphors that “spark their imaginations” and “go deeper into these values.”

For Thalhuber and Thompson, who began their collaboration while meeting at a domestic violence shelter, the use of metaphors is powerful. They observe: “Metaphors are powerful for good reason. They help us tap into powers that we all have for healing and transformation that surpass our trained intellects. When we are in conflict or pain, the best logic does very little to help. Deep, transformative shifts are far more likely to occur when someone shares a personal story or appeals to an image. If the metaphor fits, it takes hold of us, gives us a different perspective, and moves us to an inner place where change becomes possible.”

Thalhuber and Thompson argue that circle practices such as those described in this book are effective because, at least at the Roseville prison, they are used to focus on women’s emotions, feelings, and life experiences. The authors state:

Rather than talking directly about a crime that was committed, participants can use metaphors to represent situations—as well as their feelings about those situations—in nontreating, nonjudgmental, and nonaccusatory ways. A good metaphor leaves the door open for hope. The adversarial format that usually accompanies efforts to deal with harms is replaced by an inclusive format—one that invites people to draw upon the healing values inherent in reparation and resolution. Circle participants are more likely to feel that they are “all on the same side” in their search for truth, justice, and good. The natural result is that value-focused circles help unify rather than further separate already divided relationships.

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acknowledged that, like adult inmates, youth re-entering the community from the juvenile justice system have difficulty accessing healthcare. The social and financial costs of this lack of access are significant. These youth are likely to use emergency departments for routine healthcare; they are likely to postpone care, thereby aggravating routine health issues; and they are more likely to be reincarcerated. (Acoca, 2000; M. Moses and R.H. Potter, 2007.) From a public health perspective, without continuous healthcare these youth, who are at high risk for communicable diseases such as STDs, are likely to spread illness among their peers. (R.A. Gupta, K.J. Kelleher, and A. Cueller, 2005.)

Upon re-entering the community, pre-existing impediments to healthcare continue to work against access. Girls and boys re-entering the community are disadvantaged in accessing healthcare by family chaos, frequent residential transitions, poverty, race, and inconsistent parenting. In addition, they confront a range of impediments that are imposed by public and private systems. The physical and mental health needs of youth in the justice system are not sufficiently understood. There is no gender-specific, culturally competent health screen administered to all youth when they enter detention or residential placement. Juvenile systems are structured so that youth cycle in and out...
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out of detention, community, and placement, routinely disrupting community services including healthcare. Medical records do not follow the youth and no one person or agency is responsible for coordinating care. Youth do not have ongoing relationships with health clinics or doctors unless they develop them before they enter the system, and those pre-existing treatment relationships rarely continue through a youth’s time in the system, which is marked by frequent transitions. (Atkins et al., 1999; Soler, 2002; Sherman, 2005.) Pre-existing treatment relationships rarely continue through a youth’s time in the system, which is marked by frequent transitions. State and community-based agencies providing mental and physical health services, and funding for those services, tend to function independently from each other, juvenile courts, and youth services departments. Public funding for healthcare may not be available to some youth and many youth who are eligible for Medicaid due to family income, lose that eligibility when they are incarcerated and have difficulty regaining Medicaid services when they re-enter the community and once again become eligible. (S. Burrell and A. Bussiere, 2002; R. Gupta et al., 2005.) Finally, there is general mistrust of systems among delinquent youth. Many youth involved in the justice system, particularly young women with significant needs, run from the system, avoiding health (and other) services out of fear that healthcare providers are part of “one big system” which will incarcerate them. While a juvenile’s time within a facility is an important opportunity to provide healthcare, long-term positive health outcomes depend on consistent healthcare that moves with young women and men when they re-enter the community. Meaningful healthcare access must be continuous, coordinated, and lasting—linking youth to health homes in the community that will provide care to them and their children when they age out of the system and helping them acquire the skills to access that care for themselves in the community are required to report (as part of their juvenile parole). The nurse holds regular office hours and sees youth by appointment or drop-in. She provides minor medical care on-site, including pregnancy testing and reproductive health counseling for the girls. She is connected to the community health center remotely and helps youth identify a community health provider, make appointments, and keep those appointments. She makes every effort to support girls’ existing healthcare relationships and to respect family decisions about their children’s care. When needed, she attends health appointments with the girls, modeling how to access and manage healthcare, and connects the girls to health related community services such as counseling and home visiting for parenting teens. The MHPP nurse traverses the systems, quarterbacking care. She works with DYS, community healthcare providers, and families to ease youths’ healthcare transitions as they move in and out of placement.

The MHPP nurse has many roles. She serves as a direct service provider; active case manager; advocate within the justice system; health educator to the girls; health educator to justice system personnel; referral source; liaison between medical staff in lock-up, community justice staff, and healthcare centers; and community health advocate. (C. Miranda-Julian, R. Oliveri, and F. Jacobs, 2007.) In addition to the nurse, the MHPP relies on critical collaborations with juvenile justice agencies, healthcare providers, and philanthropy. These collaborators have participated in the MHPP advisory board, informed program planning, provided services to youth, technical support, and funding. The MHPP model does not create a new healthcare system, rather, it attempts to facilitate access across existing systems for youth whose personal circumstances provide significant impediments to continuity of care. (L. Jacobs and F. Jacobs, 2007.)

The MHPP program models are built through ongoing consultation with evaluators from Tufts University. Recognizing that program models must be tailored to the needs and demands of each site, before expansion to a new site or population the evaluation team conducts an assessment to determine how each

The physical and mental health needs of youth in the justice system are not sufficiently understood. There is no gender-specific, culturally competent health screen administered to all youth when they enter detention or residential placement.

The Massachusetts Health Passport Project

The Massachusetts Health Passport Program (MHPP) is an expansion of a pilot program that is facilitating continuous access to healthcare for girls (and now boys) in the juvenile justice system in Massachusetts. The project, which began in July 2004, is a collaboration among the Massachusetts Department of Youth Services, the Juvenile Rights Advocacy Project at Boston College Law School, and community health centers (Codman Square and Dorchester House in Boston and Great Brook Valley Health Center in Worcester).

The MHPP has four objectives, namely:

• Improving access to healthcare;
• Changing relevant systems;
• Improving youth’s social supports; and
• Improving health status.

Role of Nurse. Through grant funds, a nurse (RN or NP) is hired by a community health center. That nurse is placed in the community re-entry center where Massachusetts youth committed to the Department of Youth Services and living
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population of youth will best receive MHPP services. Evaluation research will allow the MHPP to better understand key aspects of health access significant to the health and juvenile justice fields in and beyond Massachusetts.

**Evaluation Goals.** Some of the questions MHPP evaluators hope to address are the following:

- What are the similarities and differences between the core needs and preferences for healthcare among system involved boys and girls?
- What are the processes by which various versions of the MHPP are delivered in different contexts?
- Within the MHPP communities, what factors (e.g., race, culture, ethnicity, family, involvement, geography, living situation) appear to or are reported to influence girls’ utilization of healthcare services?

Through our experience and research on best practices in correctional health (R. Oliveri and F. Jacobs, 2007; View Associates, 2006) a set of core program elements is emerging, namely:

- Nurse or NP with connections to local health resources based at a community center frequented by justice system youth;
- Nurse or NP employed by local community health center or hospital, not youth services department;
- Culturally and gender-competent providers;
- Parents and families actively incorporated in health education and care;
- Ongoing communication between the youth services department medical services (inside facilities) and community health providers, through all residential transitions during the duration of the program;
- Enrolling youth as soon after commitment to the juvenile justice system as possible;
- Partnerships with local health and service providers to build local supports;
- Training in health and health access issues for youth services and social services’ staff;
- Health education for youth; and

- Proactive, preventative approach to healthcare.

**Policy and Program Issues**

**Healthcare Funding.** Providing seamless Medicaid coverage for youth in the justice system and expanding that coverage to include case management services are important to providing continuous healthcare access to this population. Massachusetts is farther along in this than the vast majority of states, providing categorical Medicaid eligibility to youth committed to the juvenile justice system. Under the federal inmate exclusion rule, which denies coverage to anyone who is an “inmate of a public institution,” Medicaid does not support healthcare while youth are incarcerated or detained in the juvenile justice system in Massachusetts or elsewhere. However, youth in Massachusetts regain Medicaid services immediately upon re-entry into the community. This is not so in most other states where youth in the juvenile justice system are Medicaid eligible only if they are income eligible. Typically, these youth not only lose services when they are incarcerated or detained, but in some cases they lose eligibility or have their eligibility suspended, resulting in a delay in the resumption of benefits when they re-enter the community. That delay is either because the youth is not aware of his or her eligibility, does not know how to apply for Medicaid, or because the process of applying takes time. This gap leaves many eligible youth without Medicaid services during their critical transition into the community. (S. Burrell and A. Bussiere, 2002; Gupta et al., 2005; M. Moses and H. Potter, 2007.)

Even when Medicaid benefits are available, case management services such as those provided under the MHPP model are often not explicitly covered by state plans. Expanding Medicaid coverage to explicitly include case management for this population is critical for continuity and coordination of care. Legal strategies to access funding under Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions may be useful here. One promising example is the case of Rosie D. v. Romney, which held that Massachusetts violated the Medicaid Act by failing to offer adequate assessments, service coordination, and in-home behavioral health services to children with serious emotional disturbances (SED) who were entitled to community based health services under Medicaid’s EPSDT, “reasonable promptness,” and “equal access” provisions. (Rosie D. v. Romney, 410 F. Supp. 2d 18 (2006).) The remedial plan ordered by the court in July 2007 mandates extensive care coordination for SED youth receiving behavioral health services in the community.

Both the inmate exclusion rule and Medicaid’s EPSDT provisions suggest advocacy strategies to promote community healthcare access for girls and boys in the juvenile justice system. Youth in the juvenile justice system who live in the community (i.e., at home, in foster care, or in group care) as a disposition or while on probation or parole are not excluded from Medicaid services under the inmate exclusion rule and, if otherwise eligible for Medicaid, remain entitled to those services. In light of this, and in light of the high public health costs to interrupted healthcare, courts should be encouraged to order dispositions that maintain youth in the community with Medicaid services intact. Moreover, in cases of youth in the juvenile justice system with SED (which is likely to include many girls in the juvenile justice system), advocates and courts should develop plans for community behavioral health services rather than detaining or incarcerating girls in the hope that they will receive behavioral healthcare from within the justice system.

**Gender-Responsive Service Delivery.** There are important gender differences in the health needs, help-seeking behaviors, healthcare utilization, and types of health services available to system-involved girls and boys. An effective health access program must be responsive to these differences, which are documented in the literature and in the MHPP evaluation. (R. Oliveri and F. Jacobs, 2007.) For example, the evaluation found that there was a lack of health education and services for boys related to reproduction, sexuality, and parenting, while these services were present for girls. The evaluators also found that boys in the justice system were more likely to let their injuries remain untreated longer than girls, reportedly because they feel they are able to take care of themselves without
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the help of others to a greater extent than did their female peers. While living in the community, girls saw health providers more frequently than boys did, perhaps due to routine gynecological visits or perhaps due to their reported interest in developing relationships with healthcare providers. (R. Oliveri and F. Jacobs, 2007.) These differences underscore the need to tailor the health access program to each gender and within each gender, to the race and culture of participating youth.

Medical Consent and Confidentiality.

For the most part, statutes and regulations governing consent to medical treatment for minors in state care and custody vary by state and may not explicitly cover all the situations that arise in providing healthcare to these youth. It is critical that everyone involved in the healthcare of youth in the justice system understand the state laws of medical consent.

Despite conventional assumptions, there are many situations in which teens can consent to their own medical treatment without a parent. For example, in many states teens can consent to testing and treatment for specific communicable diseases and girls are able consent to testing for pregnancy and STDs as well as reproductive health counseling. Moreover, juvenile justice systems, which typically do not have legal custody of youth when they are in the community (even when those youth are committed to their care and on parole in the community), are likely not to have authority to consent to the adolescent’s medical treatment. That authority probably remains with parents or the youth themselves. Different rules may apply to youth in child welfare systems (through abuse and neglect petitions) because they are more likely to be in the legal custody of the state agency.

Health access programs must fully understand state laws governing medical consent.

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Health access programs must fully understand state laws governing medical consent. Like MHPP, which seek to build girls and boys’ autonomy as healthcare consumers and improve their family and other social supports, must fully understand state laws governing medical consent. That information should be readily available to justice system personnel and health centers working with these youth and to the youth themselves. (Sherman, DeMarco, Fears, and Renwick 2006; L. Rosado, 2006.) While it is often preferable to seek parental consent and fully involve parents in their child’s care, health access programs should not assume parental consent is needed in all cases and should consider the youth’s preferences in making decisions about whose consent to seek.

Similarly, laws relating to confidentiality of medical, mental health, and justice system information become important when coordinating care across juvenile justice and community healthcare systems. While detailed discussion of these laws is beyond the scope of this article, some basics are useful. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing confidentiality of health information through extensive regulations. (45 C.F.R. parts 160 and 164.) Entities covered under HIPAA include health plans and healthcare providers. HIPAA defines protected health information and only allows covered entities to disclose that information in certain situations. For example, covered information may be disclosed with the covered individuals’ consent or for treatment, which includes coordination and management of healthcare. (L. Rosado, 2006.) When minors are “individuals” under HIPAA, whether state agencies have authority to consent to the release of a minor’s protected health information and whether juvenile justice agencies are HIPAA providers will depend on the particular situation and are all issues beyond the scope of this discussion, but are important to designing and delivering coordinated care and must be addressed by health access projects.

Public Health Imperative

Case law and standards proscribe the minimum level of care required for girls and boys in the juvenile justice system as they do for adults in the correctional system. Yet that minimum standard is often not met. In order to reduce future health costs and prevent a public health crisis as these youth re-enter the community, have children, and become adults, more than the minimum is required. Providing continuous and coordinated healthcare to girls and boys in the justice system, from incarceration or detention through re-entry into the community and until youth age out of the system, requires intentional collaboration among juvenile justice agencies and community health providers as well as case management across these systems. The MHPP is one example of a program designed to coordinate care. However, any health access program for youth in the juvenile justice system must be tailored to the system context. The health needs and preferences of youth in the juvenile justice system vary by gender and probably by race, culture, ethnicity, and family involvement. To be effective, health access projects must respond to those needs and preferences. Providing continuous, coordinated care to this high-risk population when they re-enter the community is a public health imperative.

References


See HEALTHCARE, next page
The slang used to describe homosexual behavior, moreover, may be used and interpreted differently by those inside and outside prisons.

Categories of Activity. Relationships and sexual activity among incarcerated women is complicated because female prisoners identify a number of categories of homosexual activity. To the uninitiated the differences may seem quite subtle. Giallombardo notes:

The inmates apply a number of labels to homosexual behavior in the prison depending upon the specific role assumed, the adeptness with which the assumed role is played, or the motivation for the behavior. (Giallombardo, 1966, at 281.)

For example, distinctions are made as to whether the individual has her first homosexual experience in prison ("the jailhouse turnout") or whether she engaged in homosexual experiences in the free world ("the lesbian"). "True" lesbians may be viewed more negatively than jailhouse turnouts because this may be considered a choice rather than behavior motivated by lack of other options.

Motives for Relationships. Although some homosexual relationships among prisoners may arise from being deprived of heterosexual relationships (Gagnon and Simon, 1968; Watterson, 1996), many scholars believe sexual contact is less important than the emotional benefits, such as belonging, trust, and companionship. (Giallombardo, 1966; Owen, 1998.) Greer’s (2000) study, however, raises questions concerning romance as a basis for sexual relationships between imprisoned women. She identifies several alternative motives including loneliness, economic motivation, curiosity, and peer pressure and suggests the nature of interpersonal relationships among women inmates may be changing due to the "diversity of persons being committed to correctional institutions, as well as the move way from rehabilitation toward a more custodial function for prisons." (Greer, 2000, at 461.)
Many incarcerated women continue to be rather traditional in their gender role beliefs and much of their self-worth and coping revolves around their relationships.
feeling down and low. Know what I’m sayin'? Pick me back up.” She said she did not plan to continue the relationship after her release because she had a boyfriend and kids at home, though she conceded that it would hurt to leave her girlfriend behind.

Confusion About Involvement. Some women claimed they participated in same-sex relationships due to a combination of loneliness, boredom, and curiosity, but others were unsure about why they first became involved. Even positive experiences can be confusing for women trying to make sense of their own behavior and its impact on their sexual identity. This confusion was evident in their comments, such as “I’ve been going through an identity crisis here lately. Because I’m like, ‘Who am I now? What am I now?’ and ‘God brought me into this world for a man, not a woman.’ But then I ask God, ‘Why am I doing this? Why am I feeling this towards this woman?’ I haven’t figured that out yet.” The following account details one inmate’s struggle to understand her experience:

I discovered my sexuality in here. I’m still not comfortable saying I am gay, because I really don’t know for sure. I really don’t know, but I got a relationship with a woman here and I’ve been in it for seven years. I celebrate anniversaries with this woman. I go through emotional changes with this woman. I’ve had sex with this woman. I’ve pretty much done everything with this woman that I’ve done with a man except experience it outside. I had never done this before… I really don’t know if I’m gay. I will tell you this much, I am not attracted to all women. I still find men attractive, but my husband is dead…I really don’t know about that part of it…I know I’m not looking for a man to prove I’m not gay and I’m not running home to no female to prove I am…I just like this one person.

Coming Out to Family, Friends. Arguably, “coming out” to family and friends might be an indication of the sincerity with which the women might be pursuing or committing to these relationships. The extent to which inmates had discussed their relationships with loved ones back home varied. One inmate had been selective in her sharing, telling her friends, but not family: “How can I tell my son this? I don’t know… I know my son doesn’t ever want me to get with a man who’s gonna lead me back into crime, but I don’t know.”

The reactions they received from loved ones also differed, from shock and condemnation to acceptance and support. One inmate reported that her parents had surprised her with their reactions:

I ended up telling my dad about it. He asked me why I wasn’t in Merit [honor housing] and I told him I got in trouble. See, I got caught. I didn’t go to jail [solitary confinement] or nothing, but my roommate told staff…I told him I got caught messing with one of these girls in here and he was like, “What?,” so I told him about it…He was so understanding. He said it was okay and that he understood. He asked me if I was in love and I said no. He said, “If you fall in love, tell me that too. It’s okay.”…I told my mom about her too. She was like, “Oh…” She decided that she would deal with it too. She asked for a picture of her and asked me to have the girl write her a letter, so I did that. [My parents] are both trying to be understanding because they don’t want to lose me and I know that.

Impact of Release on Relationship. When asked about how release from prison might impact an ongoing relationship, the responses were generally discouraging. Factors which might influence intentions and ability to maintain ties to a girlfriend included sentence length and whether the inmate was leaving before or after her partner. Maintaining a relationship with someone who had many years left in her sentence was commonly believed to be difficult, despite the best intentions:

We talk about [my release] all the time. I been around some years and I’ve seen so many people leave and they don’t ever write or nothing. I know how resilient she is. I know she gets crushed and stuff when they don’t write and people lie all the time to her and then they come back and she’s real giving…So we talk about that and she’s pretty much like, “You got to get you a job. You got things to do. You go get a job and once you get a handle on it and you get a phone, I’ll call on the weekends.” We try to build this little plan, but things are going to happen. I don’t know, but we talk about it.

Complexity of Motivations, Unresolved Issues Compound Problems

Though prison policies forbid any sexual activity between prisoners and same-sex relationships are accorded no formal recognition, clearly some women still engage in these behaviors. Both staff and prisoners recognize and admit that sexual activity and close relationships between women exist, but the number of women involved and the extent to which such behavior is either accepted or admonished differs considerably. The findings in the current study are similar in this respect to previous reports of sexuality in women’s prisons. (Greer, 2000; Owen, 1999.)

While same-sex relationships between incarcerated women are assumed to be situational, accounts of individuals in this study highlight the complexities of sexual orientation and identity. Several women who had participated in same-sex relationships expressed uncertainty and confusion about their sexual identities and the impact these experiences would have on future relationships—not only with significant others, but with children and family as well. Considering that most of these women are mothers, the long-term implications postrelease could be far-reaching. Indeed, Watterson notes:

When women consider getting out of prison—integrating themselves back into a heterosexual world—they almost have to choose between worlds: the insular world they’ve lived in for months or years, or the world outside. Leaving any role or fantasy behind is a hard thing to do. But perhaps even more painful and confusing is figuring out what’s real about yourself—what part is you and what part isn’t…Women who have adjusted to prison relationships often have no idea of the
obstacles they’re facing when they get out and try to establish new relationships. The complexity of motivations and the surfacing of old, unresolved issues in a woman’s life only compound her problems.

(Watterson, 1996, at 306.)

Despite the potential significance of sexual identity and associated relationship issues on postrelease adjustment, the few studies (e.g., Dodge and Pogrebin, 2001; O’Brien, 2001) that have explored women’s transition from prison do not address this issue. The current study underscores the need to examine and respond to sexual identity issues among women prisoners more thoroughly. Programs should be developed and counseling available to assist women in dealing with such matters, both emotionally and psychologically.

Though postrelease ties between prisoners have traditionally been discouraged (e.g., as a condition of parole), the support provided by others may influence self-esteem and other self-processes relevant to postrelease behavior, including recidivism. Thus, the long-term impact of intimate relationships between prisoners deserves further exploration. Finally, very little is known about postrelease experiences in general and even less attention has been given to sexual identity, which has implications for both theory and practice.

While many women talked about expectations and concerns about release with respect to their relationships with other women, the reality of the postrelease experiences remains unseen.

References


My daughter actually cares if she disappoints judge. It’s like she’s afraid to disappoint her. She don’t care if she disappoints me at the moment but I mean, as for judge, yeah.

All parents also stated that finding connection to other parents, getting support when previously they felt as if they were all alone, and experiencing improved relationships with their daughters and fewer runaways were positive results of Girls Court. For example: “I feel like I have backup or I feel connected. I feel more connected to the other parents here and the girls.”

Staff Impressions. Girls Court staff’s general impressions of the program concurred with the parents’ opinions. Staff stated it was a stabilizing feature in the girls’ lives and that it has helped to reduce the number of runaways and incorrigibility:

I think runaways and beyond parental controls have been minimized. Girls Court appears as a stabilizing factor in the household. Parents are appreciative of just having someone to turn to.

Staff also felt the girls improved and learned something about themselves in the court hearings and group activities. Girls Court motivated the girls to “get out of their comfort zone.” The probation officers also felt that having the judge as a consistent mix of formal court authority and maternal nurturing was a very good feature of Girls Court. Additionally, one positive unintended consequence of Girls Court had been the strengthening of
of relationships and bonding among the probation officers: “POs have bonded during the experience.” “All the POs are supportive of each other.”

Obstacles and Issues to Overcome

Despite these positive results, the evaluation yielded several important lessons in developing this specialized court. First, the lack of a step-down component, firmly stated graduation requirements, and aftercare left some participants and parents feeling frustrated about the direction and long-term impact of the program. As one participant explained, “I want to know how to get out, you know? Right now it just seems like we’re going to be in here forever.” Other girls stated that they felt that a primary part of the program was greater surveillance and policing and not enough rewards or benefits for successfully completing program goals: “Yeah, it’s not really rewarding or anything. They’re saying if you do this, we’ll give you more consequences.” While the girls in the cohort groups and the control group were similarly situated for the most part, the lack of formal selection criteria created some difficulty in finding the best control group for comparison and ensuring adequate treatment goals and appropriateness for participation. Another issue that emerged was that many parents felt their mandatory participation was burdensome at times; the time-consuming nature created conflict with work and other schedules: “Sometimes it’s hard to do my job. Once a month is really hard because I’m a single parent, too.” In order to attend court hearings, participate in their own group sessions as well as some activities, and transport their daughters to their own group sessions as well as some activities, and transport their daughters to their mandatory participation was burdensome at times; the time-consuming nature created conflict with work and other schedules: “Sometimes it’s hard to do my job. Once a month is really hard because I’m a single parent, too.” In order to attend court hearings, participate in their own group sessions as well as some activities, and transport their daughters to court hearings, participate in their own group sessions as well as some activities, and transport their daughters to their own group sessions as well as some activities, and transport their daughters to

Lessons From the Laboratory

Based on the modest statistical data and the interview/focus group results, Girls Court appears to be a promising specialized court. However, several key issues did arise and serve as valuable lessons for other such girl-sensitive initiatives. This essay concludes with the following list of needed components for a successful Girls Court:

- Firm assessment and selection criteria that ensure girls’ appropriateness for the program as well as accuracy in matching a control group;
- Education of staff on girl offender issues;
- True willingness of staff and supportive administration to be part of a girl-only initiative;
- A consistent judge who will invest in the girls’ lives and use a mix of nurturing encouragement and formal authority;
- A strong focus on education, employment, and healthy relationships;
- Clear expectations and goals for each activity;
- Separate therapy for sex abuse survivors;
- Girl-focused drug treatment;
- Firm role definitions for probation officers;
- Solidified step-down and aftercare components;
- Clear graduation goals;
- Greater sensitivity toward the time-consuming nature of the program;
- A balance of rewards and legal consequences, treatment benefits with the (most likely increased) surveillance of the girls; and
- Expansion of the program to girls who do not have an active parent.
In May 2006, having served parents in the state prisons and community correction therapeutic units since 1993, I received a call from the chairman of the department of correction. It was an intimidating voice on the phone, a stranger’s voice. He chastised me for speaking to the press in 2004 and 2006 about the department’s use of restraints during childbirth. He informed me that I had “disrespected” the department, and I have never since been permitted to return to their prisons. Needless to say, both the parenting and the prenatal and postpartum classes came to abrupt end.

Currently, there are only three states that outlaw the use of restraints during incarcerated childbirth: California, Illinois, and New York. A national coalition is rapidly developing to support policies protecting pregnant and birthing mothers who are incarcerated. The shared mission will be the education of policymakers. Hopefully, this will lead to the swift enactment of statutes universally prohibiting the use of restraints during childbirth while incarcerated. Laws are the only effective way to assure that all incarcerated mothers and their babies will be allowed safe, dignified childbirth experiences.

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**Laws Only Effective Way to Insure Dignified Childbirth**

When her son was brought to her after delivery, she was again under two-point restraints, her wrist above her head and the opposite ankle shackled to the bed. Not surprisingly, this made holding her baby quite precarious. And since neither family nor friends are allowed to visit the new mothers from the prison, Edith was alone with her new son, and fearful of dropping him. She repeatedly asked the officer to release her wrist, suggesting that handcuffing her wrist to the bedrails at waist-level would make her less afraid of dropping her baby. In the class, she reported recurring nightmares where she drops the newborn.

Today, she is reunited with her prison-born son, while never regaining custody of her firstborn. She calls me sometimes, worried about her lack of emotional connection to this son. She has had a third baby, and compares her feelings of intimacy with the new baby, worried that she and her three-year old son are not adequately attached because of their separation just after birth. The question is a nagging one: Is this child potentially more at-risk because the mother and child were separated just after birth, damaging the attachment process?

This description of feeling distant from their prison-born babies is repeated by other mothers with whom I have been in touch after their release. They request professional support to cope with the guilt, shame, and memory of having had the child while imprisoned, and the added trauma of being under the shackles and restraints.

**-Incarcerated Mothers, from page 86**