Women in Prisons: Healthcare Injustices and Violations
Final Paper

Caroline Schiavo
PLSC/WGSS 379: Gender, Politics, and Prisons
April 20, 2020

In the last few decades, the number of women incarcerated in United States prisons has grown at an alarming rate. According to The Sentencing Project, “Between 1980 and 2017, the number of incarcerated women increased by more than 750%, rising from 26,378 in 1980 to 225,060 in 2017” (The Sentencing Project 2019). This mass incarceration of women correlates to an increase in healthcare needs for female prisons, which is inadequate and unmet with quality health. To offset overcrowding, private companies are leased to provide healthcare services, but this guise results only in profits, not better health. In fact, “former inmates from the Women's Huron Valley Correctional Facility [in Michigan] confirm . . . that access to healthcare was so nonexistent that it was known as ‘“deathcare”’ among the inmates” (Ziazadeh 2019). Incarcerated women require a wide-range of medical services; this paper will focus on the lack of health services for those with substance abuse, mental health, family planning and pregnancy while in prison and post-release transition to community medical services. In this paper, I will explore women in prison as vulnerable populations that are victimized and neglected, with barriers and obstacles to expansive healthcare services and a lack of continuity of medical care after release, violating health and human rights.

I will begin with a discussion of the socio-economic background of women in prison, which tends to be higher for marginalized populations, high-school drop-outs, and those of low-income status before incarceration. These minority women are overrepresented in the prison population and their prior experience with healthcare disparities makes their need for medical care even more chronic, while in prison. In addition, female inmates’ physical, mental, and sexual health is subject to abuse, violations, and punishment as “the patriarchal pattern of social control [is taken] to absurd lengths . . . as it reflects the belief that women should conform to gender-based stereotypes stressing obedience, dependence, and deference” (Marlow 2004, 40).

These efforts towards female prisoners to have them confirm to traditional roles endangers their health and safety offering no recourse, as the offenders are the very same correction officers intended to protect. While these gender non-conforming women are subject to cruel, but not so unusual, punishment, the process provides no protection for those identifying as lesbians, trans, non-binary. The poor, as they "are more likely than the general population to experience multiple forms of violence across the life span [in prison]" and are less likely to receive adequate medical attention. (Sevelius and Jenness 2017, 32). Gender disparities in the treatment of women in prisons differs drastically to males, where women are often victimized and expected to behave according to a higher standard than males and are provided with gender-neutral policies and procedures. While the general public's understanding of justice is to imprison criminals, the reality is that women in prisons are disruptive to the best interests of communities and cause intergenerational trauma. Women incarcerated in the United States undergo institutional racism, socio-economic exploitation, gender oppression, social inequality, and systemic injustices, and violations of human rights that are unchecked and norms in prisons. Incarcerated women and gender minorities face barriers to medical access and delivery, resulting in detrimental health.

Inadequate healthcare in prisons is not a new phenomenon; it has plagued prisons for decades starting with the overcrowding of public prisons due to unprecedented drug convictions, as a result of the War on Drugs. The overcriminalization for the use of marijuana disrupted minority populations, with a rapid rise in incarcerations for nonviolent "drug offenses which makeup 37% of the total crimes committed by women, second only to property felonies" (Weatherhead 2003, 430). These drug arrests resulted in incarcerated women offenders, many of whom were drug addicts, "who were vilified by politicians and media outlets as '"crack whores'" and '"welfare queens,'" in need of rehabilitative services, racially stereotyped as black

and '"diseased,"' as Jill McCorkel reveals in her four years of research at East State Women's Correctional Institution (McCorkel 2013, xi). While the Prison Services Company was brought into East State Women's Correctional Institution to "aim to provide health care and related services," it was ineffective, with no accountability, originally paid by grant money as a trial and later contracted by the Department of Correction (44). According to the Project Habilitate Women (PHW), "which the Prison Services Company instituted, to address the drug addiction of the female prison population, was a pharmacological and therapeutic model which was tough, controversial, and punitive" intended to rehabilitate women prisoners with substance abuse challenges. However, it was simply a response to the public prison resource crisis, segregating females (58-9). This practice of private contracting out the problem of women inmates made women literally and metaphorically invisible and left behind, with no healthy remedy. The Department of Correction simply re-branded public prisons to rid them of overcrowding, not to provide much-needed health services.

Women were categorized as "good girls" and "criminal girls," where counselors tried to breakdown the self with confrontational and "abusive disciplinary measures like having to scrub the floors with a toothbrush", yelling deprecating statements (72). With stark racial and gender divides, the health of women inmates is constantly in jeopardy. According to Jill McCorkel's Breaking Women:

> Amid a number of sensational, unfounded rumors about disciplinary practices in PHW, a few prominent and influential staff members questioned the legitimacy of the program and charged PHW with engaging in coercive punishment practices in the name of therapy. The most inflammatory and widely circulated rumors were that prisoners in PHW were made to get on the hands and knees and bark like dogs for medication, and that to punish certain prisoners, counselors shackled them to their beds at night. Neither rumor was true, and the latter was completely implausible given that PHW counselors did not have access to shackles, handcuffs, or any other restraint devices. Nonetheless, the persistence of these and similar rumors reflected the level of anxiety among both staff and inmates in relation to a changing control structure with the prison. (85)

Although these rumors were unfounded, the social, health, and safety injustice existed for white and black female inmates, but “PHW counselors reserved some of their harshest criticisms for heterosexual women who had sexual relations with other women during their incarceration” and were told that their desires and feelings were unauthentic and were inconsistent with being a real woman, making them feel less human and unimportant (137). Counselors routinely denied the feelings of all inmates, causing guilt and an inferiority complex by persisting that character was to blame for their predicament. This is the opposite of what inmates need to overcome drug addiction. They needed time to heal, appropriate therapy, and restorative programs. This confrontational and drug treatment therapy was inadequate and futile with woman inmates, who wanted to be released from PHW, as it reminded many inmates that were previous victims of physical abuse, that they continued to be victimized. Making matters worse, PHW’s “claim to provide treatment that is ‘“culturally sensitive”’ and ‘“gender specific,”’ contradicts PHW’s director that states, “therapeutic communities are the most effective way to treat addiction, [as] . . . these techniques were originally designed ‘“by and for men”’ (91). This juxtaposition in PHW claims demonstrates the insensitivity of public and private prisons, in that the program reinforced racial and gender stereotypes. This drug treatment program was unjust, unhealthy, and did not reduce recidivism. It did not prepare inmates for release to their community. Programs like this one relegates a public obligation to support women prisoners to private prison programs. PHW endangers female prisoners because its abusive and harmful practices lead to high recidivism rates, leaving them incapable of an independent and crime-free life.

Not only are women inmates often drug addicts, many of them suffer mental illness which is under-resourced while in prison and after release in the community. Mental illness combined with drug addiction is often referred to as co-occurring disorders, and it is reported

‘“to be common practice in correctional institutions to give medication without psychotherapy and to medicate inmates for minor psychosomatic complaints or as a cure for behavior problems’” (Wilson and Leasure 1991, 36). Furthermore, “treatment of co-occurring mental health and substance use disorders is complicated by the fact that most incarcerated women serve short sentences and quickly return to the community” (Johnson et al. 2014, 418). This makes community engagement and cooperation a key factor in continuity of healthcare and re-integrating women into the community, as females with a history of mental illness are already fragile and vulnerable, lacking education and job skills.

According to a survey conducted by the Bureau of Justice in 2011-20, “more than two-thirds of incarcerated women in America reported having a history of mental health problems -- a far higher percentage than their male counterparts” (Bronson and Berzofsky 2017, 4). “And although women represent only approximately 8% of all incarcerated people, in 2015,” “females are more likely to receive psychotropic medications than are men” (Sawyer 2018; Wilson and Leasure 1991, 36). While prescribing drugs for mental health problems may have a short-term effect, drugs cannot help women inmates overcome previous physical abuse or victimization or eliminate poverty. Often medicine, as treatment for trauma, is over-prescribed and not combined with psychotherapy. This leads individuals to relapse. Drugs in and of themselves are often a placebo effect and are not at the root of the problem. Mental health of women in prisons is a complex problem that requires trained professionals with expertise in women’s healthcare.

What is needed is multidisciplinary teams of mental health professionals, primary care providers, and social workers to deliver medical services to women inmates. These professionals can help with a wide range of psychological and socioeconomic problems. According to Penal Reform International:

> As women represent a small proportion of the prison population, there are fewer women's prisons – and those that exist often lack good education and training opportunities. As women's prisons are typically smaller, there may also be less financial resources and physical space available for libraries, classrooms and training workshops. In some countries, small numbers of women are housed in separate parts of male prisons, and the number of women is often considered insufficient for investment in suitable rehabilitation programmes. (Thailand Institute of Justice 2019, 14)

This disparity is seen across women's institutions as their residences and services have been based on the predominantly male prison population and model, disregarding the healthcare and medical needs unique to women. In survey after survey, inadequate mental healthcare for women inmates translates into a public health crisis, as post-release women often regress with depression and anxiety, unable to live fruitful independent lives, nor care for their children and others. There is "deliberate indifference" to the women's medical care through inadequate and delayed screening for medical treatment, inadequate record-keeping, and inadequate lab and follow-up procedures" (Wilson and Leasure 1991, 34). Not only is there gender disparity, but within the female population there is racial disparity, whereby a "New York City jail study reveals the observation that Black and Hispanic inmates are 2.52 and 1.65 times more likely to enter solitary confinement than white inmates" (Kaba et al. 2015, 1914). Females with mental illness in prisons resonates with systemic, interpersonal, and institutionalized oppressive strategies that do little to accommodate health needs and fail to challenge the broader harm that disempowers female criminals, without the necessary tools to survive successfully in the community.

While mental illness in prisons affects a significant number of women inmates, there is also a need for a comprehensive model for family planning, including reproductive counseling, and contraceptive care, which is neglected. "The majority of incarcerated women are between the ages of 18 and 44 and therefore of reproductive age, and two-thirds of incarcerated women

are mothers," who do not necessarily want a future with an unplanned pregnancy (Sufrin et al. 2017, 10). Women's pregnancy desires change drastically depending on individuals' situation and "62 percent of jailed women in one study said they did not want future pregnancies" (11). This is not surprising as many of incarcerated women have unprotected sex, unintended pregnancies, and plan to be sexually active upon release from prison. Women in prisons are often from marginally deprived communities due to societal or cultural norms and prevented from using contraceptives and have no or minimal healthcare prior to entering prisons. Incarceration provides women inmates and society with an opportunity to acquire healthcare to restore status that is socially acceptable, devoid of stigmas that prison brings, to repair women and prepare them for re-entry into their communities. Women inmates in prison and upon leaving prisons, should have control over their reproductive choices, without worrying about an unplanned or undesirable pregnancy, so they can focus on being independent and provide for their families. Within the framework of WHO's definition of health:

> ….as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide whether, when and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy child. (WHO Regional Office for Europe 2009, 29-30)

While women inmates are imprisoned to atone for criminal actions they are still deserving of human rights and comprehensive family planning and contraception, including availability of birth control pills, IUD's, oral contraceptives and condoms. They should also be able to have conjugal visits from partners in private quarters. However, there is "a lack of national policy-level emphasis on family planning for women in custody, as the National Commission on

Correctional Health Care, which accredits correctional health facilities, lists contraception as an optional standard for accredited facilities to meet" (Sufrin et al. 2017, 11). This indifference to the basic health and human rights of women is unacceptable; prisons need dedicated training and guidelines to bring women-specific healthcare to prisons, along with the necessary budget and resources to ensure these plans are extended to communities and are available upon prison release.

Family planning for preventive childbirth is critical, yet, "an estimated 6-10% of incarcerated women are pregnant" upon entry to correctional facilities and have unmet medical accommodations and facilities (Kelsey et al. 2017, 1260). Incarcerated pregnant women are a particularly high-risk population as they are frequently in poor health prior to their arrival, suffering from drug addiction, exposure to physical violence, chronic medical conditions, and limited access to healthcare. "These health disparities can lead to serious pregnancy and delivery complications, such as miscarriage, preterm deliveries, spontaneous abortions, low-birth-weight infants, ad pre-eclapsia, placing both the mother and the developing child at risk" (1261). Subpar conditions exist in jails with lack of prenatal care of pregnant inmates. In many jails and prisons, "pregnant women are handcuffed and shackled during delivery, which can lead to maternal stress and a resulting decrease of oxygen flow to the fetus during delivery" (Weatherhead 2003, 450).

This practice is inhumane and degrading, placing emotional and physical stressors unnecessary at a time when women are undergoing a difficult time of their life, worrying about their child's placement after birth. Pregnant women require regular examinations, proper nutrition, counseling, child birthing classes, parenting education, labor and delivery options, and postpartum services, not to mention the ability to breastfeed their child and be allowed visitation

with their infants. In addition, most prisons immediately take babies away from their mothers immediately after childbirth, disallowing infant bonding, although a few prison nursery programs exist. National standards must be established for the treatment of pregnant women in prison, as well as residential community-based facilities where women can live with their children upon exit, to avoid children becoming wards of the state. Residential community facilities are good alternatives to improve the health and welfare of pregnant women, addressing this underserved population, which benefits society and community's well-being and health, but they need to be established nationwide.

The intersectionality of class, gender, and politics of healthcare delivery for women prisoners must lead to best practices in and out of prison, particularly in the cases of substance abuse, mental illness, family planning and pregnancy. A healthcare crisis for women in prisons is tragic. As important is continuity of care to individuals once they are released from custody, as this vulnerable population is at risk for being neglected during transition to community-life. Programs need to be proactive with community engagement. Health records need to be released to prior inmates upon departure along with a follow up appointment to primary physicians. This is a critical juncture for women and society as paroles are released "without money, medications, or housing" based on a profile of women released from Texas prisons (Busen 2014, 360). When released from prisons often women do not want to or cannot return to their living arrangements and require social, emotional and economic support. As reported in the beginning of this report, these women lack education, job skills, and have little or no access to healthcare; community support is critical to encounter successful rehabilitation. Programs such as "Brigid's Hope in Houston," transitions women from incarceration back into the community, which houses paroles in a residential program that provides one year of transitional living, mentoring, and coordination

of social services of women between the ages of 35 and 65 coming out of Texas prisoners and jails" (363). Women's Prison Association is a liaison to women prisoners in and out of jail, providing re-entry services, training, access to health and education services, regaining custody of children, and housing and community support to ensure their re-entry to society is met with healthy outcomes and justice is served (Women's Prison Association 2019). While these programs are available to help paroles achieve a successful, healthy life there are an insufficient number available and many correctional institutions have failed to implement these practices to connect prisoners. The health of prisoners is of vital importance as the conditions of confinement for women does not comply with the eighth amendment which states "….nor cruel and unusual punishments inflicted" (U. S. Constitution). Prisoners are obligated to receive medical care as failure of medical necessities is unconstitutional. There needs to be a concerted focus to provide medical care to women inmates during their sentencing in prison, coupled with a pre-release and post-release plan with a community liaison to "positively influence health outcomes and ultimately lead to decreased female prison populations and lower rates of recidivism" (Ziazadeh 2019).

Women have unique, gender-specific needs. The systemic obstacles to healthcare of women in prison is unjust and violates basic health and human rights with broad traumatic societal impact, affecting communities. To resolve these inequities, the United States should require national standards for quality healthcare policy for incarcerated women that is preventative, restorative, rehabilitative, with an "antiracist vision of justice organized around care and compassion, respect for human life, the recognition of shared responsibility and interdependence and drastic social change" and acceptance (Richie 2004, 449). Criminal justice legislation, medical professionals, along with public and private stakeholders need to partner to

mandate quality healthcare for females, minorities with different sexual orientations and races. Prisons need standardized healthcare procedures and health standards for women and minorities enacted by legislative health policy, to view the female prisoner through a holistic lens, considering individuals' ethnographic and familial background.

Better trained and certified medical practitioners should be responsible for, and oversee, the completion of detailed and thorough health intake forms, with initial screening for women upon prison arrival for physical and mental stressors. Upon departure from prison, health exit forms, documenting medical narratives and lab reports, along with health records in hand need to leave with female prisoners, coupled with community engagement and a case manager. Current arrangements for dealing with women's healthcare in prisons fail to meet basic needs and are far short of what is required by human rights, by accepted international recommendations and by social justice. Health is after all a fundamental human right, for women in detention as well as for those in the community. Women's incarceration presents a unique opportunity to engage with underserved women and gender minorities for preventative healthcare to ensure communities keep a watchful eye on their transition to independence. The lack of healthcare for women in United States prisons requires an immediate comprehensive approach to ameliorate medical care standards and provide essential health services policies, free from victimization and discrimination.

References

Bronson, Jennifer and Marcus Berzofsky. 2017. "Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12." *Bureau of Justice Statistics* NCJ 250612: 1-16. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.

Busen, Nancy H. 2014. "An Interprofessional Education Project to Address the Health Care Needs of Women Transitioning from Prison to Community Reentry." *Journal of Professional Nursing* 30(4): 357-66. https://doi.org/10.1016/j.profnurs.2014.01.002.

Johnson, Jennifer E. et al. 2015. "Provider Experiences with Prison Care and Aftercare for Women with Co-occurring Mental Health and Substance Use Disorders: Treatment, Resource, and Systems Integration Challenges." *Journal of Behavioral Health Services & Research* 42(4): 417-36.

Kaba, Fatos et al. 2015. "Disparities in Mental Health Referral and Diagnosis in the New York City Jail Mental Health Service." *American Journal of Public Health* 105(9): 1911-16. https://doi.org/10.2105/AJPH.2015.302699 .

Kelsey, C.M. 2017. "An Examination of Care Practices of Pregnant Women Incarcerated in Jail Facilities in the United States." *Maternal Child Health Journal* 21: 1260-66. https://doi.org/10.1007/s10995-016-2224-5.

Marlow, Lana G. 2004. "Mothers in Prison, Women's Autobiography, and Activism." Order No. 3145403, The University of Texas at Austin. http://newman.richmond.edu:2048/login?url=https://search-proquest-com.newman.richmond.edu/docview/305126293?accountid=14731.

McCorkel, Jill A. 2013. *Breaking Women.* New York: New York University Press.

Richie, Beth E. 2004. "Feminist Ethnographies of Women in Prison." *Feminist Studies* 30(2): 438-450. https://www.jstor.org/stable/pdf/20458973.pdf.

Sawyer, Wendy. 2018. "The Gender Divide: Tracking Women's State Prison Growth." Accessed March 24, 2020. https://www.prisonpolicy.org/reports/women_overtime.html.

Sevelius, Jae and Valery Jenness. 2017. "Challenges and opportunities for gender-affirming healthcare for transgender women in prison." *International journal of prisoner health* 13(1): 32-40. http://dx.doi.org/10.1108/ijph-08-2016-0046.

Sulfrin, Carolyn et al. 2017. "Family planning services for incarcerated women: models for filling an unmet need." *International Journal of Prisoner Health* 13(1): 10-18. *https://doi.org/10.1108/IJPH-07-2016-0025*.

Thailand Institute of Justice. 2019. "The rehabilitation and social reintegration of women prisoners." *Penal Reform International* Guide: 1-52. https://cdn.penalreform.org/wp-content/uploads/2019/05/PRI_Rehabilitation-of-women-prisoners_WEB.pdf.

The Sentencing Project. 2019. “Incarcerated Women and Girls.” Accessed March 27, 2020. https://www.sentencingproject.org/publications/incarcerated-women-and-girls/.

Weatherhead, Kendra. 2003. “Cruel but Not Unusual Punishment: The Failure to Provide Adequate Medical Treatment to Female Prisoners in the United States.” *Health Matrix: The Journal of Law-Medicine* 13(2): 429-472. https://scholarlycommons.law.case.edu/healthmatrix/vol13/iss2/8.

WHO Regional Office for Europe 2009. “Women’s health in prison. Correcting gender inequity in prison health.” United Nations Office on Drugs and Crime. Accessed March 15, 2020. http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf?ua=1.

Wilson, Janet S. and Leasure Renee. 1991. “Cruel and unusual punishment: the health care of women in prison.” *The Nurse Practitioner*. 16(2): 32, 34, 36-39. https://www.ncbi.nlm.nih.gov/pubmed/2006040.

Women’s Prison Association. 2019. “What We Do.” Accessed March 28, 2020. http://www.wpaonline.org/about/what-we-do.

Ziazadeh, Danya. 2019. “Inadequate Health Care: A Significant Problem Affecting Incarcerated Women.” University of Michigan. Last modified May 30, 2019. https://sph.umich.edu/pursuit/2019posts/inadequate-healthcare-a-significant-problem-affecting-incarcerated-women.html.