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Female Offender

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Contents

VOL. 3, NO. 1 ■ Spring 1992

SEP 29 1992

ACQUISITIONS

3 The Female Offender: A Prologue

J. Michael Quinlan

4 The Log

Correctional notes and comments

The 5-South Unit at MCC New York

Community Corrections and Female Offenders

Turning Up the Lights

The Older Female Offender

11 A Journey to Understanding and Change

Ann D. Bartolo

16 Equality or Difference?

Nicole Hahn Rafter

This question has remained a constant in the history of incarcerated women in America.

20 The Alderson Years

Esther Heffernan



The first Federal institution for women was for many years run as a "grand experiment."

27 HIV, AIDS, and the Female Offender

W. Travis Lawson, Jr.,
and Lena Sue Fawkes

138923

A look at a growing problem for prison administrators.

33 A Profile of Female Offenders

138924

Sue Kline

A statistical overview charts the growth and changes in the Federal female offender population.

37 Linking Inmate Families Together

138925

Bobbie Gwinn

Alderson's L.I.F.T. program helps solve one of the major problems for incarcerated mothers—separation from their children.

41 Women's Spirituality in Prison

Guylan Gail Paul

Though incarcerated, women can learn to feel a sense of freedom that changes the way they see themselves.

44 Women's Prisons: Their Social and Cultural Environment

Anne Sims

Similarities and differences between female inmates in minimum- and high-security facilities.



49 Care of the Pregnant Offender

138926

Anita G. Huft, Lena Sue Fawkes,
and W. Travis Lawson, Jr.

All aspects of pregnancy are affected by incarceration, which creates dilemmas for medical staff.

54 "Constants" and "Contrasts"

David W. Helman

Managers must be aware of the ways in which such factors as the "dependency response" affect their female populations.



59 The Cycle: From Victim to Victimizer

Crista Brett

Many women inmates come from backgrounds of abuse, and need to be given the tools to form less violent relationships in the future.

63 Canada's Female Offenders

Jane Miller-Ashton

The Canadian Federal system has developed innovative options for imprisoned women.

Care of the Pregnant Offender

Anita G. Huft, Lena Sue Fawkes,
and W. Travis Lawson, Jr.

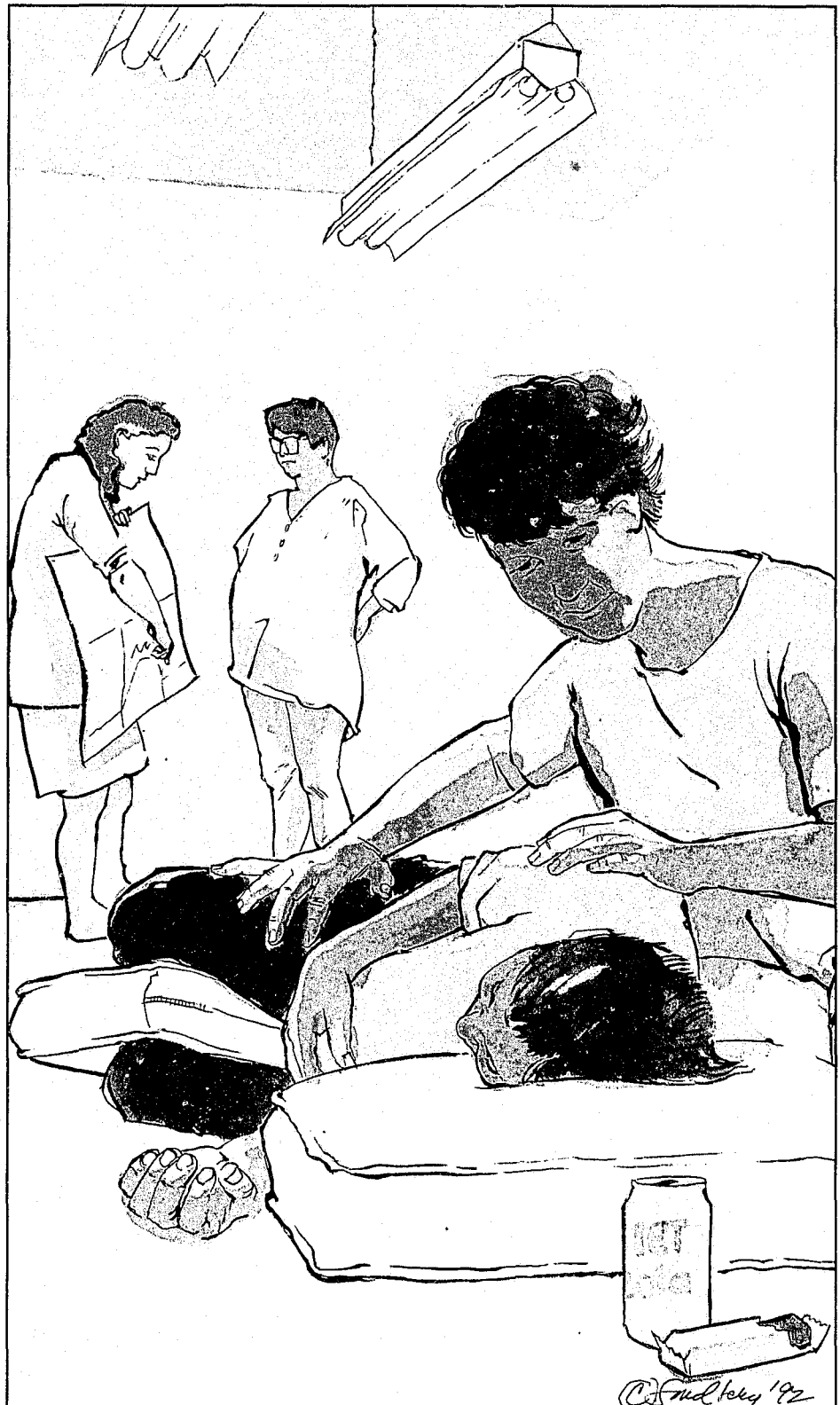
Women face many choices once they are pregnant. Even deciding to find out if she is pregnant can be an overwhelming experience for some women. Whether to continue the pregnancy, how to manage it, and how to select a particular child-birth method largely depend on the knowledge, attitudes, and disposition of people close to the pregnant woman.

While medical literature provides detailed guidelines on monitoring the fetus and performing appropriate medical interventions during labor and birth, there are few guidelines addressing the psychological issues associated with childbirth.

Pregnant women in prison face unique problems. Stress, environmental and legal restrictions, unhealthy behavior, and weakened or nonexistent social support systems—all common among female inmates—have an even greater effect on pregnant inmates.

Maternity care in the prison setting is based on the following values and assumptions:

- Pregnancy is a *healthy* state in which biological, psychological, emotional, and intellectual adaptations to one's surroundings increase the likelihood of a healthy birth.
- Every pregnant woman has the right of self-determination regarding her body and its functions.
- Every woman has the right to physical safety and access to certain health care services. Ensuring the safety of the



pregnant woman within the constraints of custody may warrant expanding her movement privileges and access to certain health care services. Staff access to previous health care records may be restricted. Violent or self-destructive women must be evaluated to ensure they are competent to select health care choices.

Prison and the experience of mothering

All of the "tasks" of pregnancy are affected by incarceration. Women in prison are placed outside the normal mothering experience in four ways:

■ **Stress**—Incarcerated women experience higher than normal levels of stress. They have a higher incidence of complications during pregnancy, labor, and delivery. Many have not practiced good health habits throughout their lives. Infants of incarcerated women are more likely to have life-threatening problems at birth, contract serious illnesses, and be exposed to a negative social environment as they grow into childhood.

■ **Restricted environment**—Adaptation to pregnancy is limited by the prison environment. Mandatory work, structured meal times, and lack of environmental stimulation may decrease the likelihood of individualized prenatal care. For instance, pregnant inmates receive standard clothing that often does not fit well. Alternatives for special clothing (e.g., stockings and shoes) may be dictated by availability within the institution or by what family and friends are willing to supply. In addition, disciplinary action or other restrictions may interfere with the offender's adaptation to pregnancy.

■ **Altered social support systems**—Even if ideal opportunities for nutritional



Physician Assistant Herminia Galang provides prenatal counseling to an inmate at the Metropolitan Detention Center, Los Angeles, California.

education and physical development are available during pregnancy, pregnant women will not take advantage of them if they do not receive support from their inmate peer groups. Limited health care facilities or staff sometimes warrant the immediate transfer of a pregnant inmate to a civilian hospital at the onset of labor. But that inmate will then miss the presence of a support person. These limitations may place certain mothers at risk for longer labor, may induce some in labor not to seek care soon enough, and may increase the discomfort of labor and the need for medical intervention.

■ **Altered maternal roles**—Maternal identity depends on rehearsal for the anticipated role after birth. Women in Federal prisons do not directly care for their infants after birth. Developing a maternal role therefore depends upon plans for placing the infant after birth. The inmate can place the infant either for adoption or for guardianship. She may choose to maintain a maternal role "in absentia" or relinquish that role to a

relative or friend, depending on factors such as support systems in prison, the inmate's self-esteem and problem-solving skills, the presence of an intact family on the outside, and the imminence of release.

Women who expect to give up their infants after birth do not experience bonding in the same way as mothers who know they will keep their babies. In addition to losing freedom, privacy, and self-esteem, inmates must also cope with losing a child and an identity as a mother. The ability to sacrifice one's own needs for another's is tested during the mothering experience. Whether the nurturing role is innate or learned, most women identify childbirth with infant care. Removing the mothering role from the woman in prison may trigger feelings of dependence, a loss of self-esteem, an inability to focus on the future, or self-destructive behavior.

For the medical staff, helping to resolve the issue of the placement of an infant after birth is based on accurately assessing the infant's potential family environment and the psychological state of the mother.

Preparation for care includes teaching the mother decision-making skills. Counseling should emphasize developing an identity during pregnancy and strategies for coping with the loss of the infant. After the birth, the mother will need counseling in making or accepting the decision to place the infant for adoption or temporary guardianship.

Plans for the female inmate's maternity and nursing care should therefore be guided by interventions to reduce stress, to decrease environmental restrictions, to

promote a healthy lifestyle, and to develop decision-making and coping skills for resolving infant placement problems and assuming a maternal role after the birth.

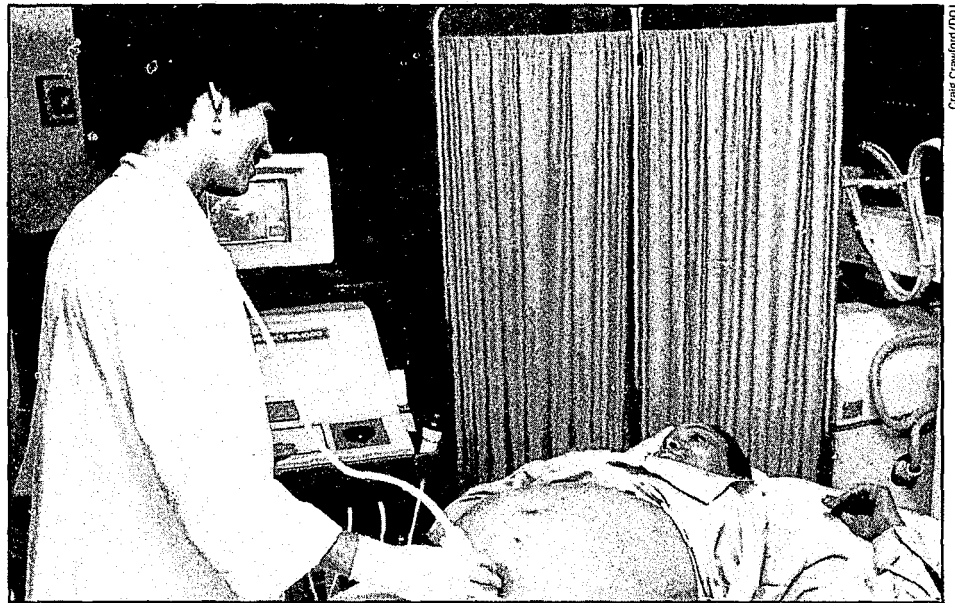
If the inmate is successful in coping with pregnancy and childbirth, she may have learned the skills necessary to successfully cope with her remaining period of imprisonment. Comprehensive maternity care for the pregnant inmate is one component of a supportive prison environment for the female offender.

The clinical dilemma

Recognizing that a small percentage of pregnancies have poor outcomes, doctors introduced the concept of "high-risk pregnancy" into clinical medicine. Early identification of high-risk pregnancies allows doctors to intensively monitor all stages. Moreover, the patient at "low risk" can receive more routine care, unless something changes her status to high risk. The central question, however, is "How do doctors recognize 'high-risk' pregnancies?"

Some high-risk factors can be recognized at the time of the first office visit; others develop or become evident in the latter months of pregnancy or during labor.

Within the unique setting of the Federal Bureau of Prisons and similar correctional systems, a majority of pregnant patients would meet at least some criteria for being high-risk. Within the correctional setting, medical staff recognize as "high-risk" the female with such demographic characteristics as: minority, older than 35 years, previous history of chemical dependency, previous history of multiple abortions or miscarriages, previous history of sexually transmitted diseases or pelvic inflammatory disease, and so on.



The Federal Medical Center in Lexington, Kentucky, is uniquely capable of offering care for high-risk inmates. Here, a physician from the University of Kentucky Medical Center monitors a fetal heartbeat.

A single major medical condition, or several minor conditions, can indicate a less than favorable birth. Such pregnancies must be termed high-risk, and these patients cared for in specially designed and staffed centers.

That many individuals within the Federal system have "at risk" characteristics increases the importance of prioritizing—allowing individuals at lesser risk to be treated at the institution or in the community, and those at significant risk to be treated at a referral facility for more intensive care.

The Federal Medical Center in Lexington, Kentucky, is uniquely capable of offering medical care for high-risk inmates. Lexington has an accredited hospital closely affiliated with the physicians and services of the University of Kentucky Medical Center. In addition, Lexington has the capability to house inmates of all security levels. However, access to obstetric and gynecological care is available at all Bureau institutions

for females. The concept of "high-risk pregnancy," for example, is well understood by the certified specialists the Bureau utilizes as local consultants.

All facilities can prudently meet the challenges of monitoring high-risk offenders. Appropriate budgetary resources can be allotted during the institution's strategic planning process.

The social network during pregnancy

Misguided advice about pregnancy impedes access to and use of prenatal care for low-income women. Low-income women—less educated, often exploited—are less likely to comply with prenatal health care advice. The prison population is an "invented family" of whom the pregnant woman is a member. Membership in this subgroup is often attained through an inmate "mentor," who offers advice and makes recommendations regarding acceptable practices during pregnancy.

Convenience is often cited as a reason pregnant women rely on peers or other sources for advice, rather than professional health care personnel. The prison subculture is a unique mix of racial, religious, and social customs and practices that, blended with institutional routines, organizes the activities of inmates, both within and outside the system. A prisoner's reference group includes family, friends, and acquaintances, who serve as a resource for acceptable information, including medical advice. This group plays a major role in the pregnant woman's interpretation of symptoms, self-diagnosis, acceptance of the need for clinical appointments, use of self-remedies, evaluation of treatment, and belief in professional explanations.

The health and lifestyle choices of pregnant inmates are determined by prison subcultures as well as inherited cultural practices. A thorough assessment of factors affecting pregnancies should include identification of groups and persons to whom the patient turns for information. While such networks can detract from the quality of health care, they can also reinforce medical advice. Knowing which is the case will help the health care practitioner use prison resources in the broadest sense possible. Areas of information concerning which patients turn to their networks for advice include:

- Diet and nutrition.
- Activity and hygiene.
- Harmful substances or practices to avoid.
- Remedies for the discomforts of pregnancy.
- When to seek advice about professional medical care.
- Information on labor and delivery.



Assistant Health Services Administrator Z.Z. Fort with an inmate at the Federal Prison Camp, Marianna, Florida.

This list suggests a pattern for dialog with the patient. Initial and followup visits should include this information, in this order, to spark the patient's attention and allow the practitioner to explore factors that may influence her compliance with medical advice. The physician should frankly and clearly explain the consequences of noncompliance—but in a nonthreatening manner, emphasizing physician-patient cooperation for a successful pregnancy.

Physicians should ask about important medical issues such as substance abuse and high-risk sexual practices in their initial assessments of the pregnant client.

Studies suggest that health education should be vigorously extended not only to the pregnant prisoner, but to her reference groups. Peers should be viewed as allies, not liabilities, in the reinforcement of good medical advice. Routine counseling and education by health care providers should dispel misinformation and the stress it causes for pregnant inmates.

Satisfaction with maternity care

A patient's satisfaction with her medical care is often cited as an ideal indicator of the quality of that care. By examining the components of satisfaction with maternity care, accurate quality assurance indicators can be developed.

Nonincarcerated patients are often afraid that voicing dissatisfaction with their maternity care will adversely affect that care. The female inmate is even more fearful: she is in a controlled environment in which every action may affect her well-being. Even though pregnant prisoners may complain about prenatal care, they are equally negative in their description of pregnancy and birth experiences. Part of this negative attitude may be due to a transference of feeling regarding their care to feelings regarding their birth experience. For quality control, it may be better to measure the frequency and total amount of satisfying conditions rather than to measure patient responses directly.

Conditions for positive pregnancies and childbirths include:

- Participation in decision-making.
- A high quality of explanations given to the mother (especially for delivery by Caesarean Section). The explanations of what could be expected are similar to the actual experience, and the woman receives emotional help from the physician and nurses.
- The nurses' responsiveness to the woman's pain.
- A short time spent waiting on appointments.

"Patient dissatisfaction" is a state of displeasure or disagreement with the

maternity care the patient actually experiences compared with the care she had expected. The stress the pregnant inmate experiences as a result of unmet expectations increases her risk of health problems during pregnancy, labor, and birth. Assuring the quality of maternity services in prisons should therefore include measures to increase patient satisfaction.

The halo effect—"satisfaction with care must make satisfaction with delivery"—does not hold up. Most studies collecting data within 2 months after delivery tend to rate the delivery experience and maternity care very highly. Satisfaction with care decreases, however, when women are interviewed more than 2 months after delivery.

Team delivery of services

Women experience pregnancy in a variety of settings and receive care from health professionals in a variety of ways. Health care delivery facilities become part of the social network of the pregnant woman; the outpatient clinic is a social system in itself. The professionals who staff the outpatient clinic represent various disciplines and clinical experiences.

The formulation of an obstetrical treatment plan for pregnant inmates is the responsibility of several different health care workers. The way such individuals work as a team affects the success of the treatment plan, and ultimately the health of the mother and infant.

The attending physician or chief obstetrical physician serves as team leader. He or she can make medical diagnoses that prioritize treatment. Other health care needs can be met (as deemed appropriate

Continued on page 58

Pregnant in prison: An inmate's experience

My name is Dana Johnson. I am incarcerated at a Federal Prison Camp in Bryan, Texas. I have a story to share that I hope will touch people's lives.

I came to prison pregnant. I thought that it was the end of the world, but it wasn't. The psychologist and chaplain counseled me and gave me advice. They told me about a program where I could spend time with my child and form a mother/child bond. The name of the program is MINT, which stands for Mothers and Infants Together. I was excited to be leaving and spending time with my child, even if it was for a short time. They explained that I would spend 2 months with my child after it was born. I had previously spoken with other inmates who told me about their experiences being pregnant in other institutions and spending only a few hours with their children. But not me, because I was here at FPC Bryan. It was then that I realized how lucky I was to have the MINT program available to me.

To make a long story short, I left Bryan on July 2 and went to the Community Corrections Center (CCC) in Fort Worth, Texas, where the MINT program is located. I was 8 months pregnant when I left and my due date was August 8. One month away! Just like any other institution, I had to get to know everyone there. I was scared at first, but the staff knew my situation and helped me in more ways than I could imagine. I was introduced to a staff member who I didn't know would have such an impact in my life—I'll use her first name only.

Thava was one of the warmest, nicest, and sincerest persons who I had met since being incarcerated. We hit it off from the start. We talked and I told her how I felt at the time, which wasn't too great. She gave me some thoughtful words. It was then that I realized I had someone to talk to. As the days passed, Thava did so much for me. She set up my doctor's appointments and had films that I could watch—the subjects included mothers using drugs, the birthing process, breastfeeding, and so on. Thava was a hardworking and dependable woman. She was even in the delivery room when I gave birth to my precious son. (I'm not from Texas, but Illinois, and my family couldn't come.) She also bought my son clothes to wear back to the MINT program. She was the greatest! When my son was a week old, he had bad stomachaches. Thava would come at any hour, day or night, to take him to the doctor. She made sure that he had milk and Pampers. I don't know what I would have done without her.

I am grateful for having the opportunity to spend 2 months with my son and establish a mother/child bond. When my son turned 2 months old, it was time for us to say our farewells. Thava took us to the airport and waved at us until we were gone. I got a furlough, which I am also grateful for, and got to see my 2-year-old daughter, who I hadn't seen in 10 months. I finally had my family together, even if it was for only 5 days.

I am back in Bryan, Texas, finishing my time. My son is now 6 months old. Programs like the MINT program help mothers in prison and their children. ■