

Issues in the Availability of Health Care for Women Prisoners

Tammy L. Anderson, Ph.D.

The considerable escalation of women sent to prison during the latter twentieth century finally helped shift attention to the various social, economic, and medical needs of this historically neglected population (Belknap, 2000). Among the concerns, and the focus of this chapter, are the numerous medical and mental health problems of today's female inmates. In comparison to their free-world female and incarcerated male counterparts, female prisoners suffer more frequent and serious disease, illness, and injuries (Maruschak & Beck, 1997) and require and utilize more medical and mental health services (Lindquist & Lindquist, 1999; Young, 1998). However, correctional institutions continue to offer inadequate health care to women inmates and far less than what they offer male offenders (Acoca, 1998; Marquart et al., 1997).

A familiar justification explains the disparity; female inmates compose a much smaller portion of the correctional population than men and, thereby, warrant less attention and investment by the state. Given the considerable growth of the female inmate population, this explanation seems increasingly problematic. The historical neglect of women prisoners, coupled with the massive increase in women's incarceration, make the health care problem increasingly salient as we begin the twenty-first century. However, two other matters promise to exacerbate it. First, the disproportionate prevalence of chemical dependencies among female offenders likely elevates physical and mental health problems, since drug offenders commonly report far more health problems than those without them. Second, and unlike their male counterparts, females' complicated reproductive systems introduce other types of health problems that current correctional systems are ill prepared to handle. For instance, female prisoners suffer considerable gynecological disease (e.g., cervical cancer), and terminal or chronic health problems such as HIV and hepatitis.

This chapter explores the health problems of female inmates, and the correctional system's responses to them, both in the past and today. It is critically important to review the health care needs of women prisoners and the correctional system's ability to deliver adequate services. Currently, a continuum of care is missing to successfully treat female prisoners' medical and mental health problems. Persistent inattention to the unique health care profiles of women offenders will likely result in an inadequate understanding of important illnesses and conditions not commonly experienced by men. Continued indifference would have great economic and social costs to society for current and future generations. According to Acoca (1999), "health care issues are a tsunami and will engulf social justice, and many other issues, within the next decade if we don't make them a priority" (p. 35).

WOMEN'S HEALTH PROBLEMS

If one were to rank population subgroups by the seriousness of their health problems, female prisoners would be located near the top of the ladder. There is a growing body of literature that shows female inmates are likely to have more serious health problems than both women and men in the general U.S. population, largely because of chronic poverty, lack of access to medical care, and problematic lifestyles. However, their health problems are also worse than those of incarcerated males (Maruschak & Beck, 1997), and the research reported below shows women often have less access to services for treatment and prevention than men.

Physical Health Problems

The differences between men's and women's physical health conditions and needs are considerable, discrepancies observable in both free society and in correctional systems. For instance, Verbrugge (1985, 1986) and Verbrugge and Wingard (1987) found that women in the general U.S. population have higher morbidity rates from acute conditions, nonfatal chronic disease, and short-term disability than men. Furthermore, the reproductive events of pregnancy, childbirth, and puerperium give women unique morbidity risks not experienced by men. Women's more complex reproductive systems increase their risks of other female-specific disorders (neoplasms of breast/genitals and genitourinary disorders, such as menstrual and menopausal symptoms). However, even when reproductive conditions are removed from consideration, significant sex differences persist in acute condition incidence and discretionary (non hospital) health care. Compared to men, women have higher illness rates for infective disease, respiratory and digestive system conditions, injuries, ear diseases, headaches, genitourinary disorders, and skin and musculoskeletal diseases.

Nonfatal chronic diseases are also more prevalent among women. They experience twice the rate as men for varicose veins, constipation, gallbladder and thyroid conditions, chronic enteritis and colitis, anemia, migraine, and chronic urinary diseases. Women also experience more psychological distress (anxiety, depression, guilt, and conflicting demands) on a day-to-day basis and over their lifetimes than do men (Verbrugge, 1985, 1986; Verbrugge & Wingard, 1987).

The research above shows women in the general population suffer more physical and mental health problems than men. The same pattern holds true when comparing women and men prisoners (Maruschak & Beck, 1997). For instance, drug use and abuse are quite prevalent in the correctional system; however, rates tend to be higher among female prisoners than among males (Graham & Wish, 1994; Fagan, 1994; Mieczkowski, 1994; Morash et al., 1998). Moreover, women inmates are more likely than men to report IV drug use (Decker, 1992) and having HIV (Wees, 1996; Maruschak, 1997). The higher rates of substance abuse and HIV among female prisoners are, once again, due to higher percentages of women prisoners with drug offenses, many of whom exchange sex for drugs (Inciardi, Lockwood, & Pottieger, 1993).

Mental Health Problems

Marquart et al. (1997) has argued that deinstitutionalization of mental health facilities in the 1980s has contributed to the growth of mental illness among the U.S. prison population. Estimates show the percentage of inmates, both male and female, with mental health problems grew in the latter part of the twentieth century. Similar to research findings on physical health problems, women inmates' mental health problems are both more frequent and more serious than their male counterparts' (Harlow, 1999). For instance, 24% of men and 36% of women inmates surveyed reported receiving mental health services at some point in their lives, whereas 10% of men and 20% of women reported receiving them since admission (Harlow, 1999). Also, women inmates more often disclosed obtaining professional counseling or being prescribed medications for mental illness, both in their lifetimes and since entering prison (Harlow, 1999). There is considerable evidence that women are prescribed more psychotropic drugs than males (Morris, 1987; Ross & Fabiano, 1986) and that medical staff frequently prescribe these drugs without checking to determine if the inmate is pregnant (McHugh, 1980), a dangerous practice.

The leading mental illness problems among female prisoners include physical and sexual abuse/trauma, victimization, depression, and substance abuse (Young, 1998). Dual substance abuse and mental health problems are very prevalent among male and female prisoners, but more so for females (Henderson et al., 1998). Women in prison have higher rates of substance abuse, antisocial personality disorder, borderline personality disorder, post-traumatic stress disorder, and histories of sexual and physical abuse than their male counterparts. Women frequently engage in self-mutilating behaviors, are verbally abusive, and report numerous suicide attempts (Henderson et al., 1998).

HISTORICAL LOOK AT HEALTH CARE AVAILABILITY FOR WOMEN PRISONERS

Throughout time, correctional institutions have struggled to provide adequate health care and other types of health services to women prisoners. Neglect is partly responsible for the current deficit of care. Health care in women's prisons received little attention, because female offenders were a small percentage of the prison population. Professional medical groups considered them to be the responsibility of the correctional system, and prison officials were paternalistic-prioritizing making inmates "good" women and girls over treating their health care problems (Wilson & Leasure, 1991). Also, early penal reform policies embraced an ideology that women inmates must have been sick or pathological to fall from grace and participate in such male activities as crime. Although this belief encouraged treatment and rehabilitation, there was little medical care (physical and psychological) to be found. Rafter (1985, 1989), a leading expert on the history of women's incarceration, has noted that early custodial institutions often warehoused women along with men and exposed them to horrible conditions. Sexual abuse was rampant, and babies born in prison often died. Prison conditions remained like this for women until recently, when inmate-initiated lawsuits in the 1970s and early 1980s, like *Todaro v. Ward* (1977) began to force improvements.

The *Todaro* case was the first major court case to challenge women's access to health care in correctional institutions. It charged the entire health care delivery system in a New York women's prison was unconstitutional, arguing women had no real access to medical care or to physicians. Afterward, the American Medical Association, American Public Health Association, and the American Correctional Association became involved in creating standards for health care in prisons (Resnick & Shaw, 1981).

Other legal reforms have followed, but haven't necessarily benefited inmates. For instance, *Estelle v. Gamble* (1976) established that all prisons have an obligation to provide for serious medical needs. However, a complainant arguing he or she didn't get mandated services would have to prove it was due to deliberate indifference on the part of prison officials. This difficult standard has made it easy for prisons to avoid medical responsibility (Marquart et al., 1997) by giving them lots of room to maneuver on health care. Later, *Brown v. Beck* (1980) held that medical care provided to prisoners need not be "perfect or even very good," it only has to be "reasonable." Some have argued decisions such as these send the message that prisoners should expect a standard of health below that of the general population (Maeve, 1999).

Today, there are more legal precedents and options to enable inmates to obtain care for their health problems. Typically, cases are filed citing violations in the Eighth and Fourteenth amendments. Unfortunately, the opportunity to initiate legal action against correctional systems does not appear to be equally available to males and females. According to Morris (1987) and Rafter (1989), women have more restricted access to legal libraries and higher levels of security than men in general. Even today, and despite enduring significantly worse prison conditions and treatment, females are far less apt than males to file lawsuits against prisons and jails (Rafter, 1989; Van Ochten, 1993).

Box 4.1

LITIGATION AND LAWS RELATED TO THE HEALTH CARE OF WOMEN PRISONERS

Estelle v. Gamble (1976) created obligation for all prisons to provide for serious medical needs of their inmates.

Todaro v. Ward (1977) argued that women had no real access to medical care or physicians in the New York penal system

Brown v. Beck (1980) ruled that medical care provided to prisoners needed only to be "reasonable."
Federal Prisoner Co-Payment Act (1999) required prisoners to pay for part of their health care while incarcerated.

HEALTH CARE AVAILABILITY AND UTILIZATION FOR WOMEN PRISONERS

Scholarly work in the area of health care for women prisoners has trickled in slowly over the course of the twentieth century. Although more is now known about the health problems and medical needs of women prisoners, far less is known about the services prisons offer, or how they are utilized by inmate populations. A major obstacle has been the absence of data collection by prisons to keep track of proffered services. Currently, most prisons do not keep adequate medical records that would allow any systematic or thorough assessment of the health problems and utilization of services by men and women prisoners. For instance, research (American Correctional Association, 2000a) shows eighteen states collected medical data on inmates in paper form, and only five had electronic information. The federal correctional system is an exception and will be discussed in detail below. The absence of data on health care availability and utilization will likely create obstacles to effective and cost-efficient provisions for inmate health care needs. Further constraints on availability and utilization pertain to ideology and economic considerations. These are reviewed below, in addition to the limited research on use of health care services by women prisoners.

Ideology and Economics in the Current Climate

Health care availability in prisons is constrained by numerous ideological and economic considerations. Ideologically, policymakers, correctional personnel, lawmakers, and the general public have been unsupportive of equitable standards of health care for inmates and have endorsed legal action to keep things that way, as already discussed. Moreover, unlike the free-world's increasing focus on preventative care, the notion of "health" in prisons is often synonymous with the absence of disease. "Real" health problems are seen as those with visible symptoms (Maeve, 1999).

Economically, prison costs have exploded thanks to punitive crime control policies that have increasingly led to the incarceration of men and women who are more and more unhealthy (e.g., drug abusers). According to the American Correctional Association's (2000b) study of health care services offered by state departments of corrections, 41 % of corrections systems spent a staggering \$83 billion, or 10% of their 1997 budgets, on inmate health care. Nearly all reported health care costs had increased since the previous year, citing the expanding prison population as a primary reason (American Correctional Association, 2000b). The study also substantiated the above research showing women's health care costs exceed those of men's.

Correctional officials are all too aware that health care costs will continue to escalate and consume an ever larger portion of their budget as long as government officials continue their commitment to extant drugs and crime policies. At least three major options are being considered to contain these costs, some of which promise to disproportionately disadvantage women. First is the increased use of fee-for-service or co-payment charges to cut down "illegitimate" inmate medical requests, curtail lawsuits, and raise funds to help cover expenses. The notion here is that such policies as the Federal Prisoner Co-Payment Act of 1999 will significantly reduce inmates' health care costs. However, because women inmates are more isolated from family and friends and typically have fewer financial resources than their male counterparts, prison co-pay policies may penalize them disproportionately and ultimately adversely affect their health. Second, as the correctional system moves toward increased privatization, women's facilities may be left behind because of their higher operational expense (e.g., greater health care costs and need for specialized services) and their inability to raise as much capital as men's prisons. The future of health care in prisons, therefore, will likely witness considerable change to foster cost containment. Finally, the trend toward telemedicine (Abt Associates, 1999) promises to cut prison health care costs by allowing doctors to assess health problems via advanced computer technologies, which means medical professionals can diagnose and treat inmates without having to travel to isolated medical facilities. Prisons also save financially and reduce security problems by not having to transport as many inmates out of institutions for medical care. Three issues promise to make prisons housing female inmates increasingly dependent on telemedicine services: (1) women's prisons are often more remote than men's, (2) women's prisons are more lacking in medical facilities, and (3) women inmates have more health care needs that require expensive outside contractors (e.g., childbirth). If the current situation is a valid indicator of what is to come, women inmates will continue to be disadvantaged in their access to health care in comparison to their male counterparts.

Box 4.2

TELEMEDICINE AND WOMEN PRISONERS

Spiraling cost for prisoner medical care are moving the correctional system toward having medical professionals diagnose and treat prisoners via computer technologies. Women prisoners are candidates for increasing use of telemedicine because of:

- Remote locations
- Lack of existing medical facilities
- Greater need for expensive outside contractors for childbirth and other health issues

To their credit, today's correctional systems offer many more health care services than they did in the past, with more and more testing and treatment required at admission and available to inmates at their request. However, although testing and treatment at admission has increased, there remains no standard policy for routine physical exams on intake in state correctional facilities, although the Bureau of Prisons has recently implemented such a policy, discussed a little later. At the state level, for instance, the content of physical exams and the medical professionals who conduct them vary considerably by institution. Research (Reed & Lyne, 1997) has shown that the quality of health care in prisons varies greatly; much is poor quality, the low standard reinforced by the legal statutes discussed above. Doctors are often not adequately trained to do the work they face, and some fail to meet basic ethical standards. Generally, the major physical health services offered are for tuberculosis, STDs, HIV/AIDS, and obstetrics and gynecology. These services partially correspond to the types of health problems reported by inmates, but leave important gaps as well: cardiovascular problems, asthma, drug and alcohol treatment, problems especially salient for women prisoners (Young, 1998; Covington, 1998).

In general, prisoners utilize medical services at higher rates than the non institutionalized population (Suls, Gaes, & Philo, 1991; Twaddle, 1976). Higher utilization rates stem from inmates having greater health care needs, health care in prison being free or inexpensive, visits to clinics representing a break in prison routines, and prison clinics functioning as a safe niche for troubled inmates (Marquart et al., 1997). The most frequent medical visits are for pain stemming from a new illness. Research also shows that women in the general U.S. population utilize more health services, such as physician's offices, outpatient clinics, and hospitals, than do men. Reasons for this include that women are generally (1) more sensitive to physical discomforts, (2) more apt to label symptoms as physical illnesses, (3) more likely to possess gender traits (nurturing and compassion) that often influence them to seek medical care more often, and (4) more likely to take follow-up actions regarding a health problem and to take them sooner (see also Verbrugge 1985, 1986 for a review). The paragraphs below describe the types of medical services offered to women inmates and how they utilize them.

Services for Women

A review of existing studies reveals at least three main problems in accessibility to health care services for female prisoners. First, access to treatment for both general and drug related health problems is seriously limited. Today, female prisoners still receive fewer health care services in comparison to their male counterparts (Acoca & Austin, 1996). Second, the health care provided to women is often mediocre. It is largely an attempt to "catch up," in that considerable effort is often necessary to raise women's health status to legally acceptable levels (Maeve, 1999). Third, women inmates have reported prison medical professionals are under skilled, often withhold medical care, and show little care or concern for them or their needs (Fletcher, Shaver, & Moon, 1993). In fact, most lawsuits filed by women in prison are for complications in receiving medical services (Belknap, 2000).

PROBLEMS IN THE HEALTH CARE OF WOMEN PRISONERS

- Access to treatment is limited.
- Care is often mediocre.
- Prison medical professionals are often under skilled.

These deficiencies in health care accessibility exist despite data confirming greater health care needs among women inmates. For instance, Young (1998) found 5% of women inmates received no medical services during a 4-month study period, while 50% received them twice a month, and 25% received them four times or more per month. These utilization patterns indicate that a substantial portion of female prisoners have numerous and serious medical problems (Young, 1998). In a thorough study of gender differences in prison health care utilization, Lindquist and Lindquist (1999) found women reported being in good health less often than men; the number of health care visits was considerably higher among female inmates; women were more likely than men to perceive access to health care as difficult and more often believed their quality of care was low as compared to what men received. The authors concluded gender was the stronger predictor of health problems and service utilization. The paragraphs below describe accessibility and utilization data on three of the most important health care issues of women prisoners today: pregnancy and gynecology, HIV and infectious disease, and mental illness (including substance abuse).

Pregnancy and gynecology. In 1995, approximately 10,800 women were pregnant at the time of incarceration. However, the number of live births in prison was considerably smaller due to miscarriage, abortion, prison transfer policies, and so on (Acoca, 1998). In general, pregnant women are transported to outside medical facilities to give birth, because their correctional institutions are not medically equipped to safely provide such services. These birth transports often result in numerous medical and mental health complications; that is, security precautions increase a woman's risk of injury and stress (Young, 1998; Belknap, 2000). Moreover, after giving birth, women inmates are confronted with the loss of their child. The problem of left-behind children of incarcerated women is one of the biggest issues confronting crime policymakers today. To date, very few prisons allow newborns to remain with their mothers and, instead, typically place them with family or in foster care immediately or shortly after birth (American Correctional Association, 2000a; Belknap, 2000).

Currently, nearly all of the correctional systems housing women contain provisions for prenatal and postpartum treatment. However, such treatments are not typically required and are only offered at an inmate's request or if clinically indicated. Shortcomings in prisons' response to pregnancy-related health issues are the result. Acoca (1998) identified deficiencies in the availability of prenatal and postnatal care, prenatal nutrition, allocation of methadone maintenance, educational support for childbirth and rearing, and preparation for mother-child separation after birth. Also, she found many women who delivered babies were not given medication to dry up their breast milk, causing them to suffer painful breast engorgement.

Health care for gynecological needs is equally problematic. Annual gynecological exams are not routinely performed at admission or at any other time during incarceration. However, an American Correctional Association (2000a) study found OB/GYN services, prenatal and postpartum care, mammography, and Pap smears were available on request at nearly all institutions housing women offenders. Fewer facilities provided counseling about women's reproductive health. Provisions for such health care needs must be researched, because there is currently no information at the state and local level on when and how these services are allocated. The Federal Bureau of Prisons has recently taken the lead in creating policy for meeting the health care needs of female inmates (see below). It is too early to tell if state and local prisons and jails will follow suit. However, the exploding costs of medical care and the growth in the number of women in prison may stymie planned progress.

HIV and infectious disease. HIV and other infectious diseases exact a considerable price on the general health care system and on those of corrections institutions as well. Funding widespread screening for the illnesses pales in comparison to providing treatment. Despite these costs, prisons today are increasingly testing for HIV/AIDS, hepatitis B and C, and tuberculosis at intake. The American Correctional Association (2000a) found that mandatory HIV testing is conducted (both men's and women's) at intake in 23 states and that a few also have follow-up testing 6 months later. HIV testing of women prisoners is conducted at intake in roughly half of facilities surveyed and/or by inmate or physician request in the others. Most prisons treat HIV-positive inmates with medications during their prison stay and will provide them with a limited supply (e.g., 30 to 60 days worth) after release. Most also refer newly released HIV-positive inmates to community resources to obtain additional medications. Specific data on treatments provided to women suffering HIV, STDs, or TB are currently not available, although the Centers for Disease Control has implemented a data collection system for correctional institutions recently.

Mental illness. To reiterate, the leading mental health problems of female prisoners are substance abuse, trauma from physical and sexual abuse, and depression. In a study of state facilities, Morash, Bynum, and Koons (1998) found women inmates were more likely to be addicted to drugs and to have mental illnesses than their male counterparts. However, women inmates report numerous complaints about obtaining services for mental illness, including no one with appropriate credentials or diagnostic skills, not enough mental health professionals at the facility, and inadequate monitoring of psychotropic drug administration (Acoca, 1998). Furthermore, an increasingly common correctional response to women's mental health needs is prescription of antidepressants (Maeve, 1999).

CONCLUSION

This chapter has attempted to outline the major health care issues facing women prisoners and correctional facilities today. Comparisons were offered between women inmates' health care status and those of the general U.S. population and of male inmates. Evidence consistently shows women inmates suffer greater and more serious health care problems than the other groups and will present considerable demand for services from correctional institutions in the future, most often for pregnancy and OB/GYN problems, HIV, STDs, and mental illness. Despite their greater medical needs, women inmates receive fewer services and inferior care in comparison to others. Restrictions on legal resources and correctional adaptations or solutions to escalating medical costs promise to preserve this disparity well into the current century.

Recently, a glimmer of hope emerged at the federal level to reverse this situation. Although the majority of women inmates are housed in state institutions, those housed in federal prisons will likely encounter greatly improved services. For instance, the Federal Bureau of Prisons (BOP) for women provides each inmate with a complete medical exam—in other words, a medical history and a physical exam—within 30 days of admission. The physical exam includes gynecological and obstetrical history, serology for syphilis, complete blood count, urinalysis, infectious disease tests (if clinically indicated), TB screening, and an audiogram (if clinically indicated). Pregnancy tests and Pap smears are also available, but are not required for all women. Immunizations are offered for measles, mumps, and rubella (Morash, Bynum, & Koons, 1998).

The BOP has taken a leading role in meeting the specific health care needs of women inmates. They now adhere to the American College of Obstetrics and Gynecology standards for yearly exams, such as mammography. Females over 50 years old are given a complete physical exam every two years (Morash, Bynum, & Koons, 1998).

New concerns about women inmates have resulted in increased mental health services as well. For instance, the BOP has added more drug treatment slots of lasting duration (i.e., 6-month therapeutic communities) at 5 of the 11 BOP facilities. Currently, all BOP facilities have some form of psychological counseling—most often group therapy for things such as values development, recovery and sexual abuse, smoking cessation, gambling addiction, and anger management.

Although these preventive-care policies promise to reverse "symptoms-based" treatment and restore women's health to adequate levels, other improvements are still needed for the treatment of existing conditions, both chronic and acute. For instance, the BOP has few medical personnel on staff at women's institutions and still contracts out with private agencies for many inmate services. Women prisoners from all over the country suffering serious and long-term health problems are sent to Texas's medical referral center for females to receive inpatient hospitalization or long-term medical care. This

typically means isolation from family and friends during an already stressful time.

Although provisions for meeting the health care needs of incarcerated men and women increased considerably during the twentieth century, the ability of correctional institutions to address and contain inmate health problems has been undercut by crime control policies that increasingly send unhealthy individuals to correctional institutions. As with many other social problems, relevant government systems have been forced to improve their health care services as a result of these crime control policies and court-based reforms following inmate-initiated legal action. Although the goal of correctional systems might be to bring inmates' health up to legally mandated standards, experts outside the system argue for vast improvements leading to a coordinated continuum of care (e.g., trained medical professionals to provide preventive care, adequate treatment for medical and mental health conditions, and coordinated community follow-up upon release) for health care needs. Absent this approach, complications are likely to result in the future, as released inmates seek high-cost medical services (e.g., emergency rooms) or disregard them completely. With continued research and additional efforts to tie findings into policy and interventions, scholars dedicated to this issue can help guide the country toward continual improvements in the future. Let us hope that such efforts are forthcoming.

DISCUSSION QUESTIONS

1. What are some of the problems faced by pregnant women in prison? What are some solutions or alternatives to issues surrounding medical care for pregnant prisoners?
2. Should prisons require mandatory HIV-testing of all entering prisoners? If so, what types of medical and mental health treatment would then be needed? If not, what are the long-term implications for women prisoners?
3. The author points out that prescription of antidepressants is an increasing response to women prisoners' mental health needs. What are the pros and cons of this type of approach?
4. At a minimum, what types of health and mental health programs are needed in women's prisons?

WEBNOTES

Read the report on women prisoner's health in California prisons at <http://www.ucsc.edu/currents/99-00/08-02/stoller.htm> and the state of Florida's health plan for women in prison (<http://www.dc.state.fl.us/pub/females/opplan/health.html>). Compare these two. Bring your comparison to class for discussion of effective programs for women's health care needs in prison.

REFERENCES

- ABT ASSOCIATES. (1999). *Telemedicine can reduce correctional health care costs: An evaluation of a prison telemedicine network*. Washington, DC: U.S. Department of Justice.
- AcocA, L. (1998). Diffusing the time bomb: Understanding and meeting the growing health care needs of incarcerated women in America. *Crime and Delinquency*; 44 (1), 49-70.
- _____. (1999). Getting healthy, staying healthy: Physical and mental health/substance abuse. In *National symposium on women offenders* (pp. 33-36). Washington, DC: U.S. Department of Justice.
- AcocA, L., & AUSTIN, J. (1996). *The hidden crisis: Women in prison*. San Francisco: National Council on Crime and Delinquency.
- AMERICAN CORRECTIONAL ASSOCIATION. (2000a, October 25). Inmate health care-Part 1. *Corrections Compendium*, (10), 1-34.
- _____. (2000b, November 25). Inmate health care-Part 2. *Corrections Compendium*, (11), 1-35.
- BELKNAP, J. (2000). *The invisible woman: Gender, crime, and justice* (2nd ed.). Belmont, CA: Wadsworth.
- COVINGTON, S. (1998). Women in prison: Approaches in the treatment of our most invisible population. *Women and Therapy*, 21 (1), 141-155.
- DECKER, S. (1992). *Drug use forecasting in St. Louis: A three-year report* (NCJRS 14281). Rockville, MD: National Institute of Justice.
- DUKE, K. (2000). Prison drugs policy since 1980: Shifting agendas and policy networks. *Drugs: Education, Prevention and Policy*, 7 (4), 393-408.
- FAGAN, J. (1994). Women and drugs revisited: Female participation in the cocaine economy. *Journal of Drug Issues*, 24 (1-2), 179-226.
- FEDERAL BUREAU OF PRISONS. (1998). *A profile of female offenders*. Washington, DC: U.S. Department of Justice.
- FLETCHER, B. R., SHAVE, L. D., & MOON, D. (1993). *Women prisoners: A forgotten population*. Westport, CT:

Praeger.

- GRAHAM, D., and WISH, E. (1994). Drug use among female arrestees: Onset, patterns and relationships. *Journal of Drug Issues*, 24 (1-2), 315-330.
- HARLOW, C. W. (1999). *Prior abuse reported by inmates and probationers*. Washington, DC: Bureau of Justice Statistics.
- HENDERSON, D., SCHAEFFER, J., & BROWN, L. (1998). Gender-appropriate mental health services for incarcerated women: Issues and challenges. *Family Community Health*, 21 (3), 42-53.
- INCIARDI, J. A., LOCKWOOD, D., & POTTIEGER, A. E. (1993). *Women and crack cocaine*. New York: Macmillan.
- KRANE, K., PEARCE, M., & MILES, J. R. (1998, April). Managing correctional health care. *Corrections Today*, 122-126.
- MCHUGH, G. A. (1980). Protection of the rights of pregnant women in prisons and detention facilities. *New England Journal on Prison Law*, 6 (2), 231-263.
- MAEVE, M. K. (1999). Adjudicated health: Incarcerated women and the social construction of health. *Crime, Law, and Social Change*, (31), 49-71:
- MARQUART, J. W., MERIANOS, D. E., HEBERT, J. L., & CARROLL, L. (1997). Health condition and prisoners: A review of research and emerging areas of inquiry. *The Prison Journal*, 7 (2), 184-208.
- MARUSCHAK, L. (1997). *HIV in prisons 1997*. Washington, DC: Bureau of Justice Statistics.
- MARUSCHAK, L. and BECK, A. (1997). *Medical problems of inmates 1997*. Washington, DC: Bureau of Justice Statistics.
- MIECZKOWSKI, T. (1994). Experiences of women who sell crack: Some descriptive data from the Detroit ethnography project. *Journal of Drug Issues*, 24 (1/2), 227-248.
- MORASH, M., BYNUM, T., & KOONS, B. (1998). *Women offenders: Programming needs and promising approaches*. Washington, DC: U.S. Department of Justice, National Institute of Justice.
- MORRIS, A. (1987). *Women, crime, and criminal justice*. Oxford: Basil Blackwell.
- RAFTER, N. (1985). *Partial justice: Women in state prisons, 1800-1935*. Boston: Northeastern University Press.
- _____. (1989). Gender and justice: The equal protection issues. In L. Goodstein & D. MacKenzie (Eds.), *The American Prison* (pp. 89-109). New York: Plenum Press.
- REED, J., & LYNE, M. (1997). The quality of health care in prison: Results of a year's programme of semi-structured inspections. *British Medical Journal*, 315, 1420-1424.
- RESNICK, J., & SHAW, N. (1981). *Prison Law Monitor*, 3 (3/4), 57, 68, 83, 89, 104, 115.
- ROSS, R. R., & FABIANO, E. A. (1986). *Female offenders: Correctional afterthoughts*. Jefferson, NC: McFarland.
- SULS, J., GAES, G., & PHILO, V. (1991). Stress and illness behavior in prison: Effects of life self-care attitudes, and race. *Journal of Prison and Jail Health*, 10 (2), 117-132.
- TWADDLE, A. C. (1976). Utilization of medical services by a captive population: An analysis of sick call in a state prison. *Journal of Health and Social Behavior* 17, 236-248.
- VAN OTHTEN, M. (1993). Legal issues and the female offender. In *Female offenders: Meeting the needs of a neglected population* (pp.31-36). Laurel, MD: American Correctional Association.
- VERBRUGGE, L. M. (1985). Gender and health: An update on hypotheses and evidence. *Journal of Health and Social Behavior*, 26 (3), 156-182.-'
- _____. (1986). Role burdens and physical health of women and men. *Women and Health*, 11 (1), 47-77.
- VERBRUGGE, L. M., & WINGARD, D. L. (1987). Sex differentials in health and mortality. *Women and Health*, 12 (2), 103-145.
- WEES, G. (1996). Inmate Health Care Part II: Women in prison accounting for an increasing percentage of HIV cases. *Corrections Compendium*, 21(11), 102-123.
- WILSON, J. S., and LEASURE, R. (1991). Cruel and unusual punishment: The health care of women in prison. *Health Care Issues*, 16 (2), 32-39.
- YOUNG, D. (1998). Health status and service use among incarcerated women. *Family Community Health*, 21(3), 16-31.