Women and the Criminal Justice System

By

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Some of the most neglected, misunderstood, and unseen individuals in our society are the more than one million women in our jails, prisons, and community correctional facilities. Although the rate of incarceration for women has increased dramatically (tripling in the last decade), prisons have not kept pace with the growth in the number of women inmates, nor has the criminal justice system adapted to meet women's needs, which are often quite different from those of men. This is particularly true in the areas of physical and mental health services. The health care needs of women have been virtually ignored by corrections and government officials, the medical and public health communities, and society at large (Freudenberg, 2002). This theme issue on women and girls in correctional settings begins to address this neglect by highlighting many of the important concerns and contributing to the growing knowledge base on the development of gender-responsive services (Covington & Bloom, 2006).

When planning, developing, and providing services, it is important to know who the client is and what she brings to the treatment setting. The following describes the demographics and history of the typical female offender population and how various life factors impact women's and girls' physical and mental health. A national profile of women offenders reveals that they typically:

- Are disproportionately women of color;
- Are in their early-to-mid 30s;

- Are most likely to have been convicted of a drug or drug-related offense;
- Have fragmented family histories, with other family members also involved with the criminal justice system;
- Are survivors of physical and/or sexual abuse as children and adults;
- Have significant substance abuse and physical and mental health problems; and
- Have high school degrees/GEDs but limited vocational training and uneven work histories (Bloom, Owen, & Covington, 2003).

Girls in the juvenile justice system have very similar profiles. They are arrested for less serious crimes than boys—more often for status offenses (e.g., running away and truancy). They frequently come from homes with substance abuse and domestic violence. Their life experiences also include high rates of physical and sexual abuse, as well as self-inflicted violence (e.g., cutting and burning) and suicide attempts.

Women and girls at risk for criminal justice involvement are an underserved population that often is disconnected from health care, other treatment services, and information about prevention. Therefore, they enter the system with many medical problems, including chronic disorders associated with poor nutrition and poverty, such as asthma, obesity, diabetes, hypertension, anemia, seizures, and ulcers (Smith, Simonian, & Yarussi, 2006a). In addition, drug-dependent women offenders are more likely than their male counterparts to suffer from tuberculosis, hepatitis, toxemia, anemia, hypertension, diabetes, and obesity (Messina & Grella, 2006). Females also have health needs related to gynecological problems and prenatal and postpartum care. Women are at greater risk than men of entering prison with sexually transmitted diseases and HIV/AIDS because of their greater participation in prostitution and the likelihood of sexual abuse. Many STDs, if untreated, can lead to cervical cancer, secondary infections, infertility, and birth defects (Messina & Grella, 2006; Smith, Simonian, & Yarussi, 2006b). In addition, imprisoned populations are at risk of contracting communicable diseases, particularly hepatitis A, B, and C, STDs (including HIV and AIDS), and tuberculosis.

It is important to acknowledge that low-income women (and girls) with serious health problems, high-risk behaviors (such as heavy alcohol and other drug use, smoking, and prostitution), and histories of trauma are increasingly enmeshed in the criminal justice system. As a result, correctional systems across the U.S. are forced to assume the responsibility of providing treatment for them. So a system designed to deal with criminal behavior finds itself in the position of needing to provide health care services to female

offenders. Unfortunately, many correctional institutions have not found the resources and facilities to do so.

In terms of mental health, a recent study conducted by the Bureau of Justice Statistics found that 73% of the women in state prisons and 75% of women in local jails have symptoms of mental disorders, compared to 12% of females in the general population. Three-quarters of the females who had a mental health problem also met the criteria for substance dependence or abuse (James & Glaze, 2006). Addicted women are more likely to experience the following co-occurring disorders: depression, dissociation, post-traumatic stress disorder, other anxiety disorders, eating disorders, and personality disorders (Bloom & Covington, in press). Teplin, Abram, and McClellan (1996) and her colleagues found that most incarcerated women with psychiatric disorders usually do not receive treatment.

What mental health care and substance abuse treatment there is in prisons is rarely consistent and does not meet optimal standards (Kosak, 2005). Women with mental health problems who do not receive appropriate psychiatric treatment or counseling while incarcerated are at high risk for homelessness, violence, and repeated involvement in the criminal justice system (often to support their substance abuse) once they are released (Smith, Simonian, & Yarussi, 2006b).

One of the most important developments in health care over the past decade is the recognition that trauma plays a vital and often unrecognized role in the evolution of physical and mental health problems (Covington, 2003). A high number of women and girls in the criminal justice system have experienced physical, sexual, and emotional abuse. The connection between trauma and subsequent health issues is substantiated by the decade-long and ongoing Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998), which was designed to examine the childhood origins of many of our nation's leading health and social problems. As the ACE score increases, so does the risk of numerous health problems throughout the lifespan.

A recent study by Green, Miranda, Daroowalla, and Siddique (2005) reported that nearly all the women in a jail study had been exposed to a traumatic event (98%); 90% reported at least one interpersonal trauma, and 71% were exposed to domestic violence. The ACE study was the model for another study of female offenders (Messina & Grella, 2006). As in the ACE study, various types of childhood traumatic events (CTEs) were assessed

(emotional abuse and neglect, physical neglect, physical abuse, sexual abuse, family violence, parental separation/ divorce, incarcerated family member, and out-of-home placement). A score of 5 or more traumatic events increased the risk of both mental and physical health problems in the women's adult lives.

CTEs were significantly and positively related to gynecological problems and STDs, with the odds of STDs increasing with the number of CTEs experienced. The number of CTEs was significantly and positively related to engaging in prostitution and having an eating-related problem. If a woman experienced 7 types of CTEs, the odds of her engaging in adult prostitution were increased by 230%. CTEs were also significantly and positively related to mental health issues. Greater exposure to CTEs increased the odds of a woman taking psychotropic medications, of having received mental health treatment, of having an alcohol problem, and of making suicide attempts. For a woman who reported experiencing 7 CTEs, the odds of having received mental health treatment as an adult were increased by 980%.

With the interrelationship between traumatic experiences in the lives of females and their physical and mental health, they are at additional risk of being retraumatized by the standard operating practices in the correctional system (e.g., pat and body searches, handcuffing, use of shackles and other restraints, and seclusion). It is clear that a gender-responsive, female-centered system of care for women and girls is essential.

Addressing the health and mental health needs of women and girls involves the development of comprehensive, coordinated services. A continuity-of-care model integrates services that address their histories of poverty and trauma, recognize their mental and physical health issues, and incorporate the emotional and psychological components that women and girls need to heal and recover. This is the opportune time for correctional facilities and community health care providers to work together and create a meaningful system of care.

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