The Female Inmate

An Examination of Female Inmates Services

Florida House of Representatives
Criminal Justice & Corrections Council
Committee on Corrections
Representative Allen Trovillion, Chair

Substantial Research Assistance from:
Florida Corrections Commission
Honorable Ray Sansom, Chair
Florida Correctional Medical Authority
Marsha Lewis Brown, Chair

July 2000

Florida House of Representatives
Committee on Corrections
1401 Capitol
402 South Monroe Street
Tallahassee, FL 32399-1300
(850) 488-6333

Florida Corrections Commission
2601 Blair Stone Road
Tallahassee, FL 32399-2500
(850) 413-9330

Florida Correctional Medical Authority
4052 Bald Cypress Way, Bin B-04
Tallahassee, FL 32399-1732
(850) 245-4044

ACKNOWLEDGMENTS

A project of this nature required the participation of a great many people besides the committee staff. This research was a joint effort between the Florida Corrections Commission, the Correctional Medical Authority, and the House of Representatives' Committee on Corrections.

We would particularly like to acknowledge the contributions made by all the state Department of Corrections employees who participated in the survey, as well as the various researchers who provided insight into the realities of working with this inmate population.

The project involved an unprecedented level of cooperation and interagency information sharing, and it resulted in three different reports -- one from the House Committee on Corrections, one from the Florida Corrections Commission, and one from the Florida Correctional Medical Authority. The final text of each document differs somewhat as a result of the different direction and perspective given by each group.

The considerable contribution of the Florida Corrections Commission staff includes the majority of the research on existing literature. The Correctional Medical Authority conducted the statistical analysis of the survey questionnaires administered.

CONTENTS

I. INTRODUCTION

The intent of this report is to illustrate the differing backgrounds of female offenders and highlight various changes in policy and procedural practices which may affect female offenders, and to provide insight into the occurrence of female suicides in prison.

The incarcerated female population has been increasing at a rapid rate over the last ten years. About 78,000 women are in federal and state government prisons. Currently, females make up 6.4 percent of the prison population of the United States. For more than a decade, the rate of increase in the number of women incarcerated in jails and prisons in the United States has consistently exceeded the rate of increase in the number of men being incarcerated. Between 1985 and 1996, the female prison population increased by an average of 11.2 percent per year compared with 7.9 percent for men.

Women in prison often enter the system with complex histories indicative of neglect and abuse, starting in childhood and continuing through adulthood. Some of the most common characteristics of women in prison are personal histories of profound physical and sexual abuse, personal histories of drug and alcohol dependence, low levels of educational achievement, and family histories of arrest and incarceration.

The Florida Department of Corrections has been successful in keeping the incarcerated suicide rate well below that of Florida's general population. But in late 1998, the department experienced its first and second female offender suicides. Both the department's own Inspector General and the Florida Department of Law Enforcement conducted independent investigations; neither discovered evidence of foul play, brutality, or falsification of records in connections with the deaths.

II. METHODOLOGY

The findings and recommendations in this report are based on the following research methodology:

- Data collected through site visits to female institutions and interviews with female inmates in the State of Florida (See Appendix A);[1]
- A survey questionnaire administered to a sample of correctional staff who work in the female institutions (See Appendix B);[2]
- A literature review on relevant topics.

[1] The sample size was based on randomly selected female offenders from each female institution. A total of 157 surveys were administered, of which 4 offenders chose not to participate, for a final sample size of 153.

[2] A total of 44 correctional staff participated in the survey.

III. FEMALE OFFENDERS

Women in prison often enter the system with complex histories indicative of neglect and abuse, starting in childhood and continuing through adulthood. Some of the most common characteristics of women in prison are personal histories of profound physical and sexual abuse, long standing histories of drug and alcohol dependence, and family histories of arrest and incarceration.[1] In a 1996 study, 92.1 percent of the female offenders interviewed reported having been victims of some form of emotional, physical, or sexual abuse prior to their current prison term. Thirty-one percent reported they had been forced to engage in sex, or had been raped or sodomized as children.[2]

In a 1996 study, 92.1 percent of the female offenders interviewed reported having been victims of some form of emotional, physical, or sexual abuse prior to their current prison term.

Female offenders, in general, are poorly educated. In one study of female offenders, 64.4 percent had not completed high school. The same study, which included Florida offenders, also reported that female offenders achieved significantly lower levels of education during their primary and secondary school years.[3]

Poor education often results in a decreased income earning capacity. When a poorly educated woman is the sole provider for her child(ren), the end result is often a cycle of poverty and a drain on the public.[4] A lack of education associated with poverty can result in survival by any means, including criminal activity, particularly when a woman is solely responsible for feeding and housing her children.

A lack of education associated with poverty can result in survival by any means, including criminal activity.

Female offenders are dissimilar from male offenders in many ways. On a national basis, researchers found that close to half of the female offenders were in prison for their first time, and

[1] Leslie Acoca and James Austin, The Crisis: Women in Prison, National Council on Crime and Delinquency Report (February 1996), 42.

[2] Ibid., 46.

[3] Ibid., 42.

[4] Ibid., 43.

the majority were there for non-violent drug and property offenses.[5] This is in sharp contrast to male offenders.

More than one half of the women interviewed in the National Council on Crime and Delinquency study on women in prison reported they were currently experiencing a physical health problem which interfered with their lives. Women offenders most commonly reported physical problems resulting from a history of sexually transmitted diseases (25.8 percent), head injuries (25.8 percent), and hepatitis (13.9 percent). Approximately twenty-six percent of the women interviewed for that study reported they had considered suicide.[6]

Many female inmates are incarcerated for drug related offenses. A recent study by the Bureau of Justice Statistics (BJS) indicates that "for the female prison population, drug offenders were the largest source of growth."[7] This is in sharp contrast to male offenders, who have much higher conviction rates for violent offenses. One explanation for the increase in the incarceration of women for drug offenses may be that the "war on drugs" has become a largely unannounced war on women.[8] In 1979, one in ten women were incarcerated for drug related offenses. In 1998, drug offenders nationwide accounted for more than a third of the female prison population (37.4 percent).[9]

Many female inmates are incarcerated for drug related offenses.

Researchers summarize the remaining profile of the typical female offender as:

- a female offender without a strong commitment to criminal behavior;
- a female teenager who drifts into criminality as a consequence of running away from sexual and physical abuse at home;
- a female who struggles to survive on the streets, which may lead her to other status offenses and crimes including prostitution and drug dealings;
- a female involved in drug abuse which escalates other criminal involvements; and
- a female vulnerable to male violence which may lead to illegal activities.

[5] Ibid.

[6] Ibid., 73.

[7] Meda Chesney-Lind, "Women in Prison: From Partial Justice to Vengeful Equity," Corrections Today (December 1998): 68.

[8] Ibid.

[9] Ibid.

However, despite histories of victimization or economic hardship, many of these women display considerable innovation and independence in their "survival strategies."[10]

A. National Statistics on Female Offenders

Nationally, since 1990, the annual rate of growth for female offenders has averaged an increase of 8.5 percent as compared to 6.6 percent for males for the same time period.[11] Comparing the percentage growth of female prisoners versus male prisoners for June 30, 1997 to June 30, 1998 shows that the female population increased 6.5 percent and the male population 4.7 percent.[12]

About 78,000 women, who have generally been sentenced to imprisonment for more than a year, are in federal and state government prisons. They make up 6.4 percent of the prison population of the United States. [13]

For more than a decade, the rate of increase in the number of women incarcerated in jails and prisons in the United States has consistently exceeded the rate of increase in the number of men being incarcerated.

The number of women incarcerated in prisons and jails in the United States is approximately 10 times more than the number of women incarcerated in Western European countries, whose combined female population is about the same size as that of the United States.

For more than a decade, the rate of increase in the number of women incarcerated in jails and prisons in the United States has consistently exceeded the rate of increase in the number of men being incarcerated.

Between 1985 and 1996:

- the female prison population increased by an average of 11.2 percent per year compared with 7.9 percent for men; and
- the female jail population grew by an average of 9.9 percent each year, and that of men by 6.4 percent.

---

[10] Ruth T. Zaplan, "The Nature of Female Offending, Patterns and Explanation," in. Female Offenders: Critical Perspectives and Effective Interventions (Gaithersburg, MD: Aspen Publishers, Inc., 1998), 14.

[11] Allen J. Beck, Ph.D., and Christopher J. Mumola, Prisoners in 1997, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (August 1998), 5.

[12] Allen J. Beck, Ph.D., and Christopher J. Mumola, Prison & Jail Inmates at Mid-Year 1998, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (August 1999), 5.

[13] Amnesty International, "Not Part of My Sentence," in Violations of the Human Rights of Women in Custody (March 1999).

According to a newspaper article, *Abuse of Female Prisoners Seen on Rise,*[14] female inmates in the nation's prisons and jails are routinely subjected to sexual abuse by male guards, including such activities as groping during body searches, male guards touching female prisoners' breasts and genitals during daily pat-down and strip searches, watching female prisoners as they shower and dress, and consensual sex and forceful rape.

B. Differing Backgrounds of Female Offenders

Female offenders have different needs than male offenders. The crimes women commit, their backgrounds, the reasons for substance abuse, and their responsibilities for their children are different from those of men. Managing female offenders therefore should be tailored to their specific needs.

> The needs and behaviors of female offenders are different from those of male offenders.

1. Female Juveniles

The differences between male and female offenders can be seen at an early age. As previously mentioned, several studies point out that females are more likely to have been sexually abused as children than males are and that this abuse starts at an earlier age. The perpetrators of these abuses are more likely to have been a family member for girls than boys, and the abuse is usually for a longer duration. This trauma affects girls differently than boys - instead of the usual "fear, anxiety, depression, anger and hostility, and inappropriate sexual behavior" exhibited by males, girls are more likely to exhibit behaviors that "include running away from home, difficulty in school, truancy, and early marriage."[15]

For girls in the juvenile justice system, 61.2 percent had experienced physical abuse and 54.3 percent had experienced sexual abuse. Alarmingly, although 68.1 percent had reported incidents of abuse, "reporting the incidents tended to cause no change or made things worse." One researcher observed that girls run away from home under such conditions, and according to the same researcher, 20.5 percent of these girls reported that their first arrest resulted from running away from home. Another 25 percent of the first arrest were for larceny-theft. Research also suggests that girls are running away from home because of their home life, and then are being forced into crime in order to survive on the streets.[16]

> Girls are running away from home because of their home life, and then are being forced into crime in order to survive on the streets.

[14] Barbara Vobejda, "Abuse of Female Prisoners Seen on Rise," Washington Post 4 March 1999, http:www.washingtonpost.com/wp-srv/national/daily/feb99/prisons4.htm (March 8, 1999).

[15] Meda Chesney-Lind, The Female Offender: Girls, Women, and Crime (California: SAGE Publications, Inc., 1997), 25.

[16] Ibid., 26, 92.

Research specific to Florida in 1995 found that girls were more likely than boys to have abuse histories and contact with the juvenile justice system for status offenses. Boys were found to have a higher rates of involvement with various delinquent offenses. The study also states that "an abusive and traumatizing home life relates to the girls' problem behavior, whereas boys' violations reflect their involvement in a delinquent lifestyle."[17]

Other studies state that the different risk factors for girls and boys should be used to formulate delinquency prevention and intervention programs. Programs for girls should deal with the physical and sexual violence in their lives, the risk of AIDS, alcohol and drug abuse, stress management, and efficacy and empowerment-development.[18]

2. Female Adults

In November of 1998, the National Institute of Justice, Centers for Disease Control and Prevention, published survey results which provide comparable data on female and male experiences. The experiences include any physical abuse they received as children and later as adults, and forcible rape or stalking experiences.[19]

Specific findings include the following:

- Both a high percentage of incarcerated men and women reported being raped or physically assaulted in their lifetimes - 66.8 percent for men and 55.0 percent for women.
- Rape is a crime committed primarily against youth. Of the 17.6 percent raped, 22 percent were under 12 years old and 32 percent were 12 to 17 years old.
- In the category of "since the age of 18," 76 percent of women reported being physically assaulted or raped by a current or former intimate partner whereas "men reported being raped and physically assaulted primarily by strangers and acquaintances."[20]
- Women experienced a much higher incidence of rape (17.6 percent as compared to three percent). Disturbingly, through overall lifetime experiences, 25 percent of women were raped and/or physically assaulted by a current or former intimate partner compared to eight percent of men.
- The majority of sexual violence is committed by men: 93 percent of women and 86 percent of men were raped/physically assaulted by a male.

---

[17] Ibid., 26-27.

[18] Ibid., 92.

[19] Patricia Tjaden and Nancy Thoennes, Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey, U.S. Department of Justice, Centers for Disease Control and Prevention (November 1998), 1.

[20] Ibid., 8.

- Reported stalking was at a much higher level than anticipated, and the study said that stalking should be considered a "significant social problem" in the United States.[21]

Studies show that women have a tendency to drink alone and deny treatment, and to drink for reasons of escape and psychological comfort. Current drug treatment programs which focus on females examining their lives and the quality of their relationships are not as successful with women as they are with men. This type of drug treatment could actually make the problem worse by exacerbating "a sense of distress, helplessness and hopelessness."[22]

Current drug treatment programs which focus on females examining their lives and the quality of their relationships are not as successful with women as they are with men.

Two different studies reviewed women offenders' backgrounds. The first study conducted interviews with 20 incarcerated women and documented how significant events in their childhood linked to their eventual criminality. All of these women had committed "street crimes" (prostitution, shoplifting, credit card fraud, drug offenses) and their current offenses included assault and battery, larceny, drug possession, and prostitution. This study report that most of these females were single mothers, 75 percent were intravenous drug users, and 17 of the 20 had histories of prostitution. Most were victims of sexual and/or physical abuse, many were runaways as children, many had violent adult relationships with men and were expected to bring in money through either prostitution or shoplifting. The study reports that these women viewed their criminal activities as work in order to support their partners, their children, and addictions. The second study involved a series of interviews with African American female offenders. The study reported that not only are African American girls victimized sexually, but they are also victims of "class oppression," a combination which may turn African American girls to lives of crime at an earlier age.[23]

Three studies support the theory that females in the criminal justice system have more problems with drugs than do men.

Three studies support the theory that females in the criminal justice system have more problems with drugs than do men. One study of women in Miami noted that "although men use drugs for the thrill, pleasure or in response to peer pressure, women are more likely to drink or use illegal drugs for *'self-medication'* ." With

[21] Ibid., 10.

[22] Meda Chesney-Lind, The Female Offender: Girls, Women, and Crime (California: SAGE Publications, Inc., 1997), 105.

[23] Ibid., 108-110.

extensive sexual and physical victimization histories, drug use among women begins as a way to "escape from the pain."[24]

A 1993 study finds that, female prostitutes view their activities as work and that prostitution is more ethical and safer than either stealing or drug dealing. While prostitution is a means of obtaining fast money, women are imprisoned more now because of the emphasis on drug crimes.[25]

The war on drugs has led to the increase in female incarcerations.

The war on drugs has contributed to the increase in female incarcerations. Approximately 36 percent of women serving sentences for drug offenses were convicted for possession of drugs. Also, improved technology contributes to sending more parole and probationers who fail to pass random drug tests back to prison. In California, 32 percent of female prisoners were there as parole violators in 1993.[26] An Amnesty International report released on March 4, 1999, also attributes the rapid increase of women in prison to the war on drugs.[27]

The hypothesis that female liberation is the reason why more females are arrested and sent to prison is disproven.[28] A 1994 Bureau of Justice Statistics study observed that half of the females in prisons had reported prior abuse by a spouse or intimate partner as compared to three percent for males.[29] This abuse continued for women from childhood. This study also reported the following differences in offenses committed by females versus males:

- Half of females were serving a sentence for a non-violent offense and were convicted in the past of non-violent offenses;
- Women prisoners were more likely to have killed an intimate partner or relative, but men were more likely to have killed strangers;
- Female inmates have more problems with drugs than do men and were more likely than men to have been under the influence of drugs while committing the crime for which they are currently incarcerated;

[24] Ibid., 135.

[25] Ibid., 137, 139, 143.

[26] Ibid., 147.

[27] Barbara Vobejda, "Abuse of Female Prisoners Seen on Rise," Washington Post 4 March 1999, http:www.washingtonpost.com/wp-srv/national/daily/feb99/prisons4.htm (March 8, 1999).

[28] Meda Chesney-Lind, The Female Offender: Girls, Women, and Crime (California: SAGE Publications, Inc., 1997), 115.

[29] Tracy Snell, Women in Prison, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Bulletin (March 1994), 5.

- Over a quarter of the female offenders had received some form of drug treatment prior to their incarceration. Over 40 percent of the females who reported using drugs had received treatment the month before committing their crime; and
- Female inmates were more likely than men to report having used a needle to inject illegal drugs, and more female inmates than male inmates reported sharing a needle at least once during drug use.[30]

Additionally, two-thirds of the incarcerated women in the 1994 Bureau of Justice Statistics had one child under 18. Fifty-two percent of women inmates with children under 18 were never visited by their children. One in five had never sent or received mail from their children, and one in four had never talked on the phone with their children.[31] Those who did receive visits from their children typically had one visit per month or less.

3. Female Offender Programming

The discussion on differences between male and female offenders often surrounds the equality versus parity argument. In other words, parity means that programming which meets the specific needs of the offender is adequate. Otherwise, programs are offered to females that have been designed for men. For example, substance abuse treatment programs are offered for both male and female offenders. However, the curriculums used by both programs were designed for men, who generally have not been sexually abused, battered, beaten, or been forced to resort to prostitution as a means of financial support.[32]

> While female offenders are entitled to equal opportunities for educational, vocational, and other programming, it does not mean that these programs have to be the same.

> Programs are offered to females that have been designed for men.

Historically, women offenders were treated differently; programming and sentencing differed.[33] Prisoners' rights litigation based on being treated equally introduced the parity example. An example is Alabama's experience with chain gangs. Reinstated in 1995, and because of a threatened lawsuit by male offenders claiming that excluding females from chain gangs was unconstitutional, the Commissioner for the Alabama Department of Corrections initiated a policy to include females on chain gangs. However,

[30] Ibid., 3-8.

[31] Meda Chesney-Lind, The Female Offender: Girls, Women, and Crime (California: SAGE Publications, Inc., 1997), 158.

[32] Ibid., 171.

[33] Ibid., 163.

this policy was not put into practice, and the Commissioner was forced to resign by the governor.[34]

In summary, female offenders are typically "poor, undereducated, unskilled victims of past physical[35] or sexual abuse, and single mothers of at least two children." Female offenders enter the criminal justice system with a host of unique medical, psychological, and financial problems.[36] There are a number of effective residential and community based programs which would better serve these offenders, their children, and the taxpayers rather than sending the offenders to prison.

C. Trends In Arrests

The latest categorical arrest data shows that the total number of all arrests increased by one percent nationally from 1996 to 1997, but fell by three percent for index crime arrests (murder, forcible rape, robbery, aggravated assault, burglary, larceny-theft, motor vehicle theft, and arson).[37] Males comprised 78 percent of all people arrested, and the majority were arrested for drug abuse violations and driving under the influence. Females accounted for 16 percent of all arrests (73 percent of which were for larceny-theft violations). Of those arrested for larceny-theft violations, 57 percent were under the age of 25.[38]

Changes in arrest patterns of female offenders are due to changes in the economic conditions of females' lives.

The table below illustrates the comparison of female and male inmate populations from 1990 to 1997.

Percent Distribution Change of Crimes by Sex 1990-1997		
	Male	**Female**
Total	58%	83%
Violent	64	68
Property	37	53

[34] Ibid., 164.

[35] Ibid., 158.

[36] Ibid., 170.

[37] U.S. Department of Justice, Federal Bureau of Investigation, Uniform Crime Reports for the United States 1997 (August 30, 1999), 221-222, 229; http:// www.fbi.gov/ucr/Cius_97/97crime/97crime.pdf.

[38] Ibid., 229.

Percent Distribution Change of Crimes by Sex 1990-1997		
Drug	48	99
Public-order	131	272

U.S. Department of Justice, Federal Bureau of Investigation, *Uniform Crime Reports for the United States 1997*

The largest group in the increase of female inmates are female drug offenders (38 percent), compared to male drug offenders (17 percent).[39]

D. Health Needs Of Female Offenders

A 1991 study conducted of North Carolina female prisoners, compared self-reports and clinical data at the beginning of incarceration and six months later.

The study found:

- Gynecological problems;
- High levels of substance abuse;
- Obesity; and
- High levels of depression and anxiety.

The study suggests that establishing of easy intervention programs such as weight reduction and stress reduction techniques could possibly lead to lower health care costs.

Alcohol, drug, and tobacco intake were reported as serious health problems among the inmates. Obesity existed in almost half of subjects and the obesity increased while incarcerated. High levels of depression and anxiety were unabated after six months in prison.[40]

The study suggests that establishing easy intervention programs such as weight reduction and stress reduction techniques could possibly lead to lower health care costs.[41]

1. Prior Physical And Sexual Abuse

A 1998 Commonwealth Fund Survey of Women's Health - a national survey on women's health care - revealed that 39 percent of U.S. women have been either abused or victims of violence,

[39] Allen J. Beck, Ph.D., and Christopher J. Mumola, Prison & Jail Inmates at Mid-Year 1998, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (August 1999), 11.

[40] Catherine Ingram-Fogel, Ph.D., "Health Problems and Needs of Incarcerated Women," Journal of Prison & Jail Health, 10, no. 1 (Summer 1991) : 49-53.

[41] Ibid., 55.

including rape, sexual assault or other physical assault. These women were more likely to have physical health problems and nearly twice as likely to have symptoms of depression or anxiety. [42] A study on self-reported prior abuse released by the Bureau of Justice Statistics in April 1999, indicates females are more abused than males.[43] State prison inmates reported both physical and sexual abuse experiences prior to their sentence: 57.2 percent of females compared to 16.1 percent of males. Of that same group, 36.7 percent of the females and 14.4 percent of the males reported that the abuse was experienced before age 18. This compares to the free world adult population where five to eight percent of free world males and 12 to 17 percent of free world females were abused as children.

> In the general adult population five to eight of males and 12 to 17 percent of females were abused as children.

From this same study other factors surfaced:

- Males are typically mistreated as children, but females are mistreated as both children and adults;
- Males are abused by family members, while females are abused by family members and intimate partners;
- Both genders received more abuse if living with a foster family or other agency;
- Higher levels of abuse are reported if parents abused alcohol or drugs;
- Higher levels of abuse reported for those with a family member incarcerated at some point; and
- Abused state prison inmates reported higher levels of alcohol and drug abuse.[44]

2. Female Offenders' Mental Health Issues

As previously noted, research suggests that childhood and adult victimization of girls and women frequently is a precursor to female

> Research suggests that childhood and adult victimization of girls and women frequently is a precursor to female criminality.

[42] CNN Interactive, "39 percent of U.S. women have been abused, survey finds," Health (May 5, 1999); http://www.cnn.com/HEALTH/9905/05/womens.health.ap/.

[43] Caroline Wolf Harlow, Ph.D., "Prior Abuse Reported by Inmates and Probationers," in U.S. Department of Justice, Bureau of Justice Statistics, Selected Findings (April 1999).

[44] Caroline Wolf Harlow, Ph.D., "Prior Abuse Reported by Inmates and Probationers," in U.S. Department of Justice, Bureau of Justice Statistics, Selected Findings (April 1999).

criminality.[45] Studies have found that, not unlike their adult counterparts, girls who have been abused, particularly at an early age, are more likely to become delinquent than girls who have not been abused.[46] Not all women or children who have been abused become criminals. The effects of familial betrayal, deception, and physical and psychological damage that abuse wages on these individuals plays itself out in ways that are unique to each person.

This is not to suggest that domestic violence, physical, sexual, and emotional abuse do not impact the male offender. However, unlike their female counterparts, studies have shown that males are abused as children less frequently than females. Also, male victimization has been shown to decrease as males grow older (25 percent of the female offenders reported adult abuse compared to 5.3 percent of male offenders).[47] Additionally, women react differently to abuse than men.

When women are abused, they are more inclined to internalize their feelings, become depressed, and assume responsibility for the abuse than men.[48] Research has found that even though men and women associate childhood abuse with depression, women's depression was more strongly associated with childhood abuse than was men's.[49] A direct relationship was determined between childhood abuse and adult psychiatric symptoms among 66 female psychiatric in-patients studied. Female patients in the study with a history of abuse had more severe symptoms, more borderline diagnoses, more suicidal symptoms, and were more likely to be given medication than male counterparts.[50] In another study, female survivors of abuse showed extreme difficulties

Research has found that even though men and women associate childhood abuse with depression, women's depression was more strongly associated with childhood abuse than was men's.

[45] Louise Bill, "The Victimization and Re-victimization of Female Offenders," Corrections Today (December 1998) : 107.

[46] Claire Windom, "The Cycle of Violence," Science Magazine 244 (1989) : 160-166.

[47] Meda Chesney-Lind, "Women in Prison: From Partial Justice to Vengeful Equity," Corrections Today (December 1998) : 70.

[48] Lorene Walker, The Battered Woman (New York: Harper and Row Publication, 1979).

[49] D. McClellen et al., "Early Victimization, Drug Abuse, and Criminality: A Comparison of Male and Female Offenders," Criminal Justice and Behavior 24, no. 4 (1997): 455-476.

[50] J. Briar, B. Nelson, J. Miller, and P. Krol, "Childhood Sexual and Physical Abuse as Factors in Adult Psychiatric Illness," American Journal of Psychiatry 144, no. 11 (1987): 1426-1430.

with anger, self-image, and trust. They turned their anger inward, resulting in self-destructive behaviors, including self-mutilation and suicide attempts.[51]

a. The Impact of Abuse on Female Offenders

Domestic violence, sexual abuse, and prostitution can injure an individual permanently. Many offenders continue to carry the scars. Failure to acknowledge that these scars exist will cost the system in terms of man-hours, system disruption, and ineffective programming. Problems which are not effectively addressed will leave the system with the same problems that caused their entry.

Research has determined that a single traumatic event can occur almost anywhere. Prolonged, repeated trauma by contrast, occurs only in circumstances of captivity. Repeated trauma occurs only when the victim is a prisoner, unable to flee, and under the control of the perpetrator. Children can be made victims because they are dependents. Captivity can be used to control and victimize children. Women can be made victims, and thus be held captive by economic, social, psychological, and legal subordination, as well as by physical force. The perpetrator's first goal appears to be the enslavement of the victim, and this is accomplished by exercising despotic control over every aspect of the victim's life. Abuse victims can find themselves trapped for hours, even days or months, with no freedom of movement. Perpetrators may dictate when the victim comes and goes, and for how long. But true damage begins to occur when the trauma is inflicted.[52]

Prolonged, repeated trauma occurs only in circumstances of captivity.

Control mechanisms over another person are based upon the systematic, repetitive affliction of psychological trauma. The mechanisms are organized techniques of disempowerment and disconnection. Battered women, for example, frequently report that their abuser has threatened to kill their children, their parents, or any friends who harbor them, should they attempt to escape. Fear is also increased by inconsistent and unpredictable outbursts of violence and by capricious enforcement of petty rules. Days may pass without action by the perpetrator, followed by aggressive and hostile attacks. The victim loses all sense of control as the abuse is unpredictable.[53]

Chronic abuse occurs over time. In addition to inducing fear, the perpetrator seeks to destroy the victim's sense of autonomy. This is achieved by scrutiny and control of the victim's body and

[51] Elaine Carmen, P. Riccard, and T. Mills, " Victims of Violence in Psychiatric Illness," American Journal of Psychiatry 141, no. 3 (1984): 378-383.

[52] Judith Herman, Trauma and Recovery (New York, NY: Basic Books, 1997), 75.

[53] Ibid., 77.

bodily functions. The perpetrator supervises what the victim eats, when she sleeps, when she goes to the toilet, and what she wears. When the victim is deprived of food, sleep, or exercise, this control results in physical debilitation. This assault on bodily autonomy shames and demoralizes her even when the victim's basic physical needs are adequately met.[54]

Additional methods are needed to achieve complete domination. As long as the victim maintains any other human connection, the perpetrator's power is limited. It is for this reason that perpetrators universally seek to isolate their victims from any other source of information, material aid, or emotional support.[55] As their captors seek to destroy their relationships, these individuals tenaciously seek to maintain communication with the world outside the one in which they are confined. Victims may attempt to communicate by phone or letter or even escape.[56]

b. Substance Abuse among Women Offenders

Abused women often use drugs or alcohol as a way of dealing with abuse issues and their associated feelings of failure and entrapment.

Research review shows many women use drugs and alcohol to avoid the pain associated with abuse. Women who have been abused are more vulnerable to a whole array of psychological and behavioral problems. Research indicates abused women often use drugs or alcohol as a way of dealing with abuse issues and their associated feelings of failure and entrapment.[57]

Female offenders establish a path from victimization to substance abuse and then to crime.

Literature review suggests women offenders tend to use drugs rather than alcohol. In that study, the women indicated that heroin and crack were their preferred drugs. Participants in that study reported using and abusing drugs before becoming involved in criminal activity. This directional information is significant, as it supports previous research establishing the pathway from victimization to substance abuse and then to crime.[58]

---

[54] Ibid.

[55] Ibid., 79.

[56] Ibid., 81.

[57] Louise Bill, "The Victimization and Re-victimization of Female Offenders," Corrections Today (December 1998): 160-166; D. McClellen et al., "Early Victimization, Drug Abuse, and Criminality – A Comparison of Male and Female Offenders," Criminal Justice and Behavior 24, no. 4 (1997): 455-476.

[58] Louise Bill, "The Victimization and Re-victimization of Female Offenders," Corrections Today (December 1998): 160-166.

Women who abuse substances bring with them different issues requiring different resolutions than their male counterparts. When compared with men, women who abuse substances are more likely to be poor,[59] are more likely to be involved with a partner who abuses drugs,[60] have lower self-esteem,[61] are more likely to differ and exhibit more severe physiologic effects,[62] and are more likely to be victims/survivors of violence as adults and as children.[63] Unfortunately for female offenders, substance abuse treatment services have traditionally been designed by and for men.[64]

Substance abusing women have survived incredible amounts of abuse and hardship, and the qualities that help them survive can be used to help them recover.

In order to achieve success and assure responsible fiscal expenditure, a substance abuse program should target the population it seeks to rehabilitate. During her presentation at the Department of Corrections Third Female Inmate Symposium held in September 1999, in Orlando, Florida, Stephanie Covington presented such a program for female offenders. Successful substance abuse intervention for women must recognize that past physical, emotional, and sexual abuse may be the root causes for substance abuse. When the root causes are not addressed, recidivism is more likely to occur. Successful substance abuse interventions should also recognize and build on the multiple strengths that enable those women to survive abuse.

---

[59] Policy Research, Inc., Practical Approaches in the Treatment of Women Who Abuse Alcohol and Drugs DHHS publication number (SMA) 94-3006 (Rockville, MD: Center for Substance Abuse Treatment, 1994); and P. Holden, J. Rann, L. VanDrasek, Unheard Voices: A Report on Women in Michigan County Jails (Lansing, MI: Women's Commission, 1993); R. Moise et al., "A Comparison of Black and White Women Entering Drug Abuse Treatment Programs," International Journal of the Addictions 17 (1982): 46-47.

[60] P. Holden, J. Rann, and L. VanDrasek, Unheard Voices: A Report on Women in Michigan County Jails (Lansing, MI: Women's Commission, 1993); N. Finkelstein et al., Getting Sober, Getting Well (Cambridge, MA: Women's Alcoholism Program of CASPAR, 1990).

[61] P. Holden, J. Rann, L. VanDrasek, Unheard Voices: A Report on Women in Michigan County Jails (Lansing, MI: Women's Commission, 1993).

[62] Policy Research, Inc., Practical Approaches in the Treatment of Women Who Abuse Alcohol and Drugs DHHS publication number (SMA) 94-3006 (Rockville, MD: Center for Substance Abuse Treatment, 1994).

[63] N. Finkelstein et al., Getting Sober, Getting Well (Cambridge, MA: Women's Alcoholism Program of CASPAR, 1990): 373-374.

[64] Policy Research, Inc., Practical Approaches in the Treatment of Women Who Abuse Alcohol and Drugs DHHS publication number (SMA) 94-3006 (Rockville, MD: Center for Substance Abuse Treatment, 1994); P. Holden, J. Rann, L. VanDrasek, Unheard Voices: A Report on Women in Michigan County Jails (Lansing, MI: Women's Commission, 1993).

The strengths should not be underestimated and should be utilized to impact or motivate the female offender's rehabilitation. Substance abusing women have survived incredible amounts of abuse and hardship, and the qualities that help them survive can be used to help them recover.[65]

c. Prostitution and Post-Traumatic Stress Disorder

Often experiences connected with prostitution are associated with Post-Traumatic Stress Disorder (PTSD). Melissa Farley is a leading researcher in exploring the association between prostitution, violence, trauma, and PTSD. Working under the assumption that prostitution itself is violence against women, prostitution is a sequela of childhood sexual abuse, prostitution is domestic violence, and is in many instances a type of slavery or debt bondage.[66]

Many authors have documented sexual and other physical violence as the normative experience for women in prostitution. Researchers likened prostitution to domestic violence. Exercises of coercive control over women in prostitution by pimps and customers are identical to the methods used by battering men to control women. Examples are isolation, verbal abuse, economic control, threats and physical intimidation, denial of harm and sexual assault used as a means of control.[67]

Researchers likened prostitution to domestic violence.

The concept of PTSD has been important in describing the psychological symptoms suffered by combat veterans, sexual abuse survivors, and concentration camp survivors. It can also be used to describe the psychological harm of prostitution. In a survey of prostitutes in five countries, 82 percent reported physical assaults since entering prostitution, and 68 percent of those interviewed reported being raped. In that regard, 68 percent of the respondents also met criteria for a diagnosis of PTSD, with 76 percent qualifying for partial PTSD.[68]

d. The "Battered Woman Syndrome"

An understanding of PTSD, it's origin, effect on female offenders, and the best means to handle offenders with this disorder should assist corrections staff in more effectively and efficiently managing female offenders. It should also assist corrections staff to maintain control, and avoid potential correctional officer and inmate injury. Because these women often complain of

---

[65] Donna Kerr, "Substance Abuse Among Female Offenders," Corrections Today (December 1998): 116.

[66] Melissa Farley and Howard Barkin, "Prostitution in Five Countries: Violence and Post-Traumatic Stress Disorder," Feminism and Psychology 8, no. 4 (November 1998): 406. ***Note****: This report included women from the United States.*

[67] Ibid.

[68] Melissa Farley and Howard Barkin, "Prostitution in Five Countries: Violence and Post-Traumatic Stress Disorder," Feminism and Psychology 27, no. 3 (November 1998): 37-49.

physical and mental symptoms which cannot be substantiated, an understanding of the disorder could also impact health care's fiscal position.

The idea of "battered women syndrome" was introduced by a nationally known expert in the field of battered women.[69] This syndrome has since become a sub-category of the diagnostic and statistical manual of mental disorders, (DSM3-R), labeled post-traumatic stress disorder syndrome. This disorder has most frequently been associated with the effects of war on United States Vietnam veterans.

Literature review of several studies report a positive correlation between a history of childhood sexual assault and the symptoms of PTSD in adult women. The symptoms of PTSD may be cumulative over one's lifetime. Post Traumatic Stress Disorder can result when people have experienced "extreme traumatic stressors which involve the direct personal experience of an actual or threatened death or serious injury; or other threat to one's personal integrity."[70] It may also occur when an individual witnesses an event which involves death, injury, or a threat to the physical integrity of another person, or in learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.[71]

Symptoms of PTS
• Repeated, disturbing memories, thoughts, or images of past trauma
• Sudden acting or feeling as if trauma from the past were happening again
• Feeling very upset when someone reminds you of past trauma
• Feeling irritable or having angry outburst
• Feeling jumpy or easily startled

Source: Melissa Farley and Howard Barkin, "Prostitution in Five Countries: Violence and Post-traumatic Stress Disorder," *Feminism and Psychology* 27(3): 37-49, November 1998.

Flashbacks to incidents of abuse may occur as both auditory and visual. Victims of PTSD may develop phobias and uncontrollable anger or rage.[72] Additional triggers may be the interaction with authority figures or with men in general (an individual who may trigger a memory of past

---

[69] Lenore Walker, The Battered Woman (New York, NY: Springer Publication, 1979).

[70] APA Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (Washington, DC: American Psychiatric Press, 1994).

[71] APA Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (Washington, DC: American Psychiatric Press, 1994).

[72] Source: Melissa Farley and Howard Barkin, "Prostitution in Five Countries: Violence and Post-traumatic Stress Disorder," *Feminism and Psychology* 27(3): 37-49, November 1998.

violence by a perpetrator), being physically threatened, restrained or locked down, and being naked. Suicide may also indirectly relate to childhood experiences of violence.[73]

From a security perspective, some psychiatric disorders such as PTSD and anxiety disorders are likely to manifest as management problems for security staff if security staff do not know how to effectively identify and address the disorder. Female offenders with PTSD may also use medical and psychiatric services inappropriately. When these disorders are not adequately and appropriately attended to or identified by a mental health unit, an increased use of staff time and unnecessary use of valuable and limited resources will be wasted.

e. The Impact of Traditional Security Methods on Women Offenders

Correctional systems nationwide have developed a system of inmate management based on managing male offenders. Without much fanfare, and with little public discussion or debate, the male model of incarceration has been increasingly accessed in responding to the soaring number of women inmates.[74]

Correctional systems nationwide have developed a system of inmate management based on what has worked with managing male offenders.

The corrections field in general, and specifically in institutions, is mission-driven to be in control, to hold the power, to be in charge. Sociologists recognize that it is much more a male phenomenon than a female one to want control and power, and to be willing to physically challenge another for that power.[75]

In contrast, female offenders do not see the prison experience as a quest for control. Instead, the offender naturally moves towards establishing relationships. For staff unfamiliar with female offenders' behavior, this may be very threatening.[76] Because of the difference in sexes, it is important to address how corrections professionals approach female offenders.

Many corrections professionals adhere to the adage of treating all inmates the same. Cranford and Williams maintain that this should not occur, nor should it be demonstrated in other groups of inmates. As an example, inmates with mental impairments are not treated the same as

[73] Judith L Herman, Trauma and Recovery (New York, NY: Basic Books, 1997), 109.

[74] Meda Chesney-Lind, "Women in Prison: From Partial Justice to Partial Equity," Corrections Today (December 1998): 68.

[75] Susan Cranford and Rose Williams, "Critical Issues in Managing Female Offenders," Corrections Today (December 1998): 130.

[76] Ibid.

mentally healthy inmates. Female behavior is different from male behavior. The prison environment doesn't make a female offender any less a woman.[77]

Unfortunately, the prison system often contributes to the re-victimization of girls and women.[78] Canadian researchers Jan Haney and Connie Kristiansen suggest that most prison operations include procedures that can cause vulnerable women to relive their abusive experiences. Such women may demonstrate a renewed sense of powerlessness, a feeling many have repeatedly experienced during previous victimization.[79]

Prison operations include procedures that can cause vulnerable women to relive their abusive experiences.

Because of the concern for security, prison operations may include unannounced searches for contraband where both female inmates' personal spaces and bodies are searched.[80] The searching of cabinets and storage spaces, violent stripping of beds, and violent searching through personal items can be traumatizing for women.[81] Many women with histories of abuse have experienced the violent ransacking of their living spaces by their abusers. While in a prison setting, there is a constant awareness and reminder of sexual assault through the search and security activities.[82]

Because of the concern for security, prison operations may include unannounced searches for contraband where both female inmates' personal spaces and bodies are searched.

Other routine procedures used in processing individuals into a prison setting and the providing of medical care may inadvertently re-traumatize women with abuse histories. They include:

Routine procedures used in processing individuals into a prison setting and the providing of medical care may inadvertently re-traumatize women with abuse histories.

[77] Ibid.

[78] Louise Bill, "The Victimization and Re-victimization of Women in Prison," Corrections Today (December 1998): 107.

[79] J. Haney and C. Kristiansen, "An Analysis of the Impact of Prison on Women Survivors of Childhood Sexual Abuse," Women in Therapy 20, no. 4 (1998): 13.

[80] Louise Bill, "The Victimization and Re-victimization of Women in Prison," Corrections Today (December 1998): 110.

[81] L. Zupan, "Men Guarding Women: An Analysis of the Employment of Male Correctional Officers in Prisons for Women," Journal of Criminal Justice 20 (1992): 297-309.

[82] Ibid.

- Removal of clothing (strip searches, suicide precautions, medical examinations);
- Intimate touching of individuals' bodies (strip searches, medical examinations);
- Threat or use of physical force;
- Isolation (confinement, suicide precautions); and
- Being held in locked rooms or spaces, and use of handcuffs or other restraint devices.

Each of these activities may be reminiscent of previous abuse which may cause flashbacks, or disassociation from the situation at hand. In addition, security procedures become more difficult when conducted within a vacuum of information and when they appear coercive.[83]

[83] Bonita M. Veysey, Ph.D., Kate DeCore, and Laura Prescott, "Effective Management of Female Jail Detainees With Histories of Physical and Sexual Abuse," American Jails (May-June 1998): 57.

IV. Florida's Female Offenders

Since 1988, Florida's female prisoners as a percentage of the total inmate population have remained between five and six percent. Since 1988, Florida's female population has increased a total of 89 percent versus 97 percent for the male population.

The following charts provide an overview of the female offender population in Florida.

This chart reflect the growth in the female offender population in both the incarcerated and supervised populations.

FLORIDA'S FEMALE OFFENDER POPULATION						
	INCARCERATED OFFENDERS			SUPERVISED OFFENDERS		
	1978	**1988**	**1998**	**1978**	**1988**	**1998**
Status Population	798	1,858	3,526	4,556	16,875	32,254
Percentage of Total Population	4.2%	5.5%	5.2%	12.9%	19.3%	21.6%
Percentage Increase over Ten Years		132.8%	89.0%		270%	83%

Source: *Status Report on Female Offenders*, Florida Department of Corrections, 1999

In 1990, the American Correctional Association published the results from a survey conducted on female offenders. A very detailed profile was produced. As of FY 1997-1998, Florida's average female population was determined to be 34 years of age. Other typical characteristics included:

- an economically disadvantaged minority;
- unmarried;
- single parents;
- ran away from home as a youth;
- had attempted suicide;
- had serious drug problems;
- had been a victim of physical or sexual abuse;
- had never completed high school; and
- had been unemployed in the three years before going to prison.

The following charts illustrate age, race, primary offenses and the number of commitments to the State of Florida's Department of Corrections.

ETHNICITY OF FLORIDA'S FEMALE OFFENDER		
RACE	**NUMBER**	**PERCENTAGE**
WHITE	1,587	43.7%
BLACK	1,894	52.1%
OTHER	152	4.2%
TOTAL	**3,633**	**100%**

Source: *Status Report on Female Offenders*, Florida Department of Corrections, 1999

AGES OF FLORIDA'S FEMALE OFFENDER					
Category	**White**	**Black**	**Other**	**Total**	**Percentage**
16-24	183	311	27	753	13.9%
25-49	1290	1510	118	2686	80.7%
50+	114	73	7	194	5.4%
TOTAL	**1,587**	**1,894**	**152**	**3,633**	**100%**

Source: *Status Report on Female Offenders*, Florida Department of Corrections, 1999

Most of the females were first imprisoned for larceny, theft, or drug offenses, and at the time of the survey, Florida's offenders were serving time for drug offenses, murder, larceny, theft or robbery. The top five crimes for which the women were incarcerated are:

- Drugs (28.7 percent);
- Murder/Manslaughter (16.8 percent);
- Violent Personal (15.7 percent);
- Property/Theft/Fraud/Damage (13.6 percent);
- Burglary (10.8 percent).

V. POLICY PROBLEMS AND REMEDIES

A. Search Procedures

Routine institutional practices which cause concern are strip and body searches. Approximately 20 percent of the states have had lawsuits filed relating to these policies. Many of the actions involve strip searches on female inmates being conducted or viewed by male correctional officers. The prevalence of the lawsuits may be a result of the prior physical and sexual abuse of those female inmates, which cause these searches to have a more traumatic effect on females than on males. Other legal actions involve actual sexual abuse by correctional officers.[83]

A specific example is the case of *Jordan v. Gardner, 986 F.2d 1521(9th Cir. 1993),* filed by female inmates at the Washington Corrections Center for Women regarding the prison's policy on cross-gender clothed body searches. Prior to January 1989, only female officers conducted searches of female inmates at the institution. A new warden wanted to increase the number of searches performed, so he ordered the searches to be conducted by correctional officers of either gender. This policy became effective July 5, 1989, and lasted only one day. The inmates filed for, and received, a temporary injunction of the policy.

Testimony at the district court revealed extensive physical and sexual abuse histories of the female inmates and that, given the differences between men and women, searches of this type "may well cause women, and especially physically and sexually abused women, to react differently to searches of this type than would male inmates subjected to similar searches by women."[84] The district court held that psychological damage and emotional pain and suffering would occur even if the searches were properly conducted. Based upon the Eighth Amendment, which protects incarcerated persons from unwarranted infliction of pain, the Third Circuit Court of Appeals upheld the district court's ruling in favor of the inmates' complaint.

B. Sexual Misconduct

In the early 1990's, at least twenty-three departments of corrections were involved in class action or individual damage lawsuits related to sexual misconduct.[85] The Justice Department has filed civil lawsuits in two states (Arizona and Michigan) alleging systemic sexual misconduct by male correctional staff in women's prisons. The Association of State Correctional Administrators

---

[83] Meda Chesney-Lind, The Female Offender: Girls, Women, and Crime (California: SAGE Publications, Inc., 1997), 166-167.

[84] *Jordan v. Gardner*, 986 F.2d 1521, 1525 (9th Cir. 1993) .

[85] U.S. Department of Justice, National Institute of Corrections, Sexual Misconduct in Prisons: Law, Agency Response, and Prevention (November 1996), 1.

("ASCA") identified staff sexual misconduct as a major management concern in 1996.[86] The ASCA resolution on sexual abuse of inmates by staff was approved and adopted by the Association in January, 1999. As of April 1999, forty-one states, the District of Columbia, and the federal system have passed laws prohibiting certain types of staff sexual misconduct in prisons.[87]

In March of this year, the state of Arizona and the Justice Department entered into a settlement agreement which requires the state to provide adequate employee and inmate training, improve investigative techniques, and require male correctional officers to announce their presence (unless they reasonably suspect inappropriate behavior by inmates). The agreement requires the department to strengthen its policies and procedures on inmate-staff behavior consistent with the terms of the agreement. It addresses background screenings and requires the use of the same pre-employment screening for non-correctional staff having significant inmate contact as is used for correctional staff.

The agreement gives Arizona the option of installing privacy screens in toilet and shower areas or the scheduling of two 15-minute periods each day in which female inmates are allowed to shower and dress. Normally, only female correctional officers would be monitoring the showers and dorm areas; however, the agreement specifically states that equal opportunity rights are not to be affected. Male officers would generally announce their presence in the areas where female offenders are in a state of undress. In May 1999, Michigan also entered into an similar agreement with the Justice Department, and has begun a six-month moratorium on cross-gender pat searches.[88]

A report by the Human Rights Watch Women's Rights Project reviewed alleged sexual misconduct at eleven state prisons. The report indicated that male correctional officers "vaginally, anally, and orally raped female prisoners and sexually assaulted and abused them."[89] Officers used not only actual or threatened physical force, but also their authority "to provide or deny goods and privileges to female prisoners," or "to reward them for

> Sometimes administrative confinement is used to punish inmates who report sexual misconduct, which in effect is putting the accuser in prison as opposed to the perpetrator of the alleged misconduct.

[86] United States General Accounting Office, Women In Prison, Sexual Misconduct by Correctional Staff GAO/GGD-99-104, Report to the Honorable Eleanor Holmes Norton, House of Representatives (June 1999), 3.

[87] Ibid., 1.

[88] Ibid., 3.

[89] Women's Rights Project, "All Too Familiar, Sexual Abuse of Women in U.S. State Prisons, U.S.A.," Human Rights Watch (New Haven, CT: Yale University Press, 1996), 1.

having done so." The report cited the problems associated with mandatory pat-frisks or room searches which allow male correctional officers to place their hands on females' bodies and to view female inmates while in a "state of undress in the housing or bathroom areas." The report also described verbal degradation of female prisoners, which contributes to a hostile environment in state prisons.[90]

Contributing factors which lead to to sexual misconduct are the lack of specific training, the lack of clear prohibitions against such behavior, and the lack of educating prisoners about sexual misconduct.

The report stated that one of the contributing factors in sexual misconduct is permitting male correctional officers to have positions of authority over female prisoners contrary to international rules of conduct. The report cited the passage of the Civil Rights Act of 1964 which stated that employers could not withhold a person from carrying out the duties and responsibilities of the position based solely on gender. The Human Rights Watch states that it has no opposition to male correctional officers supervising female offenders as long as sufficient safeguards are in place to prevent or report sexual misconduct.

Other factors contributing to sexual misconduct include: lack of specific training; clear prohibitions against such behavior; and the lack of education for prisoners about sexual misconduct. The Human Rights Watch report states that not only do some states lack specific prohibition against such activity, but those states with specific prohibitions often do not fully

States with specific prohibitions against sexual misconduct do not enforce the laws to the fullest extent possible and record keeping is not conducted to maintain information regarding specific allegations against officers.

[90] Ibid., 1-2.

enforce them. In many cases, record keeping regarding specific allegations against officers is not maintained. The report cited problems with existing internal grievance and investigative processes to report and review sexual misconduct. Also cited was the perceived lack of credibility of inmates' testimony, and the need to establish to a very high burden of proof - clear and convincing evidence - in order to proceed with sexual misconduct charges. Another problem cited was the use of administrative confinement for inmates who report sexual misconduct, which in effect is putting the accuser in prison as opposed to the perpetrator of the alleged misconduct. Noted also is the lack of a reliable centralized database of reported sexual misconduct. The group also stated the need to establish independent oversight groups with sufficient investigative powers to review allegations of sexual misconduct. To date, non-governmental agencies have mostly acted as independent monitors, but they don't have the authority to go inside prisons for interviews, or have access to records and information.[91]

Despite lawsuits, legislation and increased attention by the news media and correctional agencies, sexual misconduct incidents still occur, and the problems are usually under reported.

[91] Ibid., 2-7.

VI. FLORIDA'S FEMALE POLICIES AND PROCEDURES

A. Florida's Policies and Procedures on Searches

Rule 33-602.204, Florida Administrative Code, provides for three levels of inmate searches which maybe conducted by correctional staff: clothed searches; strip searches; and body cavity searches.

Random searches of clothed inmates may be conducted by the appropriate staff who may be of the opposite sex of the inmate. These searches do not require approval of the staff person's supervisor.[92]

Random searches of clothed inmates may be conducted by the appropriate staff who may be of the opposite sex of the inmate.

Strip searches shall be conducted by correctional staff of the same sex of the inmate being searched, except in emergency situations. The supervisor of a strip search should have the rank of at least Correctional Officer II (Sergeant), and if the Sergeant is not physically present then he/she must give permission before the search can be conducted. If no Correctional Officer II in on duty, the shift officer in charge must authorize the search. The rule is silent as to the sex of the supervisory staff. A search of one inmate is to be conducted in an area accessible only to the inmate and the staff conducting the search. If there is more than one inmate involved in the search, they may all be searched at the same time and in view of each other. Only those inmates and staff involved are to be present during the search.[93]

Body cavity searches are conducted only by Health Services staff who may be of the opposite sex. Body orifice and cavity searches are conducted only when authorized by the Warden, Assistant Warden, or the Correctional Officer Chief if there exists reasonable cause to believe that an inmate has contraband hidden in a body cavity.[94]

B. Florida's Sexual Misconduct Statutes

Section 944.35(3)(b)2, F.S. (1999), provides that Department of Corrections employees who engage in sexual misconduct with an inmate or any other person supervised by the department, without committing sexual battery, commits a third degree felony. As used in the statute, the term "sexual misconduct" means oral, anal, or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object. Sexual misconduct does not include a bona fide medical act or an internal search conducted in the lawful performance of the employee's duty. Section 944.35(3)(b)1, F.S. (1999).

---

[92] Section 33-602.204(1), F.A.C.

[93] Section 33-602.204(2), F.A.C.

[94] Section 33.602.204(3), F.A.C.

Additionally, Florida law requires correctional employees to report their knowledge or reasonable suspicions of sexual misconduct, and it also provides that the failure to report, or reporting inaccurately, is a first degree misdemeanor while any attempt to coerce the person required to report is a third degree felony. Section 944.35(3)(d), (4)(a), (4)(b), (4)(c), F.S. (1999).
Section 944.35(3)(b)3, F.S. precludes any employee of the department who engages in prohibited sexual misconduct from using consent as a defense.

Section 944.35(3)(c), F.S. provides that any sexual misconduct violation shall constitute sufficient cause for dismissal from the department and the staff involved shall not be employed in any capacity in connection with the corrections system.

VII. SEXUAL ABUSE OF WOMEN IN PRISONS

The exact number of sexually assaulted prisoners is unknown, but the Bureau of Justice Statistics estimates that there are 135,000 rapes of women inmates a year nationwide, though many groups believe the number is higher.[95]

In corrections, staff-on-inmate sexual misconduct is defined as "consensual" sex; the near-total control and power imbalance given in a prison environment. It may also include using lewd or sexually offensive language, observing an inmate showering without reason, and other behavior. Verbal harassment, improper visual surveillance including male staff watching female inmates while naked, improper touching of breasts and genitals, consensual sex or rape are among the types of incidents reported.

A. Statutes on Custodial Sexual Conduct

Under federal and state laws, rape and other forms of coerced sexual contact are prohibited by general criminal laws. Additionally, laws exist which recognize the potential for abusive relationships between female inmates and correctional officers. Such laws have criminalized custodial sexual contact.[96] In addition, 37 states, the District of Columbia and the federal government have laws specifically prohibiting sexual relations between jail and prison staff and inmates.[97] Thirteen states do not have such laws. [98]

When an officer's conduct is such that it violates criminal law or institutional or criminal rules, the victim is often reluctant to complain; frequently her accusations will not be taken seriously by investigators. She may also fear retaliation by the perpetrator or other correctional staff.

---

[95] "The Rape Crisis Behind Bars, " The New York Times**,** December 29, 1993.

[96] Custodial sexual conduct is any sexual conduct that involves a person under the custody of the state.

[97] Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas and Wyoming. See B. Smith, "Fifty-State Survey of Criminal laws Prohibiting Sexual Abuse of Prisoners," National Women's Law Center, Washington DC, 1998.

[98] Alabama, Kentucky, Massachusetts, Minnesota, Montana, Nebraska, Oregon, Utah, Vermont, Virginia, Washington, West Virginia and Wisconsin (this state has a law prohibiting "abuse" of people in penal institutions). Massachusetts prison staff rules prohibit sexual relations between staff and inmates.

Many correctional experts report that staff-on-inmate sexual misconduct is under reported nationally due to fear of retaliation and the vulnerability felt by the female inmates.

In the 1990's, the concern over sexual misconduct by correctional staff has increased.

In the 1990's, concerns regarding sexual misconduct by correctional staff increased. Twenty-three departments faced class action or individual damage suits related to sexual misconduct, according to a report by the National Institute of Corrections.

B. Incidents in Florida of Custodial Sexual Conduct

In March 1998, a former prison guard was convicted of raping a female inmate at the Florida Correctional Institution in Lowell. Sentencing the guard to serve nine years in prison, the judge said, "It's clear from the evidence that you abused the trust that was put in you as a corrections officer." Recently, an employee working at the Gadsden Correctional Facility (a privately operated facility) was charged with engaging in sexual misconduct with an inmate, but the case was dismissed because the employee was not at the time, or had ever been, an "employee of the department." [99]

Due to the high incidence among female inmates of prior sexual abuse and rape, most inmates in this group are not aware of what actually constitutes sexual harassment or rape.

[99] State of Florida vs. Jonathan Henry, Case No. 97-834, Motion to Dismiss, Second Judicial Circuit for Gadsden County, Florida, September 16, 1998. Legislation for the past two legislative sessions in Florida has proposed creating a new section of statute to provide the same sexual misconduct offense to employees of county or municipal detention facilities as well as to employees of private detention facilities on contract with a county commission. However, passage has not occurred.

VIII. SUICIDE PREVENTION POLICIES AND PROCEDURES

A. Theories of Suicide for the General Population

Nationally, the suicide rate in 1995 for the general population for adults ages 20 to 24 years old was 6.2 per 100,000 persons. The percentage rate was 27.7 for males and 4.3 for females.[100]

Prisons are considered a deviant type of society where social regulation is extremely high, and some prison suicides would be categorized as fatalistic.[101]

In the general population the typical suicide *completer* is elderly, male, white, psychiatrically disturbed, lives alone, and uses a violent method to complete suicide. A typical suicide *attempter* is under 30 years old, white, female, married, and typically uses an overdose of medications to attempt suicide.[102]

Prison can exacerbate severe and chronic mental illnesses. Brutality and overcrowding can also affect inmates, even if they had no prior history of mental illness. Many people become depressed and suicidal in prison. Prison can not only deteriorate existing mental conditions, but can cause breakdowns in previously sane prisoners.[103]

1. Profile of Inmate Suicides

Suicidal inmates do not meet the general population profile, and the typical suicidal inmate differs between jails and prisons. The profile of a typical suicide completer in jail is a single white male, in his early twenties, arrested for drunkenness, who has no prior history of arrests, is placed in isolation for either his own protection or for surveillance, and is dead within three hours by hanging.[104]

---

[100] Kathleen Maguire and Ann L. Pastore, eds., Sourcebook of Criminal Justice Statistics 1997, U.S. Department of Justice, Bureau of Justice Statistics (Washington DC:USGPO, 1998), 299.

[101] *Fatalistic* behavior is demonstrated when social regulation is too strong. According to Lester and Danto, people commit suicide as method of escaping from "bonds of society" such as slaves did in the past. David Lester, Ph.D. and Bruce L. Danto, M.D., Suicide Behind Bars: Prediction and Prevention (Pennsylvania: The Charles Press Publishers, Inc., 1993), 14.

[102] David Lester, Ph.D., and Bruce L. Danto, M.D., Suicide Behind Bars: Prediction and Prevention (Pennsylvania: The Charles Press Publishers, Inc., 1993), 23.

[103] Terry Kupers, M.D., Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It (San Francisco, California: Jossey-Bass, Inc., 1999), 15, 18.

[104] David Lester, Ph.D., and Bruce L. Danto, M.D., Suicide Behind Bars: Prediction and Prevention (Pennsylvania: The Charles Press Publishers, Inc., 1993), 28.

Studies have shown that there are varying profiles of prison suicides. In a Texas study in 1985, the typical suicide completer was single, white, catholic, male, under 30 with one or more prior arrests, and sentenced for a crime against a person. One third of the inmates who attempted suicide had prison sentences of less than five years or more than 25 years. Most suicides were completed after the inmate has served one to two years of his sentence. Eighty-nine percent committed suicide by hanging.[105] A 1989 Maryland study found the typical suicide completer to be black, 25 to 34 years old, housed in a maximum security institution, and received a sentence of more than 97 months. The Maryland study found that the typical suicide was completed by hanging oneself. In the federal prison system, between 1983 and 1987, the most common suicide completer was found hanging in a single cell between midnight and five a.m. in late spring. A study of Canadian federal prisoners yielded the following profile: male, suicide by hanging, frequently attempted shortly after sentencing, most likely single, had attempted suicide before, history of drug or alcohol abuse and of psychiatric illness.[106]

One third of the suicides had prison sentences of less than five years and those with sentences of more 25 than years.

PRISON SUICIDE PROFILES	
Morality Shock - commits suicide shortly after admission	*Chronic Despair* - served several months and developed "persistent sense of hopelessness and futility regarding future," disconnected from family, friends
Manipulative - antisocial person who may make nonlethal attempts at suicide in order to manipulate prison staff; typically cuts his wrists or swallows glass; uses suicidal behavior to enhance life, not to end it	*Self-Punishment* - mutilates himself as a form of punishment and humiliation and is making his life as miserable as possible [107]

Source: David Lester, Ph.D. and Bruce L. Danto, M.D., Suicide Behind Bars: Prediction and Prevention

In general, suicidal people have more psychological disorders, addictions to alcohol and drugs, and a depressed state of mind.

Childhood experiences which influence suicidal behavior include having parents who

[105] Ibid., 29.

[106] Christopher Green et al., "A Study of 133 Suicides Among Canadian Federal Prisoners," Prison Violence and Inmate Suicide and Self Injury 4, no. 3 (1992); http://www.csc-scc.gc.ca/crd/forum/e043/3043i.htm

[107] David Lester, Ph.D., and Bruce L. Danto, M.D., Suicide Behind Bars: Prediction and Prevention (Pennsylvania: The Charles Press Publishers, Inc., 1993), 35.

were psychiatrically disturbed, abused drugs and alcohol, or were neglectful or abusive. Other childhood experiences which influence suicidal behavior include loss of parents through death or divorce, physical or sexual abuse, and having family members who committed suicide. Other recognized stressors that contribute to suicide include recent experiences with high levels of stress, and breakdowns in interpersonal relationships. In general, suicidal people have more psychological disorders, addictions to alcohol and drugs, and a depressed state of mind. A potential suicide attempter may have a genetic predisposition for biochemical brain defects, low self esteem, irrational thought processes, poor problem solving skills, inability to deal with great levels of stress, and a lethal method of suicide available.[108]

Research on inmate suicides has raised the question of whether suicide in prison is a result of the commitment to prison or of the prison environment. Overcrowding (which is a part of the prison environment) can be a significant stressor. There may also be a link in personality and background between those who are susceptible to suicide and those who commit crimes.[109]

B. Mental Health

While some prisoners are manipulative, many also suffer from mental illness. Because of a lack of mental health treatment in prisons, sometimes inmates are forced to be manipulative in order to get attention and treatment.[110]

Many mentally ill inmates remain in their cells during the day to avoid problems with other inmates. However, this behavior of self-isolation actually worsens the mental condition. Confinement in a cell with no real social interaction or meaningful activity tends to exacerbate all types of mental disorders.[111]

Confinement in a cell with no real social interaction or meaningful activity tends to exacerbate all types of mental disorders.

The three main reasons prisoners suffer severe psychiatric disorders are traumatic pasts, overcrowding and other restrictive prison conditions, and confinement in isolation or secure housing units.[112]

---

[108] Ibid., 59, 61, 64-65.

[109] Ibid., 65, 72.

[110] Terry Kupers, M.D., Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It (San Francisco, California: Jossey-Bass, Inc., 1999), 86-87.

[111] Ibid., 28-29.

[112] Ibid., 64.

Given the high percentage of inmates with some type of pre-prison trauma, it is probable to assume there is a high prevalence of post traumatic stress disorder (PTSD) in the prison setting. The effect of PTSD on inmates is that the new traumas of prison life cause a replay of the original trauma. One method used by inmates who are dealing with PTSD is self imposed isolation, but another is to become verbally and physically abusive towards staff or other inmates. One potential sign of PTSD is rule-breaking. Most prison staff do not view rule-breaking as a sign of mental illness, and instead invoke disciplinary measures. The discipline can create a vicious cycle because isolating a previously traumatized prisoner will make them even more short-tempered and violent, and then the officers feel justified once again in locking the inmate down.[113]

One potential sign of PTSD is rule breaking. However, most prison staff do not view rule-breaking as a sign of mental illness, and instead invoke disciplinary measures.

Gender differences also have an impact on mental illness. There is a higher incidence of depression and other mental disorders with female inmates than with male inmates. Recognized gender differences in the free world tend to be exaggerated in prison. Male oriented classification systems applied to female inmates may cause the special needs of females to be overlooked and result in the application of unwarranted control measures.

There is a higher incidence of depression and other mental disorders in female inmates than male inmates.

Specific female problems include: dependent children; pregnancy in prison; maintenance of the family while the female inmate is in prison; fewer visits by children; lack of knowledge of children's day-to-day activities; and lack of counseling or therapeutic services. Female inmates are cited more for disciplinary infractions than are male inmates, mostly for minor rule infractions. The design of facilities provides for direct and total observation of inmates at all times. This includes observation of dressing/undressing and the use of shower and toilet facilities. Some female inmates reported that they felt like they were being watched all the time and that the lack of privacy was "humiliating and shame-inducing."[114] Another concern is the fact that "strip searches and probes of body cavities when male staff are nearby or involved in the procedure creates an ambiance of intimidation and disrespect that implies official toleration of sexual harassment and rape."[115]

[113] Ibid., 44-45.

[114] Ibid., 124.

[115] Ibid., 113-114, 124, 126-128.

There is a programming need for psychiatric treatment and substance abuse treatment to help inmates work through traumatic childhood experiences. There is also a need for post-release support to assist the inmate in obtaining work and to provide social services for reunification with children.[116]
A shocking example of rape in prison is the California federal prison in Dublin where male correctional officers were accepting money from male inmates to leave the female inmates' doors unlocked so that the male inmates could rape the female inmates. The female inmates sued the federal prison system and in 1998 the lawsuit was settled.[117]

Lack of contact visits with family worsens mental health conditions. There are many benefits of visitation including lower recidivism rates and a reduction of violence inside prisons. Extended separation from an inmate's family can lead to a mental breakdown. Inability of inmates to see their children on weekly basis is a cause for stress. Without these visits, the inmates cannot see how their children actually are doing. It is an accepted fact that people in the free world who do not have close friends or family are more at risk for suicide. Another problem is the lack of contact between mental health staff and families of prisoners.[118]

In summary, the "overwhelming majority who commit suicide [in prison] are those who are in confinement, have a history of serious mental illness, and have attempted suicide." Researchers also indicate that the typical inmate who commits suicide has been labeled as a manipulator, had just received bad news from home, had been acting in an uncharacteristic or bizarre fashion, and had told someone that he was thinking of committing suicide."[119]

C. Prevention Techniques

Development of a suicide prevention assessment scale takes into account age and sex, symptoms, stress and its occurrence, prior suicidal behavior, availability of resources, communication with family, and reaction of family. A potential suicide screening checklist should include symptoms of depression, and the inmate's past history. Symptoms of depression include loss of appetite, insomnia, lethargy, restlessness and agitation, anger, self-blame, guilt, irritability, and social aloofness. Correctional systems may want to review the use of a computer-administered interview for suicidal inmates potentiality because of the distrust by some inmates of staff.[120]

Correctional facility design can contribute to inmates succeeding in suicide. Hanging is the most common method of suicide in prison. Evidence has shown that a person does not have to be off the

---

[116] Ibid., 134.

[117] Ibid., 147.

[118] Ibid., 157-158, 161-162.

[119] Ibid., 185.

[120] David Lester, Ph.D., and Bruce L. Danto, M.D., Suicide Behind Bars: Prediction and Prevention (Pennsylvania: The Charles Press Publishers, Inc., 1993), 81-82, 87-88, 94-95.

ground to die. "Only 2 kilograms of pressure is required to obstruct the flow of blood to and from the brain. An adult's head weights about 3 kilograms, and so a person only has to kneel, stand, sit or even lie down while his neck is in a noose in order to die."[121] Typically fifteen minutes is sufficient to induce total asphyxia. Three minutes without air has been proven to cause brain damage. Prison cells should be examined from the ground upward to determine if a noose or other type of restraint could be attached to anything fifteen inches off the floor. There are some arguments that suicide cells may actually increase suicides by dehumanizing the inmate's living space, and some literature suggests that suicidal inmates should be placed in areas with increased contact and interaction with staff, thereby preventing sensory deprivation by housing the inmate in a facility with windows, with a cell mate, or in a dormitory.[122]

Monitoring should be conducted more than every fifteen minutes, because an inmate can hang oneself within fifteen minutes. Contact visits between correctional officers and inmates should be more than simple viewing - staff should converse with the inmate. Timing of the suicide is indicative of intent. Serious attempts are those in which an inmate attempts suicide immediately after a correctional officer's scheduled visit; those just prior to a scheduled visit are more indicative of a cry for help. Correctional staff assigned to suicidal housing units should be trained both in cardiopulmonary resuscitation and first aid techniques.[123]

Correctional officers should be on the lookout for the following behavior:

- Bad news from home, such as the death or sickness of a loved one, or infidelity of a spouse;
- Homosexual rape;
- No contact from home;
- Solitary confinement for a first time offender;
- Unexpected sentence of unusually long duration from the court system;
- Guilt from crime committed, or unacceptance from other inmates because of crime committed;
- Beating by another inmate or correctional officer; and
- Confinement for a long period of time in an unsentenced status.[124]

Recent prevention programs include the use of inmate counselors. The theory is that inmates have more interactions with other inmates and are more aware of what's going on in their lives. Inmate counselors are trained in crisis counseling and form patrols. At the Rhode Island

---

[121] Ibid., 103-104, 106.

[122] Ibid.

[123] Ibid., 107.

[124] Ibid.,. 73.

Correctional Institution inmate suicide prevention workers are trained to be peer counselors to spot potential suicidal inmates and refer them to medical personnel.[125]

Correctional agencies are advised that contact with families is extremely important to the inmate, especially during times of stress, despair, and crisis. After a suicide, psychological autopsies provide benefits for staff and for the development of future policies.[126]

Although hanging is the most prevalent method of suicide, suicide can be completed also by cutting oneself, burning oneself, jumping to one's death, and overdosing on prescribed medications. Agencies are cautioned to recognize that inmates who discuss suicide are at more of a risk than inmates who do not. Suicide indicators include changes in inmate behavior; for example, those who are normally combative become pliant, and those who are quiet suddenly become aggressive. Attempted suicides and completed suicides have links. Almost fifteen percent of inmates who attempt suicides go on to attempt and complete suicide later. Suicide attempts should be viewed as a high suicide risk, and should be used to evaluate inmates for future attempts.[127]

D. Suicide Policies and Procedure Survey

During January, 1999, the Florida Corrections Commission, on behalf of both the Corrections Commission and the House Committee on Corrections, telephoned the other 49 states and asked the following questions:

> *In the event of an inmate suicide, is an internal or external investigation performed?*
> *If internal, is the investigation done by investigators or medical personnel?*
> *Please provide copies of inmate suicide investigation and suicide prevention policies.*

Responses were obtained from 45 states. Thirty-two states reported that both internal and external investigations are performed in the event of an inmate suicide.[128] The external investigation in most states involved notifying either the coroner/medical examiner and the state police, or both. When internal investigations were done, 18 states reported a medical component to the inquiry, 22 states reported an investigative, procedural, or administrative review, 8 states did not specify, and 9 states contained both medical and investigative components.

---

[125] Ibid., 117,121, 133-134.

[126] Ibid., 121, 124.

[127] Ibid., 84, 38-39.

[128] Twelve states provided only an internal investigation and Wyoming reported only an external investigation. Kansas will initiate an investigation at the request of the inmate's family. In Nebraska, all in-custody deaths must be brought before a grand jury, and in North Dakota the coroner holds an inquest into any inmate death.

Of those, the policies of 6 states[129] comply with all American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC) standards. Only Nevada reported that it had no written suicide prevention policy.

The ACA suicide prevention standards require written policies and procedures:

> *There is a suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with the responsibility for inmate supervision are trained in the implementation of the program. The program should include specific procedures for intake screening, identification, and supervision of suicide-prone inmates.*[130]

The NCCHC's Suicide Prevention standard (P-54) requires "... a written policy, defined procedures, and a program for identifying and responding to suicidal individuals," including:

- Identification - intake screening;
- Training - all staff who supervise inmates should be trained to recognize suicidal behaviors;
- Assessment - by a qualified mental health professional;
- Monitoring - regular, documented supervision;
- Housing - never left alone unsupervised (checked every 10-15 minutes);
- Referral - to mental health professional;
- Communication - between health care and correctional personnel;
- Intervention - of a suicide in progress;
- Notification - of prison administrators, outside authorities and family;
- Reporting - attempted, potential, or completed suicide; and
- Review - medical and administrative review of completed suicide.[131]

---

[129] Alaska, Idaho, Montana, Nebraska, Ohio, and Oregon

[130] 3-4364 (Ref.2-4285-1) American Correctional Association, Standards for Adult Correctional Institutions, 3rd ed., 3-4364 (Ref.2-4285-1) (Lanhan, MD: American Correctional Association), 123.

[131] National Commission on Correctional Health Care. Standards for Health Services in Prisons (P-54) (Chicago, IL:National Commission on Correctional Health Care, 1997).

IX. FLORIDA ADDRESSES FEMALE OFFENDER ISSUES

The Florida Department of Corrections has been successful in keeping the incarcerated suicide rate well below that of Florida's general population.[132] But in late 1998, the department experienced its first two female offender suicides. Both the department's own Inspector General and the Florida Department of Law Enforcement conducted independent investigations; neither discovered evidence of foul play, brutality, or falsification of records in connection with their deaths which resulted from asphyxia due to hanging.[133]

The Florida House of Representatives and the Florida Senate requested a review of the suicides by the Correctional Medical Authority.[134] These reviews suggested significant changes be made in the delivery of mental health services to inmates.

A. Policies and Procedure Changes for Florida

As a result of the investigations of the suicides (which both occurred at Jefferson Correctional Institution), a number of changes were made to the department's suicide policies and procedures, including the re-establishment of the Standing Advisory Committee on Female Offender Issues.

1. Standing Advisory Committee on Female Offenders

In response to the suicides, the department re-established the Standing Advisory Committee for Female Offenders.[135] The Committee only met twice in early 1999 before being disbanded in July. The Committee has now been re-established for a second time, and it is currently comprised solely of Departmental staff.

At the time of publication, the intra-departmental committee had convened twice in 2000. During its May meeting, the committee evaluated the department's progress toward achieving goals two, three, and six of the Operational Plan for Female Offenders. (See next section.)

---

[132] Florida's general population suicide rate was 15.1 percent in 1995 while the Department of Corrections' rate was 6.26 percent. Kathleen Maguire and Ann L. Pastore, eds., Sourcebook of Criminal Justice Statistics 1997, U.S. Department of Justice, Bureau of Justice Statistics, Washington DC:USGPO, 1998, 229.

[133] http://www.state.fl.us/eog/press_releases/1999/February/2-17_jeffcorr.html

[134] The Correctional Medical Authority (CMA) is a unique statutory entity created to end federal judicial involvement in state prisons following the filing of Costello and Celestineo v. Wainwright, 387 F. Supp. 324 (M.D. Fla 1973). The full report, including the opinions of retained mental health experts, may be obtained by contacting CMA.

[135] The Advisory Committee was originally established in 1996 in relationship to section 944.24, F.S., the "Corrections Equality Act." The Advisory Committee was intended to be an interdisciplinary team composed of experts in health services, inmate programs, domestic violence, sexual abuse, and other women's issues.

2. Operational Plan for Female Offenders

The department initially developed an *Operational Plan for Female Offenders* in 1996, and revised the plan substantially in July 1999. Included in the plan are vision and mission statements, project statements, goals and objectives, and action plans. The table below illustrates the goals currently defined by the department.

Operational Plan for Female Offenders	
Goal 1	Ensure that the specific needs of female offenders are met throughout the correctional system.
Goal 2	Develop a continuum of programs that foster personal growth, accountability, maturity, and value based actions that lead to successful reintegration into society.
Goal 3	Ensure opportunities for female offenders to develop vocational and job related skills that support their capacity for economic freedom.
Goal 4	Prepare all institutional and community corrections staff to understand and appropriately address female gender specific topics and issues.
Goal 5	Ensure broad public access to the DOC information specific to female offender issues and related topics.
Goal 6	Ensure a holistic approach for meeting appropriate physiological, psychological, and substance abuse needs of female offenders.
Goal 7	Foster staff attitudes and actions that demonstrate professionalism and encourage an atmosphere that promotes the positive opportunities for self-development of the female offender.

Source: Florida Department of Corrections, *Operational Plan for Female Offenders, July 1999*

Through the newly established Female Offender Program Unit, the department's plan for female offenders will be implemented, monitored, and improved as needed. The plan provides for a needs-assessment of female offenders, by which programs will be developed to match female offenders' specific needs. There is an emphasis also on staff development and training. This unit is staffed with one full-time position, and a part-time position is sometimes available to the unit.

3. Training

The department developed a specialized training curriculum for all staff assigned to female offender facilities. All new employees of the department who will be working with female offenders will be required to attend a 20-hour training entitled "Working with the Female Offender." All existing staff who work with female offenders will be required to attend a 4-hour course based on the 20-hour training.[136] The department is seeking approval from the Criminal Justice Standards and Training Commission to designate this training as a specialized course to be taught at certified training centers. The curriculum includes:

[136] Florida Department of Corrections, Operational Plan for Female Offenders (July 1999).

- Gender and cultural diversity;
- Stereotyping;
- Communication;
- Dependency;
- Abuse impact;
- Effects of the incarceration experience;
- Coping behaviors of female offenders;
- Professional interaction strategies;
- Modesty;
- Privacy; and
- Significance of the extended family.[137]

The department sponsored two "Female Focused Symposiums" in the summers of 1996 and 1997. The symposiums focused on providing information to individuals working with female offenders to develop and strengthen professional skills. The department sponsored a third Female Focused Symposium which was held in Orlando in September, 1999. The Florida Correctional Medical Authority arranged for portions of the third symposium to be videotaped and given to the department to be used as supplemental training for staff unable to attend the symposium.

The symposium offered a variety of workshops for the over 200 participants to choose from. A training presentation made by Dr. Stephanie Covington emphasized that a time of transition for programs for female offenders is needed, and the moderator discussed the specific differences between not only male and female offenders, but between men and women nationally and internationally.

4. Conversion of Facilities

At the recommendations of several research projects, the department began to address the policy of the relocation of female inmates to facilities closer to their children. The department organized a team to research the most appropriate institution, and recommendations were made to the Secretary. The department also requested technical assistance from the National Institute of Corrections on this issue.

In August 1999, the department began transferring female inmates from Jefferson Correctional Institution to either Dade Correctional Institution (converted from a male institution) or the other existing female facilities. Jefferson Correctional Institution was converted to a male facility.

The department converted a male facility in Hernando to house female youthful offenders. Prior to this effort, such a facility had not existed in Florida for female youthful offenders.

5. "Reading Family Ties - Face to Face"

---

[137] Florida Department of Corrections, Operational Plan for Female Offenders (July 1999), 14.

On November 23, 1999, the Florida Department of Corrections announced that it had received a $300,000 federal grant to create an innovative program to strengthen family ties and increase literacy among inmates.

"Reading Family Ties - Face to Face" is a program designed to keep incarcerated mothers in touch with their children. The program allows mothers to read a storybook with their children via interactive sight and sound tele-conferencing. Mothers will also be taught remedial reading and writing skills in a weekly communication class.

The mothers will use tele-conferencing monitors to read storybooks to their children, who will follow along in the same book at a location in Miami. The non-profit group Alliance for Media Arts in Miami provides two offices for the children to use during the one-hour reading sessions. The program targets the children of indigent inmate families who cannot afford to travel long distances to prisons to visit their mothers.

Approximately 200 inmates at the Hernando Correctional Institution in Brooksville and Lowell Correctional Institution-Women's Unit in Marion County participating in the program.

6. Gadsden Correctional Institution Training Incident

On March 15, 1999, a fourteen member team of female correctional officers employed by Corrections Corporation of America from various states conducted a training operation at Gadsden Correctional Institution in order to become the company's first all-female Special Operational Response Team (SORT). The formation of this all-female team was in response to meeting the special needs of female inmates.[138]

However, on March 16, 1999, the Florida Department of Corrections' Office of Inspector General received numerous calls alleging a two-day lockdown and strip searches of female inmates by male officers.[139] The results of the investigation indicate that female inmates were indeed strip searched, but by female correctional officers. However, male correctional officers were able to view female inmates in their bras and panties during the initial stages of searches. Additionally, one female inmate in orientation was touched by a correctional officer on the chin when she did not respond to the officer's commands (a violation of Florida Administrative Code), and one male staff member was searched by a female staff member in the presence of inmates (both violations of Florida Administrative Code).[140] A June 1999, monitoring report of the Gadsden Correctional Facility indicated concerns regarding the SORT operations in that these correctional officers were from other

---

[138] The Private Line, published by Corrections Corporation of America (May 1999) : 3.

[139] Investigation 99-10769, Florida Department of Corrections, Office of Inspector General, June 11, 1999.

[140] Investigation 99-10769, Florida Department of Corrections, Office of Inspector General, June 11, 1999.

states and therefore, not certified in Florida. The report further states that in their opinion, persons from other states not certified in Florida may not perform correctional officer duties in this state.[141]

B. Policies and Procedures for Further Review

Research has indicated that two very specific issues need to be addressed: female diets and canteen operations.

1. Health Issues

One health issue which clearly has consequences for female offenders is their diet. As previously noted, obesity is a health concern for female offenders and can lead to a host of related medical problems.

In Florida, the master menu plan is the same for male and female offenders. The master menu plan is a highly detailed and structured menu which lists all meals and the amounts to be served daily. It is used system-wide in all institutions, regardless of gender. The menu ensures that all inmates will receive balanced meals with minimum daily levels of calories, protein, carbohydrates, and fat. Both male and female offenders are offered the same exact menu; more specifically: 3,100 calories per day, 30g of fiber, less than thirty percent of the total calories from fat, moderate sodium, and meets the RDA's for men 25 to 50 years of age.[142] This lack of addressing gender specific caloric needs could contribute to obesity and other subsequent health problems.

In June 1998, the department's Bureau of Food Services conducted a survey of all other state correctional systems to determine if they fed male and female inmates differently. Thirty-eight percent of the states do have different menus for female offenders. Discussed at the March 2, 1999, Standing Advisory Committee for Female Offenders was the implementation of a pilot program to offer a menu specific to females: 2,200 - 2,600 calories per day; high fiber; thirty percent or less of calories from fat; moderate sodium; and meet the RDA's for females ages 25 to 50 years of age or maximum level needed by non-pregnant females.

2. Canteen Operations

A secured statewide contract for all canteen services should be instituted. In areas where there is a mixture of cultures and ethnic groups, offer items that will meet the needs of the population. The following options should also be considered:

- Analyze the waste factor in each facility and revise the menu to eliminate items that are seldom eaten;
- Review the inmate population and determine if there are health problems that relate to

---

[141] Monitoring, Marketing and Consulting, Inc., Monitoring Report for Gadsden Correctional Institution (June 1999), 38.

[142] Female Offender Menu Pilot, FDOC paper handout, March 2, 1999, Standing Advisory Committee meeting.

weight, dental caries, and insufficient intake of vitamins and minerals. Provide items in the canteen that contain fewer carbohydrates and fat. (Reduced sugar and fat content; added calcium to juices);

- Provide nutritional classes/data on good nutrition (proper food choices, healthy eating) to personnel and inmates;
- If feasible, begin a weight reduction program;
- Determine the items that are most often purchased and then provide those items or like items on menus (not candy, cookie, and sodas);
- Provide milk/dairy products (yogurt, cheese, fresh milk) in all correctional institutions;
- Provide fresh and canned fruit in all correctional facilities;
- Reduce the number and quantity of cookies, crackers, and candy offered;
- Provide a more consistent offering at all facilities; evaluate the pricing structure and provide a more consistent price structure;
- Review the methods used in rotating and dating stock; make any necessary changes to comply with state health codes;
- Evaluate the safety and sanitary conditions of food handling in the canteen; if necessary, provide in-services on hand-washing, proper food handling techniques, and cleaning/sanitizing of equipment;
- Develop a self-monitoring checklist to ensure a safe and sanitary food service environment; and
- Establish outcomes and monitor for compliance.

X. OTHER STATES FEMALE OFFENDER INITIATIVES

New York
The Inmate Family Service Program operates at numerous facilities to enhance visiting centers, provide play and interaction areas for children, and present parenting education and family living programs for inmates.

Children's Summer Visits at Bedford Hills Correctional Institution involves a ten-week summer camp for children where incarcerated mothers participate with their children in a day camp. Children stay with volunteer host families near the prison or are transported daily from home. Volunteer hosts found this summer program so gratifying that some now also host a child one Saturday night a month year-round.

The Children's Center at Bedford Correctional Institution offers a wide range of services to inmates and children. The center helps women preserve and strengthen family ties and receive visits from their children.

The Children's Playroom at Bedford Correctional Institution and Arthur Kill C.I. have equipped recreation centers for visiting children, set up through the cooperative efforts of inmates and staff. Profits from vending machines were used to purchase toys and furniture, and the prison art classes painted murals on the walls, while a floor covering class installed carpeting. Inmates maintain all of the equipment utilized and clean the center. At Bedford, this visiting area is staffed by a teacher and eight inmate caregivers. Arthur Kill C.I. utilizes volunteers from the Foster Grandparent program. The program fosters a closer relationship between the mother and child, provides a well-staffed recreation and education program for children, and teaches inmates to become competent care givers and mothers. It also makes the adult visiting area an easier place to talk. In addition to these two institutions, the department reports that several women's institutions have outside play areas for children.

Illinois
Camp Celebration allows 12 mothers and their minor children to spend a weekend camping together to support a nurturing bond with the children. Although initially federally funded, this program is now state funded.

Children's Visiting Areas offer a place in which books, games and toys are available to visiting children. This creates a more relaxed atmosphere which allows families to develop a closer bond.

Children's Corners are a child-oriented visiting setting with structured play learning activities while adults re-establish family relationships. Inmate volunteers staff this program.

North Carolina
Children's Visiting Area at Orange C.C. was improved using community grants. Inmates installed playground equipment, and also provided labor for landscaping and building tables and benches.

Family Visit Program permits inmates in their final stage of imprisonment to be considered for a family visit program which assists the adjustment back to society.

Kentucky
Family Oriented Programming is provided by Dismas Charities which offers an 8-week parenting course designed to reunite families. Parenting skills development includes group education and individual counseling sessions. Parenting skills are the key elements; the women commit to being good parents who do more for their children. The program teaches participants to take a strong positive role in their family. When strong parents provide a structured environment, both parent and child benefit. Enhancing parenting skills lowers recidivism and the probability that these children will enter the criminal justice system.

Camp Dismas is a family program that brings children to the center each month to give them and their mothers an opportunity to build stronger relationships.

Anger Management is provided to all residents in a 6-week course. The program assumes that the residents are victims of sexual abuse and domestic violence.

X. CONCLUSION

The nation's prison population is undergoing rapid changes. As prison populations continue to grow, female offenders are accountable for an increasing percentage of those incarcerated.

Female offenders present special and unique challenges which are different from those presented by male offenders. Learning to recognize those differences and to adapt the prisons and the treatment programs to meet the needs of female offenders is crucial to their successful rehabilitation.

Female offenders typically are young and have one or more children in their care before committing the offense that lead to incarceration. In addition, many female offenders have poor health, little education, few life skills, and low self-esteem. Prior to incarceration, female offenders were often victims of sexual, physical, or mental abuse. Drug or alcohol abuse is typically a part of their past personal history. These characteristics create special problems for prison managers and planners.

When incarcerating female offenders, the corrections industry must be prepared to deal with and address the unique needs and histories of women. In order to prevent lawsuits, correctional managers and planners need to provide a safe and secure environment free from sexual and mental abuse. Anti-recidivism measures should be adopted which promote strong family ties, provide treatment for drug and alcohol dependency and psychiatric illnesses, and raise the educational levels. The need for well-developed suicide prevention measures is also very important when dealing with female inmates.

In summary, addressing the unique issues of female offenders through gender-specific, program-oriented treatment and planning is a goal which will benefit both the female offender and the state of Florida.

BIBLIOGRAPHY

A. Jacobson and Richardson, B.
"Assault Experiences of 100 Psychiatric In-Patients: Evidence of the Need for Routine Inquiry." American Journal of Psychiatry. 144:7; 908-913, 1987.

Allen J. Beck, Ph.D. and Christopher J. Mumola.
Prisoners in 1998, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, (August 1999).

Amnesty International.
Not Part of My Sentence: Violations of the Human Rights of Women in Custody, March 1999.

American Correctional Association.
1999 Directory: Juvenile & Adult Correctional Departments, Institutions, Agencies & Paroling Authorities. Lanham, Maryland.

American Correctional Association.
Standards for Adult Correctional Institutions, 3rd. Edition, Lanhan, Maryland.

American Psychiatric Association.
Diagnostic and Statistical Manual of Mental Disorders (4th ed.) Washington, D.C. American Psychiatric Press, 1994.

Bonita Veysey, M., Ph.D.; Kate DeCore; and Laura Prescott.
"Effective Management of Female Jail Detainees With Histories of Physical and Sexual Abuse." American Jails. May-June 1998.

Barbara Vobejda.
"Abuse of Female Prisoners Seen on Rise," Washington Post (4 March, 1999). http:www.washingtonpost.com/wp-srv/national/daily/feb99/prisons4.htm, March 8, 1999.

Claire Windom.
"The Cycle of Violence." Science Magazine, 244;1989. p. 160-166.

Caroline Wolf Harlow, Ph.D.
Prior Abuse Reported by Inmates and Probationers. U.S. Department of Justice, Bureau of Justice Statistics, Selected Findings, April 1999.

Catherine Ingram-Fogel, RNC, Ph.D.
"Health Problems and Needs of Incarcerated Women," Journal of Prison & Jail Health, Vol. 10, No. 1, Summer 1991.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, *Responding to the behavioral health care issues of persons with histories of treatment and substance abuse*. April 2-3, 1998, Final Report July 1998.

Center for Substance Abuse Treatment, 1994 and P. Holden, J. Rann, and L. VanDrasek, *Unheard Voices: A Report on Women in Michigan County Jails*. Lansing, MI Women's Commission, 1993.

Christopher Green, Andre Glenn, Kathleen Kendall, Terah Looman and Natalie Polvi. "A Study of 133 Suicides Among Canadian Federal Prisoners." Prison Violence and Inmate Suicide and Self Injury, Volume 4, Number 3, 1992, http://www.csc-scc.gc.ca/crd/forum/e043/3043i.htm, March 25, 1999.

Corrections Corporation of America. *The Private Line*. May 1999.

CNN Interactive. "39 percent of U.S. women have been abused, survey finds" Health, http://www.cnn.com/HEALTH/9905/05/womens.health.ap/, May 5, 1999.

Darrell K. Gilliard and Allen J. Beck, Ph.D. *Prisoners in 1997*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, (August 1998).

Darrell K. Gilliard. *Prison and Jail Inmates at Midyear 1998*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, (March 1999).

Darrell Steffensmeier and Emilie Allan. *The Nature of Female Offending, Patterns and Explanation* in Ruth T. Zaplan, Female Offenders: Critical Perspectives and Effective Interventions, 1998, Aspen Publishers, Inc., Gaithersburg, MD.

David Lester, Ph.D. and Bruce L. Danto, M.D., Suicide Behind Bars: Prediction and Prevention, (Pennsylvania: The Charles Press, Publishers, Inc., 1993).

D. McClellen, et al. Early Victimization, Drug Abuse, and Criminality: A Comparison of Male and Female Offenders. Criminal Justice and Behavior, 1997.

Donna Kerr. "Substance Abuse Among Female Offenders." Corrections Today, December 1998. p. 116.

Florida Correctional Medical Authority.
April 9, 1999 meeting handouts.

Florida Department of Corrections.
Status Report on Female Offenders, 1999.

Florida Department of Corrections.
Statement of John Burke, DC Office of Health Services, Correctional Medical Authority minutes from December 11, 1998, page 4.

Human Rights Watch.
Human Rights Watch Women's Rights Project, *All Too Familiar, Sexual Abuse of Women in U.S. State Prisons, U.S.A.*, distributed by Yale University Press, December 1996.

Human Rights Watch.
"Nowhere To Hide: Retaliation Against Women in Michigan State Prisons." http://www.hrw.org/reports98/women/Mich.htm, March 5, 1999.

International Journal of the Addictions.
"A Comparison of Black and White Women Entering Drug Abuse Treatment Programs." R. Moise, J. Kovach and B. Reed, et al, 1982.

J. Haney and C. Kristiansen.
"An Analysis of the Impact of Prison on Women Survivors of Childhood Sexual Abuse." Women in Therapy, 20(4);1998.

Jordan v. Gardner, 986 F.2nd 1521 (9th Cir. 1993),
http://caselaw.findlaw.com/scripts/getcase.pl?navby=search&case=/uscircs/9th/2/986/1521.html, December 29, 1998.

Judith Herman.
Trauma and Recovery. Basic Books, New York, NY, 1997.

Kathleen Maguire and Ann L. Pastore. eds.,
Sourcebook of Criminal Justice Statistics 1997. U.S. Department of Justice, Bureau of Justice Statistics, Washington DC:USGPO, 1998.

Leslie Acoca and James Austin..
"The Crisis: Women in Prison." National Council on Crime and Delinquency Report, February, 1996.

Louise Bill.
"The Victimization and Re-victimization of Female Offenders." Corrections Today, December 1998.

L. Walker.
The Battered Woman. New York: Harper and Row Publication, 1979.

L. Zupan.
"Men Guarding Women: An Analysis of the Employment of Male Correctional Officers in Prisons for Women." Journal of Criminal Justice. 1992.

Margie J. Phelps.
"Officers Having Sex With Inmates." Corrections Technology & Management. January/February 1999.

Meda Chesney-Lind.
The Female Offender: Girls, Women, and Crime. (California: SAGE Publications, Inc., 1997).

Meda Chesney-Lind.
"Women in Prison: From Partial Justice to Vengeful Equity." Corrections Today. December 1998.

Melissa Farley and Barkin Howard.
"Prostitution in Five Countries: Violence and Post-Traumatic Stress Disorder." Feminism and Psychology 27(3), November 1998.

Monitoring, Marketing and Consulting, Inc.
Monitoring Report for Gadsden Correctional Institution, June 1999.

National Commission on Correctional Health Care. Standards for Health Services in Prisons. 1997, Chicago, Illinois.

N. Finkelstein, S.A. Duncan and L. Derman, et al.
Getting Sober, Getting Well. Women's Alcoholism Program of CASPAR 1990, Cambridge, MA.

Patricia Tjaden and Nancy Thoennes.
Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey. U.S. Department of Justice, Centers for Disease Control and Prevention, (November 1998).

P. Holden, J. Rann, and L. VanDrasek.
Unheard Voices: A Report on Women in Michigan County Jails. Lansing, MI; Women's Commission, 1993.

Policy Research Inc.
Practical Approaches in the Treatment of Women Who Abuse Alcohol and Drugs. DHHS publication number (SMA) 94-3006, Rockville, MD.

Ruth T. Zaplan.
Female Offenders: Critical Perspectives and Effective Interventions. (Gaithersburg, Maryland: Aspen Publishers, Inc., 1998).

Susan Cranford and Rose Williams.
"Critical Issues in Managing Female Offenders." Corrections Today, December 1998.

The Center for Mental Health Services Substance Abuse and Mental Health Services Administration.
"Childhood Sexual and Physical Abuse as Factors in Adult Psychiatric Illness." American Journal of Psychiatry J. Briar, B. Nelson, J. Miller and P. Krol,1987.

Tracy Snell.
"Women in Prison." U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Bulletin. (March 1994).

Terry Kupers, M.D.,
Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It, San Francisco, California: Jossey-Bass, Inc., 1999.

U.S. Department of Justice.
Federal Bureau of Investigation, *Uniform Crime Reports for the United States 1997*. http://www.fbi.gov/ucr/Cius_97/97crime/97crime.pdf, August 30, 1999.

U.S. Department of Justice.
National Institute of Corrections, *Sexual Misconduct in Prisons: Law, Agency Response, and Prevention*, November 1996.

United States General Accounting Office.
Women In Prison, Sexual Misconduct by Correctional Staff, GAO/GGD-99-104, Report to the Honorable Eleanor Holmes Norton House of Representatives June 1999.

Washington Post
Abuse of Female Prisoners Seen on Rise, (March 4, 1999).

Female Questionnaire

Demographic Information:

Race

	Black	White	Other
Statewide (N=144)	46%	46%	8%

Age

	17 – 24	25 – 34	35 – 44	45 – 54	55 +
Statewide (N=152)	26%	23%	26%	16%	9%

Custody Level

	Minimum	Medium	Maximum	Close	Unknown
Statewide (N= 137)	51%	34%	3%	11%	1%

End of Sentence Date

	0 – 3 mos.	3 – 6 mos.	7 – 12 mos.	1 – 2 yrs.	2 – 5 yrs.	5 + yrs.
Statewide (N= 78)	22%	14%	19%	20%	16%	9%

Housing

	Closed Management	Confinement	General Population	Other
Statewide (N= 139)	2%	12%	85%	1%

Section A

Q.1. How long have you currently been in prison?

	0 – 1 yrs.	2 – 5 yrs.	6 – 10 yrs.	10 + yrs.
Statewide (N= 153)	45%	41%	8%	6%

Q.2. Is this your first prison incarceration?

	Yes	No	N/A
Statewide (N= 146)	69%	31%	N/A

Q.3. If not, how many previous incarcerations?

	1	2	3 or more
Statewide (N= 48)	40%	19%	41%

Q.4. Do you have any children?

	Yes	No	N/A
Statewide (N= 149)	75%	25%	N/A

Q.5. If yes, what are their ages? 1st child

	0 – 4 yrs.	5 – 10 yrs.	11 – 18 yrs.	19 + yrs.
Statewide (N= 111)	16%	20%	22%	42%

2nd child

	0 – 4 yrs.	5 – 10 yrs.	11 – 18 yrs.	19 + yrs.
Statewide (N= 79)	10%	28%	24%	38%

3rd child

	0 – 4 yrs.	5 – 10 yrs.	11 – 18 yrs.	19 + yrs.
Statewide (N= 45)	24%	20%	18%	38%

4th child

	0 – 4 yrs.	5 – 10 yrs.	11 – 18 yrs.	19 + yrs.
Statewide (N= 20)	25%	35%	10%	30%

5th child

	0 – 4 yrs.	5 – 10 yrs.	11 – 18 yrs.	19 + yrs.
Statewide (N= 9)	33%	44%	23%	N/A

6th child

	0 – 4 yrs.	5 – 10 yrs.	11 – 18 yrs.	19 + yrs.
Statewide (N= 3)	67%	N/A	N/A	33%

Q.6. (a) Where do your children live?

	In-State	Out-State	Other
Statewide (N= 114)	46%	16%	38%

(b) With whom?

	Foster care/ Adoption	Family	Of Legal Age	Other
Statewide (N= 103)	4%	55%	25%	16%

Q.7. Do you get to see them?

	Yes	No	N/A
Statewide (N= 126)	33%	53%	14%

Q.8. If yes, how often?

	Monthly	Quarterly	Yearly	Never	Other
Statewide (N= 63)	28%	22%	17%	20%	14%

Q.9. Do you think the visitation program is satisfactory?

	Yes	No	N/A
Statewide (N= 127)	38%	31%	31%

Q.10. (a) If no or N/A: why?

	Distance	Individual Preference	Visitation Conditions	Not suitable for children	Other
Statewide (N= 79)	19%	3%	33%	9%	36%

(b) How would you improve it?

	Improve for children	Procedures	Visitation Area	Other
Statewide (N= 87)	20%	27%	19%	34%

Q.11. How do you most often communicate with your family/friends?

	Call	Write	Both	Other
Statewide (N= 151)	16%	21%	60%	3%

Q.12. Would you attend parenting classes if available?

	Yes	No	N/A
Statewide (N= 140)	57%	10%	33%

Q.13. Do you have a place to live/go when you have completed your sentence?

	Yes	No	N/A
Statewide (N= 147)	85%	12%	3%

Q.14. If not, what will you do?

	No plans	Live w/ family	School	Work	Other
Statewide (N= 35)	17%	31%	20%	3%	29%

Q.15. Have you received any skills training while incarcerated which will help you find employment after your release?

	Yes	No	N/A
Statewide (N= 141)	50%	49%	1%

Q.16. If yes, what kind of training?

	GED	Business	Culinary	Cosm.	Computer	Other
Statewide (N= 96)	22%	17%	4%	3%	7%	47%

Q.17. Do you have any employment or educational plans following your release?

	Yes	No	N/A
Statewide (N= 128)	82%	18%	N/A

Q.18. If yes, explain:

	School	Work	Other
Statewide (N= 133)	39%	45%	16%

Q.19. Do you think the food service at this institution is satisfactory?

	Yes	No	N/A
Statewide (N= 145)	25%	75%	N/A

Q.20. How often (per day) do you get fruit?

	None	1 per day	2 + per day	Weekly	Monthly	Other
Statewide (N= 146)	1%	18%	5%	63%	7%	6%

Q.21. How often (per day) do you get vegetables?

	None	1 per day	2 + per day	Weekly	Monthly	Other
Statewide (N= 143)	1%	34%	57%	1%	N/A	7%

Q.22. How often (per day) do you get milk/dairy products?

	None	1 x per day	2 + per day	Weekly	Monthly	Other
Statewide (N= 146)	N/A	86%	12%	1%	N/A	1%

Q.23. Does the canteen offer healthy snacks?

	Yes	No	N/A
Statewide (N= 140)	50%	49%	1%

Q.24. Besides the canteen, are you able to get any between meal snacks?

	Yes	No	N/A
Statewide (N= 143)	6%	93%	1%

Q.25. Do you have any suggestions to improve the food service?

	Quality	Cleanliness	Variety	Other
Statewide (N= 137)	45%	12%	39%	4%

Q.26. Have you gained or lost a significant amount of weight while in prison?

	Yes	No	N/A
Statewide (N= 140)	73%	16%	11%

Q.27. If yes, approximately (+) or (-) pounds.

	-5-10 lbs.	-11-25 lbs.	-26 + lbs.	+5-10 lbs.	+11-25 lbs.	+26 lbs.
Statewide (N= 102)	13%	8%	26%	4%	22%	27%

Q.28. Are you provided clothing that is appropriate for the different seasons?

	Yes	No	N/A
Statewide (N= 138)	53%	43%	4%

Q.29. If no or N/A, explain:

	Not enough	Warmer	Cooler	Maternity	Other
Statewide (N= 98)	17%	56%	10%	3%	14%

Q.30. Are you provided an adequate amount of undergarments weekly? (panties & bras)

	Yes	No	N/A
Statewide (N= 135)	55%	45%	N/A

Q.31. If not, how many of each are you provided?

(a) Panties?

	1 – 3	4 – 6	7 +
Statewide (N= 133)	43%	47%	10%

(b) Bras?

	1 – 3	4 – 6	7 +
Statewide (N= 138)	65%	34%	1%

Q.32. Do the bras provide you with adequate support?

	Yes	No	N/A
Statewide (N=139)	38%	61%	1%

Q.33. Are you able to hand-wash soiled items?

	Yes	No	N/A
Statewide (N= 150)	67%	33%	N/A

Q.34. Are you given a choice of: Sanitary pads? Tampons? Both?

(a) Sanitary pads?

	Yes	No	N/A
Statewide (N= 134)	89%	7%	4%

(**b) Tampons?**

	Yes	No	N/A
Statewide (N= 115)	66%	30%	4%

(c) Both?

	Yes	No	N/A
Statewide (N= 126)	69%	28%	3%

Q.35. Are you furnished an adequate supply of sanitary pads/tampons?

	Yes	No	N/A
Statewide (N= 139)	65%	28%	7%

Q.36. If not how many are you given at one time?

	1 – 10	11 – 20	21 +
Statewide (N= 52)	32%	30%	38%

Q.37. How do you get them?

	Monthly	As needed	Ask	Other
Statewide (N= 130)	29%	11%	29%	31%

Q.38. Do you have a history of drug or alcohol abuse?

	Yes	No	N/A
Statewide (N= 152)	54%	46%	N/A

Q.39. If yes, any drug or alcohol use while incarcerated?

	Yes	No	N/A
Statewide (N= 149)	5%	64%	31%

Q.40. If yes, are you able to attend any meetings such as AA or NA?

	Yes	No	N/A
Statewide (N= 133)	48%	13%	39%

Q.41. At what age did you become sexually active?

	9 – 11	12 – 15	16 – 17	18 +
Statewide (N= 147)	3%	50%	32%	15%

Q.42. a. Were you ever physically abused?

	Yes	No	N/A
Statewide (N= 151)	41%	59%	N/A

b. Were you ever sexually abused?

	Yes	No	N/A
Statewide (N= 147)	58%	42%	N/A

Q.43. If yes, as a child?

	Yes	No	N/A
Statewide (N= 140)	56%	41%	3%

As an adult?

	Yes	No	N/A
Statewide (N= 138)	34%	63%	3%

Q.44. While incarcerated in jail?

	Yes	No	N/A
Statewide (N= 138)	4%	76%	20%

Q.45. While incarcerated in prison?

	Yes	No	N/A
Statewide (N= 136)	7%	72%	21%

Q.46. Would you attend an anger management group if available?

	Yes	No	N/A
Statewide (N= 140)	66%	14%	20%

Q.47. Would you attend a survivors of abuse group if available?

	Yes	No	N/A
Statewide (N= 136)	53%	14%	33%

Q.48. While incarcerated, have you ever experienced what you believe to be inappropriate behavior by male correctional officers or other male correctional staff?

	Yes	No	N/A
Statewide (N= 145)	53%	47%	N/A

Q.49. If yes where:

(a) This institution?

	Yes	No	N/A
Statewide (N= 114)	64%	13%	23%

(b) Another state institution?

	Yes	No	N/A
Statewide (N= 106)	30%	36%	34%

(c) An institution in another state?

	Yes	No	N/A
Statewide (N= 105)	2%	26%	72%

(d) County jail in Florida?

	Yes	No	N/A
Statewide (N= 105)	9%	59%	32%

(e) County jail in another state?

	Yes	No	N/A
Statewide (N= 104)	N/A	31%	69%

Q.50. If yes explain:

	Sexual	Physical	Verbal	Other
Statewide (N= 76)	40%	9%	40%	11%

Q.51. While incarcerated here, have you ever experienced what you believe to be inappropriate behavior by female correctional officers or other female correctional staff?

	Yes	No	N/A
Statewide (N= 144)	48%	52%	N/A

Q.52. If yes explain:

	Sexual	Physical	Verbal	Other
Statewide (N= 74)	9%	1%	70%	20%

Q.53. Are male correctional officers or other male correctional staff ever present while you shower?

	Yes	No	N/A
Statewide (N= 149)	35%	65%	N/A

Q.54. If yes, how often?

	Occasionally	Daily	Sevaral Times A Week	Announce Presence	Other
Statewide (N= 61)	24%	35%	22%	19%	N/A

Q.55. Are male correctional officers or other male correctional staff ever present while you are changing your clothes?

	Yes	No	N/A
Statewide (N= 149)	30%	70%	N/A

Q.56. If yes, how often?

	Occasionally	Daily	Several Times a Week	Announce Presence	Other
Statewide (N= 46)	36%	45%	9%	10%	N/A

Q.57. Are male correctional officers or other male correctional staff ever present when you are using the toilet?

	Yes	No	N/A
Statewide (N= 149)	34%	66%	N/A

Q.58. If yes, how often?

	Occasionally	Daily	Several Times A Week	Announce Presence	Other
Statewide (N= 56)	43%	37%	12%	8%	N/A

Q.59. What do you think is the most difficult aspect of being in prison?

	Away from family	Treatment	Pregnancy	Loss of freedom	Other
Statewide (N= 151)	39%	15%	1%	11%	34%

Section B

Q.1. In your opinion, since you have been in prison, has your overall physical health: Stayed the same? Improved? Declined?

	Stayed the same	Improved	Declined
Statewide (N= 145)	40%	19%	41%

Q.2. Has your overall mental health: Stayed the same? Improved? Declined?

	Stayed the same	Improved	Declined
Statewide (N= 141)	35%	25%	40%

Q.3. Has your overall dental health: Stayed the same? Improved? Declined?

	Stayed the same	Improved	Declined
Statewide (N= 135)	51%	21%	28%

Q.4. Have you received health education on the following:

Breast cancer?

	Yes	No	N/A
Statewide (N= 150)	62%	37%	1%

Breast self-examination?

	Yes	No	N/A
Statewide (N= 151)	71%	28%	1%

AIDS prevention?

	Yes	No	N/A
Statewide (N= 151)	63%	36%	1%

Contraception?

	Yes	No	N/A
Statewide (N= 150)	38%	61%	1%

STDs?

	Yes	No	N/A
Statewide (N= 151)	61%	38%	1%

Smoking?

	Yes	No	N/A
Statewide (N= 150)	58%	41%	1%

Alcohol/Drug abuse?

	Yes	No	N/A
Statewide (N= 149)	62%	37%	1%

Exercise/cardiovascular benefits?

	Yes	No	N/A
Statewide (N= 148)	61%	38%	1%

Stress management?

	Yes	No	N/A
Statewide (N= 149)	47%	52%	1%

Q.5. Do you currently smoke?

	Yes	No	N/A
Statewide (N= 151)	46%	54%	N/A

Q.6. If yes, have you been offered any assistance to stop smoking (i.e., classes, patches)?

	Yes	No	N/A
Statewide (N= 129)	24%	43%	33%

Q.7. Do you receive an annual examination which includes a PAP smear and breast examination?

	Yes	No	N/A
Statewide (N= 145)	87%	7%	6%

Q.8. Have you been provided education on osteoporosis?

	Yes	No	N/A
Statewide (N= 145)	9%	90%	1%

Q.9. Has a calcium supplement been prescribed for you?

	Yes	No	N/A
Statewide (N= 140)	9%	89%	2%

Q.10. Do you exercise on a regular basis?

	Yes	No	N/A
Statewide (N= 144)	63%	37%	N/A

Describe:

	Aerobics	Walk	None	Other
Statewide (N= 90)	23%	53%	10%	14%

Q.11. Are you offered annual (50 yrs. and older) or biennial (40 – 50 yrs.) mammograms?

	Yes	No	N/A
Statewide (N= 58)	78%	17%	5%

Q.12. Do you receive annual (50 yrs. and older) or biennial (40 – 50 yrs.) mammograms?

	Yes	No	N/A
Statewide (N= 55)	80%	18%	2%

Q.13. Have you had a total hysterectomy?

	Yes	No	N/A
Statewide (N= 63)	25%	73%	2%

Q.14. Are you currently going through menopause?

	Yes	No	N/A
Statewide (N= 54)	29%	67%	4%

Q.15. If no, have you completed menopause?

	Yes	No	N/A
Statewide (N= 54)	27%	17%	56%

Q.16. Have you been given education on hormones (estrogen replacement therapy)?

	Yes	No	N/A
Statewide (N= 50)	34%	56%	10%

Q.17. Were the benefits and risk factors of Estrogen Replacement Therapy explained to you?

	Yes	No	N/A
Statewide (N= 46)	26%	44%	30%

Q.18. Have hormones been recommended for you?

	Yes	No	N/A
Statewide (N= 48)	50%	35%	15%

Q.19. Are you currently taking hormones?

	Yes	No	N/A
Statewide (N= 48)	33%	67%	N/A

Q.20. Do you have problems with depression?

	Yes	No	N/A
Statewide (N= 127)	70%	30%	N/A

Q.21. If yes, are you receiving mental health services?

	Yes	No	N/A
Statewide (N= 122)	53%	30%	17%

Q.22. If not, why?

	Handles on own	Hasn't asked	Other
Statewide (N= 38)	26%	16%	58%

Q.23. If yes, have you been prescribed anti-depressant medication?

	Yes	No	N/A
Statewide (N= 120)	43%	26%	31%

Q.24. In your opinion, is your medical care at this institution satisfactory?

	Yes	No	N/A
Statewide (N= 121)	41%	58%	1%

Q.25. (a) If not, why?

	Restricted Access	Poor care	Poor Treatment	Other
Statewide (N= 75)	43%	36%	12%	9%

(b) How would you improve/change it?

	Improve Access	Improve Treatment	Additional or Better staff	Other
Statewide (N= 107)	19%	13%	30%	38%

Final comments:

	Add More Programs	Additional Staff	Improve Medical Care	Improve Treatment	Other
Statewide (N= 86)	12%	5%	25%	13%	45%

Staff Questionnaire

Job Title

	Warden Asst. Warden	Chief Health Officer HSA*	Clerical	CO*	Classifica -tion	Physical Health	Mental Health
Statewide (N=39)	10%	5%	5%	41%	5%	10%	24%

* HSA – Health Services Administrator * CO- Correctional Officer

Q.1. Do you think the visitation program at this institution is satisfactory?

	Yes	No	N/A
Statewide (N=44)	89%	11%	N/A

Q.2. (a) If not, why?

	Lack of Professionalism	Noise Level	No play area for kids	Not familiar w/ process	Other
Statewide (N=10)	10%	10%	10%	30%	40%

Q.2 (b) How would you improve it?

	Improve visitation area	Add/improve play area	Fine as it is	Other
Statewide (N=19)	37%	16%	16%	31%

Q.3. In your opinion, is it appropriate for children to visit a parent who is in prison?

	Yes	No	N/A
Statewide (N=46)	87%	13%	N/A

Q.4. Describe the visitation program for inmate families at this institution:

Not tabulated.

Q.5. Do you have any comments or recommendations regarding the visitation program?

	Yes	No	N/A
Statewide (N=45)	22%	78%	N/A

Q.6. If yes, comments:

	Improve visitation area	More security	Other
Statewide (N=14)	29%	14%	57%

Q.7. Do you think the food service at this institution is satisfactory?

	Yes	No	N/A
Statewide (N=44)	89%	11%	N/A

Q.8. On a regular basis do you eat institutionally prepared food?

	Yes	No	N/A
Statewide (N=48)	17%	83%	N/A

Q.9. If not, explain:

	Brings own food	Poor quality/ cleanliness	Eats occasionally	N/A	Other
Statewide (N=35)	23%	34%	9%	9%	25%

Q.10. Do you have any suggestions to improve the food service?

	Yes	No	N/A
Statewide (N=47)	34%	66%	N/A

Q.11. If yes, suggestions:

	Variety	Hygiene	Other
Statewide (N=15)	40%	20%	40%

Q.12. Are inmates provided clothing appropriate for the different seasons?

	Yes	No	N/A
Statewide (N=46)	91%	9%	N/A

Q.13. If not, explain:

	Variety	Warmer	Procedures	Other
Statewide (N=6)	33%	17%	17%	33%

Q.14. Are inmates provided an adequate amount of undergarments weekly (panties and bras)?

	Yes	No	N/A
Statewide (N=37)	92%	8%	N/A

Q.15. (a) How many panties are provided per week?

	1 – 3	4 – 6	7 +
Statewide (N=35)	20%	29%	51%

(b) How many bras are provided weekly?

	1 – 3	4 – 6	7 +
Statewide (N=35)	37%	60%	3%

Q.16. Are inmates able to handwash soiled items?

	Yes	No	N/A
Statewide (N=40)	60%	40%	N/A

Q.17. Do you have any comments or recommendations regarding inmate clothing or undergarments?

	Yes	No	N/A
Statewide (N=43)	37%	63%	N/A

Q.18. If yes, comments:

	Bras need more support	Quantity	Laundry Procedures	Other
Statewide (N=19)	16%	21%	26%	37%

Q.19 (a) Are inmates given a choice of: Sanitary pads?

	Yes	No	N/A
Statewide (N=38)	95%	5%	N/A

(b) Tampons?

	Yes	No	N/A
Statewide (N=37)	87%	13%	N/A

(c) Both?

	Yes	No	N/A
Statewide (N=38)	71%	28%	N/A

Q.20. How many pads/tampons are issued at one time?

	1 – 10	11 – 20	21 +
Statewide (N=33)	27%	15%	58%

Q.21. Describe the process for the distribution of sanitary supplies:

	Monthly	As needed	Ask	Other
Statewide (N=40)	45%	15%	28%	12%

Q.22 (a) Are the following available to pregnant inmates: Abortion?

	Yes	No	N/A
Statewide (N=31)	45%	48%	7%

(b) Adoption services?

	Yes	No	N/A
Statewide (N=31)	58%	36%	6%

(c) Keep the child-temporary placement?

	Yes	No	N/A
Statewide (N=30)	47%	47%	6%

Q.23. Is counseling offered to assist in the decision?

	Yes	No	N/A
Statewide (N=33)	58%	30%	12%

Q.24. Is there an active anger management group at this institution?

	Yes	No	N/A
Statewide (N=44)	68%	32%	N/A

Q.25. Is there an active survivors-of-abuse group at this institution?

	Yes	No	N/A
Statewide (N=41)	81%	19%	N/A

Q.26. Do the inmates receive childbirth education?

	Yes	No	N/A
Statewide (N=40)	55%	35%	10%

Q.27. Are inmates allowed privacy during labor and/or delivery?

	Yes	No	N/A
Statewide (N=28)	39%	36%	25%

Q.28. If not, please explain:

	No pregnant inmates	Inmates have private rooms	Constant Supervision	Other
Statewide (N=17)	35%	18%	18%	29%

Q.29. Are inmates shackled during labor and/or delivery?

	Yes	No	N/A
Statewide (N=25)	N/A	72%	28%

Q.30. If yes, please explain:

Not tabulated.

Q.31. How would you improve/change the medical care at this institution?

	Additional staff	Fine as it is	Add MH Programs	Improve/change procedures	Other
Statewide (N=41)	46%	22%	12%	10%	10%

Q.32. What special needs do female inmates have?

	Health issues	Hygiene needs	Communication w/ family/children	Emotional/ MH needs	Other
Statewide (N=37)	30%	14%	11%	24%	21%