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Deprivation and "Deviance": The Disability and Health Experiences of Women in North Carolina's Prisons

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DEPRIVATION AND “DEVIANCE”: THE DISABILITY AND
HEALTH EXPERIENCES OF WOMEN IN NORTH
CAROLINA’S PRISONS*

CARRIE GRIFFIN BASAS AND LISA PETERS**

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INTRODUCTION

Just a little comment: . . . in life after prison, my downfall is always going back around old people, places, and things. This is my 6th time. I'm ashamed . . . embarrassed by it that's why I'm going a different route B4 I the way I normally do. (I want different) I want freedom you know. I'll blow my brains out B4 I re-enter the prison, that's why I'm choosing to start my change on the inside this trip.

—Survey Respondent¹

In 2011, we began a survey of women inmates in North Carolina's state prison system, spurred by interests in how disabilities and other health challenges present themselves in the criminal justice system and can be alleviated, addressed, or exacerbated by it.² At the time, we were told by the prison research director that women with disabilities constituted a small portion of the inmate population—perhaps a dozen or so individuals. This number seemed far too low. Inmates and people with disabilities are overlapping populations with intersecting social and moral histories.³ Both exist on the fringe of society because of their perceived violations of standards of normalcy and social rules.⁴ Neither

1. We preserved the inmate's words as written, even if there were issues with grammar or spelling.

2. On June 30, 2011, the total female inmate population in North Carolina was 2,846. Of those women, 1,634 were white, 1,096 were black, and 116 identified as another race. N.C. DEP'T OF CORR., 2010–2011 ANNUAL STATISTICAL REPORT 23 (2011), available at <http://randp.doc.state.nc.us/pubdocs/0007068.PDF>.

3. See Michael L. Perlin, "Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did, 10 J. CONTEMP. LEGAL ISSUES 3, 23 (1999).

4. See Cassandra A. Ogden, *Disability*, in SHADES OF DEVIANCE: A PRIMER ON CRIME, DEVIANCE, AND SOCIAL HARM 171, 171–73 (Rowland Atkinson ed., 2014) (discussing how disability and criminality are perceived as located within individuals that violate social norms and practices, rather than linked with social structures and attitudes that marginalize others). See generally Lisa T. McElroy, Is It Crazy to Think that Attorneys with Mental Health Disabilities are Uniquely Situated to Help Prisoners?, 93 N.C. L. REV. 1419 (2015) (discussing the marginalization of attorneys with mental health disabilities); Katie

population is well understood, unless the observer has personal experience with prisons or disability. Yet, people with disabilities occupy positions of duality. They are often perceived as both aggressors, when it comes to stereotypes of people living with mental illnesses such as schizophrenia and borderline personality disorder, and victims, when it comes to stereotypes of people using wheelchairs or survivors of cancer.⁵ There are, therefore, faultless people with disabilities and those who somehow deserve their fate. Similarly, there are “good” criminals, such as women who steal food for their starving children, and “bad” criminals, such as women who are perceived as heartless, psychopathic, and selfish. The reality, however, is that people with disabilities and inmates are both “victims and villains” (and neither)—with far too little attention paid to their vulnerabilities and the necessity of society to address them in comprehensive ways.⁶

Part of society’s impairment in seeing people with disabilities or people living behind bars for who they are, and the constraints under which they live, is a byproduct of the separation of public health and criminal law scholars. This separation means that campaigns to prevent crime or to punish it appropriately do not often encompass preventive measures to support individuals living in dire circumstances and to improve their contexts, and, therefore, their options for survival. For example, while most scholars and policymakers recognize that crime and health are connected in meaningful ways, much of the focus is on the effects of crime on victims and the injuries that they suffer from those experiences.⁷ Concerns about curbing violence are at the core of these initiatives.⁸ If defendants and offenders are recognized in the system, it is through a lens of preventing crime by dealing with a concrete set of physical or mental conditions, such as drug and alcohol use, mental illness, and unsafe sexual activity.⁹ Under this approach, defendants and offenders then can be broken into “risk factors” that help us to predict their

Rose Guest Pryal, Heller’s *Scapegoats*, 93 N.C. L. Rev. 1439 (discussing how people with mental health disabilities are specifically marginalized through current gun laws).

5. Ogden, *supra* note 4, at 171–173.

6. See generally Victoria A. Lewis, *BEYOND VICTIMS AND VILLAINS: CONTEMPORARY PLAYS BY DISABLED PLAYWRIGHTS* (Victoria A. Lewis ed., 2006) (exploring the motif of people with disabilities as both victims and aggressors).

7. See NAT’L CRIME PREVENTION COUNCIL & OFFICE OF JUSTICE PROGRAMS, *CONVERGING CONCERNS: CRIMINAL JUSTICE AND HEALTH PARTNERSHIPS*, at v–vi (2001) (highlighting partnerships that bring criminal justice and health care professionals together).

8. Bill Sanders, Yonette F. Thomas & Bethany G. Deeds, *Introduction*, in *CRIME, HIV, AND HEALTH: INTERSECTIONS OF CRIMINAL JUSTICE AND PUBLIC HEALTH CONCERNS*, at vii (Bill Sanders et al. eds., 2013) [hereinafter *CRIME, HIV, AND HEALTH*].

9. See NAT’L CRIME PREVENTION COUNCIL, *supra* note 7, at v–vi.

chances for recovery, as well as for reoffending.¹⁰ This Article diverges from that approach by explaining how, while these factors are important considerations in ensuring wellness for inmates and released individuals, they are inadequate to prevent crime and to support individuals postincarceration. Former inmates, before prison, during their sentences, and upon release, experience other kinds of disability that are intersectional, multifaceted, contextual, and complex—such that a simple “war” on crime and drugs or crime and HIV¹¹ fails to capture. Without this more nuanced understanding of disability and health, which the data from this study present, policymakers will be left to attempt solutions to public health and criminal activity concerns without full insights into the complexities of those experiences.

The most troubling feature of our current criminal justice system is the extent to which it underestimates the importance and frequency of disabling health conditions in the lives of people who commit crimes. For example, even the U.S. Department of Justice tends to focus its research efforts on singular health issues within the prison population, such as HIV or mental health, rather than investigating how chronic disease can be a constellation of issues that have reverberations after release; these studies are not nuanced when it comes to gender either.¹² This study was one effort to tackle that misinformation or ignorance. Inmates have poorer health than similar adults who are not incarcerated in the United States.¹³ These risks include both the exacerbation of illnesses that preceded incarceration and the risk of exposure to new ones, such as HIV,¹⁴ tuberculosis,¹⁵

10. Sanders et al., *supra* note 8, at vii.

11. African American and Hispanic/Latina young women aged thirteen to twenty-four years old are 80% of HIV/AIDS diagnoses. Erin G. Romero et al., *A Longitudinal Study of the Prevalence, Development, and Persistence of HIV/STI Risk Behaviors in Delinquent Youth: Implications for Health Care in the Community*, in *CRIME, HIV, AND HEALTH*, *supra* note 8, at 19, 21. Across all age groups, African American women have HIV diagnosis rates that are nineteen times that of white women. Kim M. Blankenship & Amy B. Smoyer, *Between Spaces: Understanding Movement to and from Prison as an HIV Risk Factor*, in *CRIME, HIV, AND HEALTH*, *supra* note 8, at 207, 208.

12. See, e.g., DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, SPECIAL REPORT: MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1–11 (2006), available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>; Press Release, U.S. Dep't of Justice, Bureau of Justice Statistics, Rates of HIV/AIDS and AIDS-Related Deaths in Prison Continue to Decline (Sept. 13, 2012), available at <http://www.bjs.gov/content/pub/press/hivp10pr.cfm>.

13. Bill Sanders, Bethany Deeds & Yonette F. Thomas, *Crime and Public Health in the United States*, in *CRIME, HIV, AND HEALTH*, *supra* note 8, at 1, 3.

14. One-and-a-half percent of prison inmates are HIV-positive or have AIDS. *Id.* at 5. AIDS rates are about two-and-a-half times that of the general population. *Id.*

physical violence,¹⁶ sexual assault, and mental illness.¹⁷ Life expectancy rates of incarcerated or released inmates who are or were serving time for drug offenses, for example, are similar to those of people affected by war, epidemics, and terrorism.¹⁸ Incarceration impacts communities by increasing unemployment and family separation and strain, particularly in minority communities.¹⁹

The stories of women in prison communicate the complexities of why they commit crimes—from troubled relationships with family members to exposure to childhood violence, abusive and manipulative romantic partners to lack of access to health-care options.²⁰ These women are embedded in communities and social systems (e.g., social services agencies, benefits programs, health clinics and hospitals, and schools) that have not functioned well in supporting them and have even caused disabilities in their lives. Prison is one such example. Those are the structures to which they will return.

This Article takes the perspective that health is more than a set of risk factors. Rather, it is multifaceted, or a “continuum of increasing biological, social, and psychological complexity” that is affected by “subjective and objective domains,” including the communities in which people live and their interactions with institutions, such as prisons, schools, hospitals, and government services.²¹ The study poses these research questions: What health-related conditions and experiences disable women inmates? How frequent are those experiences? What do we need to know to begin to tackle health issues in our communities that might also affect crime rates? One important facet of this approach is placing stress and trauma, both everyday and extreme, in their roles of influencing states of health and disability.²²

15. Annually, 25% of all HIV-positive people, 33% of all HCV-positive people, and 40% of people with active tuberculosis spend time in correctional facilities. *Id.*

16. “Suicide and homicide are the third and fourth leading causes of death among inmates respectively and, in comparison to the general population, . . . inmates are significantly more likely to be a victim of either form of violence.” *Id.*

17. *Id.* at 3.

18. Ernest Drucker, *Population Impact of Mass Incarceration Under New York's Rockefeller Drug Laws: An Analysis of Years of Life Lost*, 79 J. URB. HEALTH 434, 435 (2002).

19. *Id.*

20. See generally MICHELLE OBERMAN & CHERYL L. METER, *WHEN MOTHERS KILL: INTERVIEWS FROM PRISON* (2008) (attempting to explain the complex life trajectories that lead women to prison).

21. Paula P. Schnurr & Bonnie L. Green, *A Context for Understanding the Physical Health Consequences of Exposure to Extreme Stress*, in *TRAUMA AND HEALTH: PHYSICAL HEALTH CONSEQUENCES OF EXPOSURE TO EXTREME STRESS* 3, 6 (Paula P. Schnurr & Bonnie L. Green eds., 2004) [hereinafter *TRAUMA AND HEALTH*].

22. Bonnie L. Green & Rachel Kimerling, *Trauma, Posttraumatic Stress Disorder, and Health Status*, in *TRAUMA AND HEALTH*, *supra* note 21, at 13, 16.

The discussion begins with an overview of the study in Part I, followed by a summary of the results in Part II. Then, in Part III, we introduce criminal epidemiology—an emerging field and one that is new to legal scholarship—that brings together practices from public health, sociology, and criminology to begin to tease out the nexus between poor health and criminal activity. In Part IV, we take four examples of health and disability issues that the women experienced and view them through this lens to postulate what correctional systems and policymakers might need to consider in improving inmate health and addressing crime. What we learn about trauma, coexisting health conditions, poverty, and stigma from the stories of the women behind bars in North Carolina has reverberations for not only their futures upon release but also the pipeline that leads to prison and the communities that surround it. These experiences have profound effects on communities that are oversimplified and underestimated.

I. OVERVIEW OF THE STUDY

During the fall of 2010, Professor Basas, one author of this piece, approached the research office of the State of North Carolina's Department of Correction to inquire about the possibility of beginning a survey project to better understand the health and disability experiences of women inmates in that system. Over several months of collaboration with the research office, she developed a twenty-eight item survey that would be distributed to the entire female inmate population that was available for mailing at that time. The survey instrument was designed to be easy to read and to take into account a range of literacy levels.

The state correctional system Institutional Review Board ("IRB") committee, as well as the IRB committee at the University of North Carolina, approved the survey items, as well as the data collection and storage processes.²³ The IRB process was lengthy, as it is with most inquiries regarding sensitive or vulnerable populations.²⁴ Furthermore,

23. At the time, two protocols were approved: the one implemented for this Article, a survey of the women inmates; and a second protocol that would allow Professor Basas to visit the five correctional facilities in North Carolina to administer the survey orally to inmates unable to take it on their own. Unfortunately, due to time and budget constraints, she was unable to implement the second protocol. Therefore, any numbers presented are actually underestimates of disability incidence given that inmates with profound vision impairments, learning disabilities, or cognitive conditions were less likely to respond to a paper survey.

24. The IRB process for this study involved obtaining approval from both the Department of Correction as well as from the University of North Carolina. The research director of the Department of Correction assisted in explaining the guidelines for survey

the survey itself had to be easy to read and not coercive.²⁵ Additional limitations on incoming and outgoing mail in the prison system that were oriented toward the safety of the prison environment made logistics different than they might have been for a survey involving noninmates.²⁶ For example, the survey could not be stapled, as staples could be used as weapons or bartered for goods in prison. Prisoners could not receive pencils to complete the survey for the same reasons.

During the summer of 2011, Professor Basas distributed the survey to the women inmates, using a list provided by the North Carolina prison system.²⁷ This list totaled over 1,300 inmates, the current women's population that was available for mail at the time. The state prison system provided the addresses of the inmates and the University of North Carolina offered copying and mailing support to facilitate the survey's distribution. Of the women, 989 responded to the survey, generating a yield of approximately 76%.

The survey items, found in Appendix B of this Article, consisted of forced-choice questions, but participants often commented on the questions themselves and wrote narratives at the beginning and conclusion of the surveys. The questions covered a range of topics, from basic demographic data to experiences with physical and sexual abuse. Several different kinds of questions about disability and health conditions were asked, with the goal that approaching serious health limitations from several angles would give both the researchers and

research within the prisons and answering questions as they arose. Professor Basas drafted several iterations of the survey instrument and cover letter for informed consent. She also developed a template of the actual mailed instrument before obtaining approval to be in compliance with prison mail procedures. *See generally* N.C. DEP'T OF CORR., POLICY AND PROCEDURE MANUAL (2013), available at http://www.doc.state.nc.us/dop/policy_procedure_manual/d0300.pdf (detailing these policies).

25. *See generally id.* (same).

26. *See generally* N.C. DEP'T OF CORR., CONDUCTING RESEARCH WITHIN THE NORTH CAROLINA DEPARTMENT OF CORRECTIONS (2013), available at <http://www.doc.state.nc.us/rap/researchguidelines.pdf> (discussing procedures for interviewing inmates). Inmates are considered to be a vulnerable population for research ethics purposes. To meet IRB guidelines, as developed by the University of North Carolina, the U.S. Department of Health and Human Services, and the Department of Correction, we needed to provide an informed consent instrument that was written in accessible, minimal literacy language—which ended up being our cover letter—as well as demonstrate that inmates were able to understand it. We also needed to ensure that inmates' information would be private and confidential, as to avoid increased vulnerability within prison. Given the nature of prison environments and the great potential for exploitation of a captive population, research participation must present minimal risks of harms to prisoners and not be coercive. *See generally* U.S. DEP'T OF HEALTH & HUMAN SERVS., IRB GUIDEBOOK, SPECIAL POPULATIONS: PRISONERS, available at http://www.hhs.gov/ohrp/archive/irb/irb_chapter_6ii.htm#g6 (detailing these requirements).

27. *See infra* Appendix A for the informed consent letter sent to inmates.

the prison system a better understanding of how to serve the current inmate population, prevent crime in the future, and facilitate transitions to the community postincarceration.

For example, the women answered the following questions that targeted disability and health experiences:

- Do you currently have or have you ever had any of the following health issues? Choose as many as apply. [List provided in original survey.]
- Were you ever in special education as a child?
- Were you ever diagnosed with a learning disability as a child?
- Have you ever received Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) (disability-based assistance from Social Security)?
- Have you ever been physically assaulted or physically abused?
- Have you ever been sexually assaulted or abused?
- How many times, over the course of your life, have you been physically assaulted or abused? Please choose one answer below.
- How many times, over the course of your life, have you been sexually assaulted or abused?
- Have you ever received mental health care services before entering prison?
- Have you received mental health care services since entering prison?
- Before being incarcerated, how often did you use illegal drugs, on average, when you used drugs the most frequently?
- Before being incarcerated, how many alcoholic beverages a week did you drink, on average, during the period when you drank the most frequently? (As a guideline, a drink is generally 4 oz. wine, 12 oz. beer, 12 oz. wine cooler, or 1 oz. hard liquor/spirits.)

- Do you receive any accommodations in the prison system related to the Americans with Disabilities Act (ADA) or a disability that you have?
- Do you need any accommodations or special assistance related to a disability that you have that affects you in prison?

Given the range of questions asked, the data had to be handled with care and confidentiality. This approach honored the ethics of working with vulnerable populations and asking sensitive questions about topics such as sexual abuse history and health issues and kept with the commitments made in the IRB process. Participants were not allowed to provide their names or other identifying information. To be able to refer to specific responses as needed, the research team assigned a distinct number to each survey.

After the surveys were returned, Professor Basas solicited the collaboration of Lisa Peters, librarian at Case Western Reserve University School of Law, the co-author of this Article, to assist with the data input and analysis. We met to develop an input manual that was revised and revisited as the data entry progressed. The input manual can be found in Appendix C of this Article (provided online).²⁸ After inputting the data, we discussed the input manual and any conflicts that had emerged. We conferred to resolve these conflicts and to refine the input rules, flagging issues for future resolution as the work progressed. Data were inputted into a database designed for this project. Significantly, in this process, we preserved written comments on the survey, as well as deviations from the directions and developed consistent approaches for their handling of this particular data. The goal was to make the data as transparent as possible in case future investigators wanted to use it to explore additional research questions. Our primary interest was to assemble as much data about the women's experiences as possible and, thus, to begin to grapple with how their experiences fit with or departed from existing data about women inmates and their health experiences.

28. Appendix C, available at http://www.nclawreview.org/wp-content/uploads/2015/05/Appendix_C_Coding_Manual.pdf

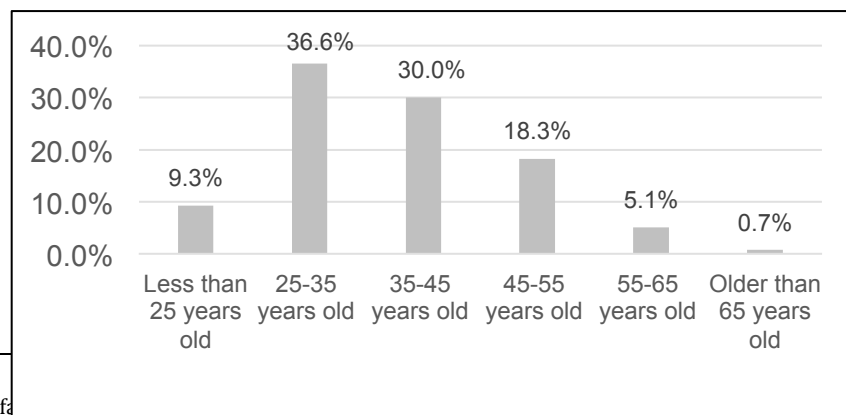
II. SURVEY RESULTS

A. *Demographics of Women Inmates in North Carolina's Correctional System*

North Carolina has over 3.7 million women aged eighteen or older.²⁹ On June 30, 2011, 2,846 women lived in North Carolina's prisons.³⁰ Of those women, 1,634 were white, 1,096 were black, and 116 identified as another race.³¹ The average monthly exit rate from prison was less than 250 women each month.³² The average yearly cost of keeping an inmate in prison in North Carolina was \$29,307 in 2013.³³

The demographics of our survey results track the North Carolina inmate population at the time of the study, making it a representative sample.³⁴ The results of our survey show a fairly young inmate population; see Chart A.³⁵ Most of the respondents were between twenty-five and forty-five years old. They were also predominantly white, with black/African American women being the second largest respondent population; see Chart B.³⁶

Chart A. Age of Inmates



for information about people" hyperlink; then select "age" and "sex"; then search "North Carolina"; then follow "SKIP THIS STEP" hyperlink; then follow "ACS Demographic and Housing Estimates" hyperlink).

30. N.C. DEP'T OF CORR., *supra* note 2, at 23.

31. *Id.*

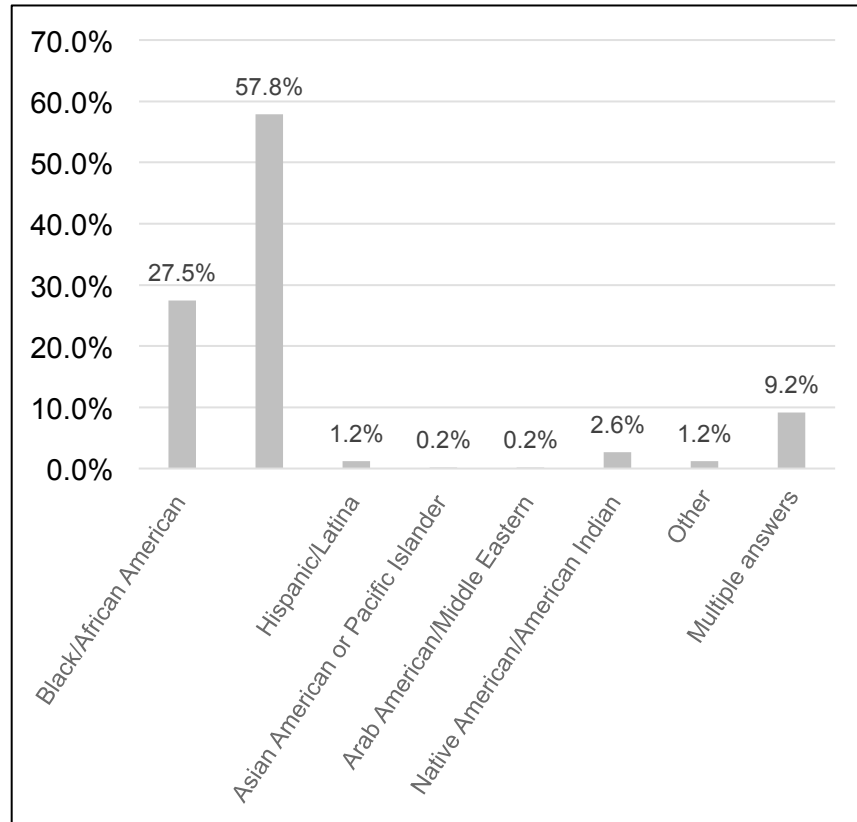
32. *Offender Population Statistics*, N.C. DEPARTMENT OF PUB. SAFETY (Mar. 2015), <http://randp.doc.state.nc.us/kimdocs/0003560.htm>.

33. *Cost of Supervision*, N.C. DEPARTMENT OF PUB. SAFETY (Mar. 6, 2015), <https://www.ncdps.gov/Index2.cfm?a=000003,002391,002325>.

34. N.C. DEP'T OF CORR., *supra* note 2, at 23.

35. The overall survey results in table form appear in Appendix C ("Input Manual") of the Article. *North Carolina Quick Facts*, U. S. CENSUS BUREAU (Dec. 4, 2014, 2:54 PM), <http://quickfacts.census.gov/qfd/states/37000.html>.

36. Women account for 51.3% of North Carolina's population. *Id.* African Americans are 22% and whites not of Hispanic or Latino origin are 64.4% of the overall state population. *Id.*

Chart B. Inmates' Racial Identities

Most of the women had graduated high school or obtained a GED, while some of them had taken college classes (42.4%).³⁷ Less than 7% of the women had a bachelor's degree and only 1.2% had a graduate degree.

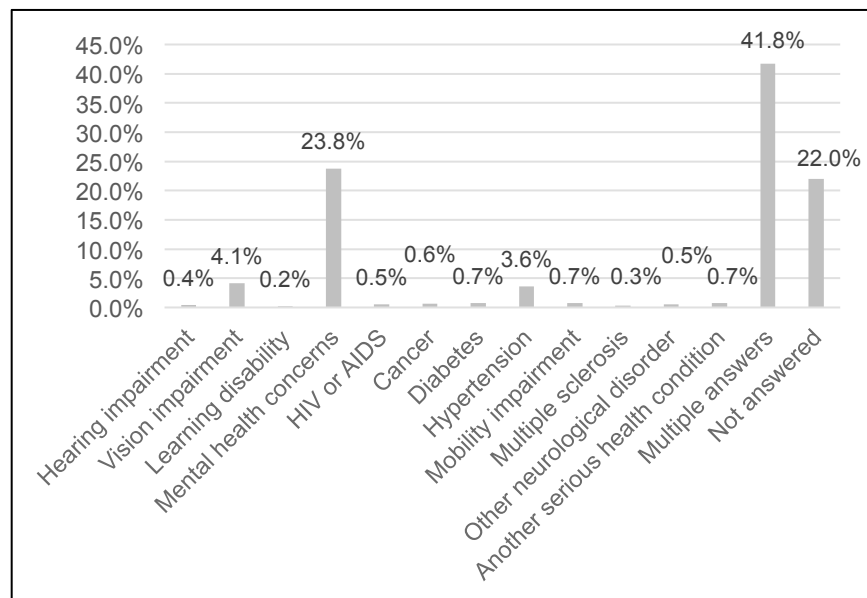
Major health impairments were common among the inmates, with multiple health issues being the largest area of concern (41.8% of the women), followed by mental health concerns (23.8% as the only issue reported); see Chart C.³⁸ Less than 1% of the inmates reported having

37. These results are less than the U.S. Census numbers for educational achievement in North Carolina, not broken down by gender. About 84% of North Carolinians have completed high school or education beyond that level, while 26.8% of residents have completed bachelor's degrees by age twenty-five or beyond. *Id.*

38. The estimated rate of disability in 2012 in North Carolina for adults, aged twenty-one to sixty-four years old, not living in institutions, was 11.4%. *Disability Characteristics: 2010-2012 American Community Survey 3-Year Estimate*, U.S. CENSUS BUREAU, <http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t> (type "2012 disabilities" into "topic or table name" field and type "North Carolina" into "state,

learning disabilities as their only health issue—at least under this question; in a later question (Question 7), 7.8% of women reported having learning disabilities. Ten percent of the women reported being in special education at some point, as captured by a separate question about this educational experience (Question 6).

Chart C. Health Issues Faced by Inmates



Most of the women identified as being heterosexual (57.6%), but a significant population identified as being bisexual (29.6%), while only one inmate (0.1%) identified as being transgender.³⁹

These women had a range of interactions with the social service system. Almost 13% of them had been in foster care and almost 17% had received SSI/SSDI (disability-based unemployment benefits), while an overwhelming 73.6% had received welfare at some point in their lives.⁴⁰

county, or place" field, then click "go"; go to page 2 of results and select "S1810 Disability Characteristics 2012 ACS 3-year estimates") (last visited Mar. 1, 2015).

39. North Carolina, as of the 2010 Census data, had 18,309 same-sex couples (4.89 same-sex couples per 1,000 households). THE WILLIAMS INST., CENSUS SNAPSHOT 2010, at 5 (2011), available at <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Census2010Snapshot-US-v2.pdf>.

40. Seventeen and a half-percent of North Carolinians live below the poverty level. *State & County Quick Facts: North Carolina*, U.S. CENSUS DATA 2010, <http://quickfacts.census.gov/qfd/states/37000.html> (last visited May 5, 2015).

The women inmates had shared experiences of abuse—both physical and sexual, with 82% of them reporting that they had experienced physical abuse, generally at the hands of multiple abusers (most commonly romantic partners and family members) and 64.5% of them reporting sexual abuse, usually at the hands of multiple abusers again (most commonly romantic partners and family members again); see Charts D and E. While physical abuse generally happened eleven or more times in their lives, sexual abuse was less clear in its frequency—with groups of women reporting abuse one to two times (16.7%), three to five times (15.2%), and eleven or more times (14.9%).

Chart D. Identities of Inmates' Physical Abusers

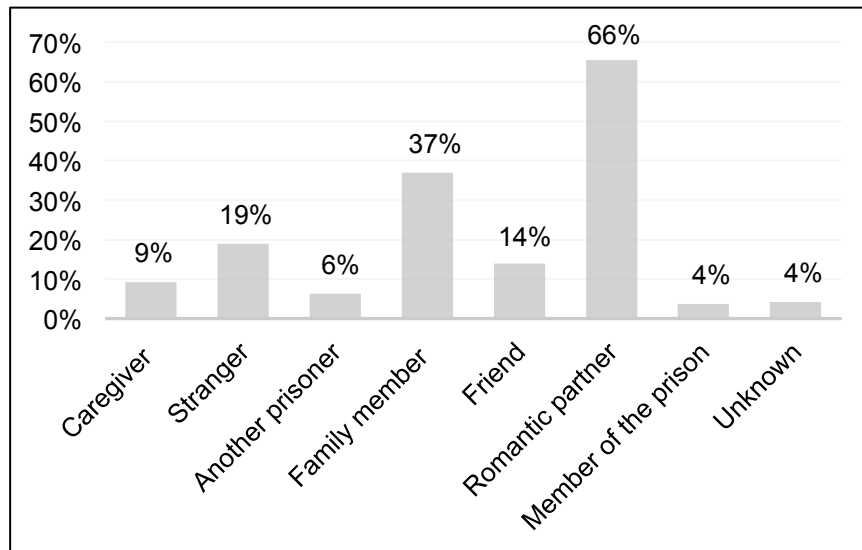
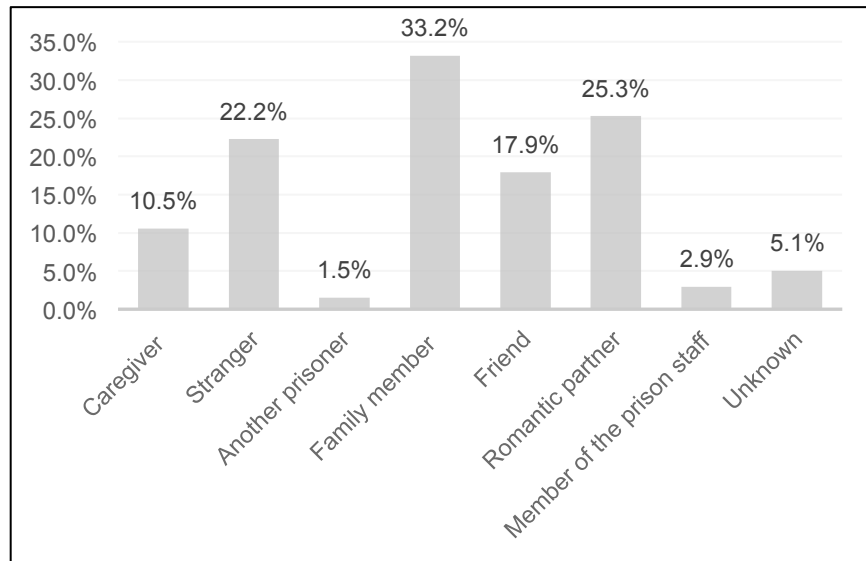


Chart E. Identities of Inmates' Sexual Abusers

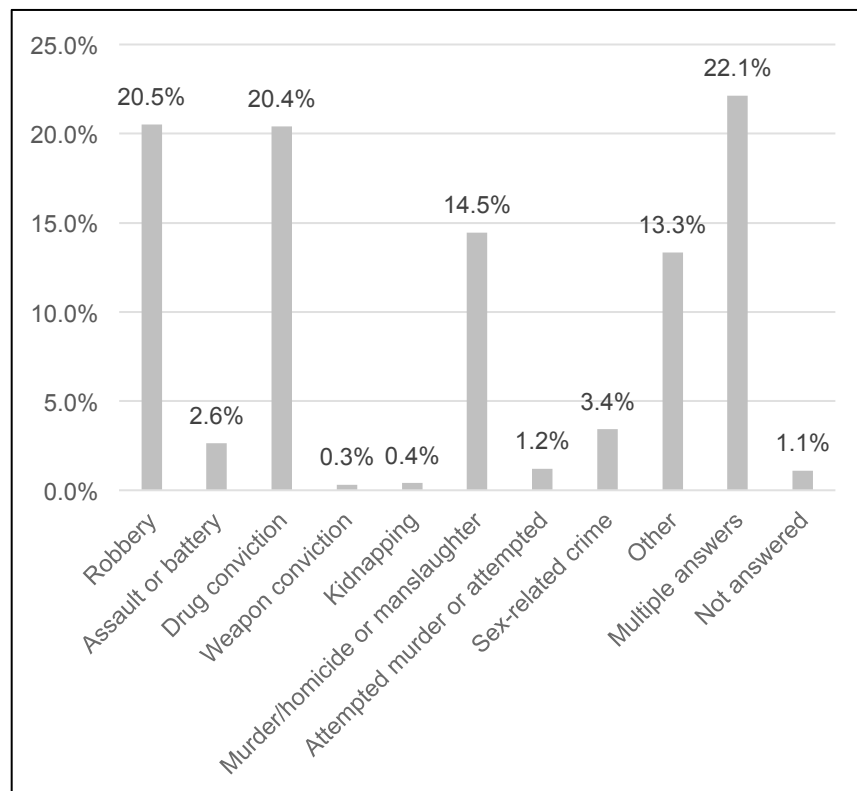
Given the concerns of these women, mental health services could play a vital role in reducing recidivism and building positive skills for the future. In fact, many of the women had received mental health care *before* prison (61.4%), and only slightly fewer women received mental health care *in* prison (56.7%). However, among the women who did not receive mental health care in prison, there was a sense that such care would not be beneficial. Due to the structure of the survey, we were unable to capture why that was the case. Future work might identify how mental health care is inadequate in prison or how women without experience with mental health care before prison could see benefits from it while incarcerated.

Drug-related offenses led many women to prison. Over 29% of the women in the study reported drug offenses as the basis for their conviction (approximately 20% as the sole basis for the conviction); see Chart F. When asked about their drug use before incarceration, 35.3% of the women reported using illegal drugs eleven or more times a week. Alcohol use was less common in its severity than drug use, with 26.8% of women reporting never using alcohol on a weekly basis and 23.7% of women reporting that they drank one to two times a week. While more of the women had never tried drugs than alcohol, they reported higher levels of frequency of drug use overall. Therefore, drugs played a more significant role in the lives of many of these women than alcohol abuse.

Based on the picture that was developing about respondents' challenges in the areas of mental health and other health issues, the study also addressed whether inmates identified as having disabilities and whether those disabilities were being accommodated in prison. Only 2.1% of respondents reported receiving federal disability-related accommodations in prison, but 16.1% of respondents suggested that they could use them. Another 7% were not sure if accommodations would help them.

Most of the women were serving short sentences of one to three years (21.9%), but 14% were serving longer sentences of six to eight years. Another 5% of inmates were serving life sentences. Being incarcerated for multiple offenses was common, especially for crimes involving robbery, theft, forgery, and drugs. Murder and/or manslaughter convictions accounted for 14.5% of the inmates' sentences, while attempted murder and/or attempted manslaughter convictions were only 1.2% of the respondents' crimes; see Chart F.

Chart F. Crime



In prison, these women reported being routinely disciplined (55%), usually for multiple rules violations or violating prison rules that were not related to assaulting prison employees or fellow inmates. Physical assault/abuse of another inmate was much more common than those behaviors toward prison staff (2.7% versus 0.7%).

As many of these women were serving sentences of just a few years, issues of reentry into the community upon release were at the forefronts of their minds. When asked in the final question of the survey about their “biggest concern about what your life will be like when you are released from prison,” women were primarily concerned about their abilities to find jobs postincarceration (44.9%), but another 24.2% selected “other” as their answer. The comments to this question reveal some of those concerns: “[A] combination of several of the factors above”; “just having a good support system to stand beside me is my biggest fear”; “getting my children back”; “I am scared to death.” Many of the “other” answers evinced a positive outlook, citing faith, self-reform, and good family support. Interestingly, while most of the women had histories of physical and/or sexual abuse by intimates, very few of them chose as their largest concern that they would become dependent on others after their release (only 1%). The women in the study also shared concerns about health care (6.1%), community acceptance (6%), the ability to live independently (5.7%), and problems of recidivism (8.6%).

B. Increased Rates of Disability and Health Concerns Among Inmates

When we looked at the data, we realized that inmates, in many instances, had higher rates of health concerns than we might expect in the nonincarcerated, or general, population; see Table 1. This finding was one of the study’s most significant, given the correctional system’s impressions that they were serving the existing population of women with disabilities. At first glance, poor health and disability experiences among women inmates is not surprising because many of them have low socioeconomic status (“SES”). From the existing literature on the connection of SES and gender to health outcomes, we know that women with low SES experience profound effects on their psychological and physical health, as well as their quality of life.⁴¹ They are more likely to experience depression, anxiety, domestic violence,

41. *Fact Sheet: Women and Socioeconomic Status*, AM. PSYCHOL. ASS’N (Apr. 3, 2015), <http://www.apa.org/pi/ses/resources/publications/factsheet-women.aspx>.

breast cancer, obesity, complications in their pregnancies, and fatality from heart disease.⁴²

However, no comprehensive study exists to our knowledge that connects SES and gender to each of the health issues that we identified. Rather, as scholars, we are left to compare our impressions with stand-alone studies on many, but not all, of these health concerns. SES is not an experience that can be neatly factored out of experiences of health. As we did not collect specific data on individual or family income from each of the respondents, we find that the best way of comparing these women's rates of illness and disability to other women is one based on using general population figures. While such an approach has its limitations because it does not create clear comparators based on shared SES factors, it does account for the range of backgrounds, both in terms of education, social standing, occupation, and income, that the women capture through their varied life experiences *before* prison.

Before delving into the nuances of our findings, we highlight what is the most significant finding of all—the relatively high rate of disability among the women. Rather than being a small population in the prison system, as the administrators of that system intimated, the respondents represented a significant share of the population and a range of disabling health concerns. In completing the survey, respondents could select more than one answer as a health or disability concern. For example, a respondent might select under Question 3, Health Issues, that she had “mental health concerns,” “multiple sclerosis,” and a “learning disability.” In our initial round of inputting these answers, we combined these multiple answers in our notes into a new, working “multiple health concerns” category that made for easier calculations. However, we soon realized that the combined category, while easier to use for our calculations, was hiding a rich set of experiences, such as comorbidity of different health concerns. Thus, we, too, had minimized the experience of disability in our data analysis procedures and underestimated the complexities of the issues faced by these women.

The data follow in the table below and demonstrate that women overwhelmingly experienced multiple disabling health concerns.

42. *Id.*

Table 1. Health Experiences of Inmates Compared to Nonincarcerated Individuals

Disability or Health Issue⁴³	Expected Rate in the Population	Rate in the Inmate Sample (One Answer Choice Only)	Rate in the Inmate Sample ("Multiple Answers" Unpacked)	Higher or Lower than General Population
Hearing impairment or deafness	1.3–5.9% ⁴⁴	0.4%	4.26%	On par
Vision impairment, such as low vision or blindness	6.4–11.9% ⁴⁵	4.1%	21.2%	Higher
Learning disability	1.6% ⁴⁶	0.2%	5.8%	Higher
Mental health concerns	3.7% ⁴⁷	23.8%	56.7%	Higher

43. These statistics were based on answers to Question 3 of the survey, but other parts of the survey revealed alternative ways of measuring disability. For example, 82% of the women had been physically abused and 65% had been sexually abused. Sixty-one percent had received mental health treatment. Sixty-four percent had used illegal drugs. Twenty-three percent of respondents used alcohol eleven or more times a week.

44. This range captures women aged eighteen to seventy-four. CTRS. FOR DISEASE CONTROL, HEALTH, UNITED STATES 2012, at tbl.51 (2013), available at <http://www.cdc.gov/nchs/data/hus/2013/051.pdf>.

45. *Id.* at tbl.50.

46. These figures are based on Census data capturing people aged fifteen years or older, not limited by gender. MATTHEW W. BRAULT, AMERICANS WITH DISABILITIES: 2010, CURRENT POPULATION REPORTS tbl.A-1 (2012), available at <http://www.census.gov/prod/2012pubs/p70-131.pdf>.

47. These figures are based on Census data capturing people aged fifteen years or older, not limited by gender. *Id.*

HIV or AIDS	0.075% ⁴⁸	0.5%	1.8%	Higher
Cancer	2.3-15.2% ⁴⁹	0.6%	5.3%	On par
Diabetes	10.1% ⁵⁰	0.7%	8.1%	Slightly lower
Hypertension	29.3% ⁵¹	3.6%	21.30%	Lower
Mobility impairment	9.3% ⁵²	0.7%	9.3%	On par
Multiple sclerosis	.1% ⁵³	0.3%	1.2%	Higher
Other neurological condition	Less than 1% ⁵⁴	0.5%	4.9%	Higher

48. Approximately 1.1 million Americans live with HIV or AIDS and of those diagnoses, 25% are women. NAT'L CTRS. FOR HIV/AIDS, VIRAL HEPATITIS, STC, & TB PREVENTION, HIV AMONG WOMEN (2014), available at <http://www.cdc.gov/hiv/risk/gender/women/facts/index.html>.

49. This range captures women aged eighteen to seventy-four. CTRS. FOR DISEASE CONTROL, HEALTH, *supra* note 44, at tbl.44, available at <http://www.cdc.gov/nchs/data/hus/2013/044.pdf>.

50. This figure is based on women aged twenty years or older. *Id.* at tbl.46, available at <http://www.cdc.gov/nchs/data/hus/2013/046.pdf>.

51. This figure is based on women aged twenty years or older. *Id.* at tbl.65, available at <http://www.cdc.gov/nchs/data/hus/2013/065.pdf>.

52. This figure is based on Census data, not differentiated by gender. BRAULT, *supra* note 45, at tbl.A-1.

53. *Who Gets MS?*, NAT'L MULTIPLE SCLEROSIS SOC'Y (Jan. 21, 2015), <http://www.nationalmssociety.org/What-is-MS/Who-Gets-MS>.

54. This estimate is approximate, based on rates of stroke, Alzheimer's, spinal cord injury, and other neurological conditions. See D. Hirtz et al., *How Common are the "Common" Neurologic Disorders?*, 68 NEUROLOGY 326, 329-30 (2007), available at <http://members.sirweb.org/members/misc/Hirtz.pdf>; *Updated Rates of Common U.S. Neurological Disorders*, SCIENCE DAILY (Jan. 30, 2007), www.sciencedaily.com/releases/2007/01/070129172536.htm.

Another serious health condition	9.9% ⁵⁵	0.7%	8%	Lower
Multiple disabilities	1.7–6.5% ⁵⁶	41.8%	N/A	Higher

C. Missed Opportunities

As we began to delve into the data, we realized that we had missed several opportunities to gain a robust picture of the experiences of these women. While the process of data analysis and the development of input rules could consume a separate article, we were left with some of the following questions that our initial survey instrument did not anticipate or capture:

- What was your initial age at incarceration?
- How many times have you been incarcerated?
- Did physical health issues cause you to commit the crime(s) that you did or for which you were accused?
- Did mental health issues cause you to commit the crime(s) that you did or for which you were accused?
- Did drug or alcohol use cause you to commit the crime(s) that you did or for which you were accused?
- Were you an accomplice or accessory to a crime that your spouse or partner committed or was accused of committing?
- How many children, if any, do you have?
- Do you have contact with your children while in prison?

55. There was not an ideal way to capture this category. The best parallel available might be respondents' perceptions of fair or poor health status. Therefore, this number comes from Center for Disease Control data regarding that perception, gathered from women aged eighteen or older. CTRS. FOR DISEASE CONTROL, *supra* note 44, at tbl.52, available at <http://www.cdc.gov/nchs/data/hus/2013/052.pdf>.

56. This range is based on Census data, not differentiated by gender. BRAULT, *supra* note 46, Tbl.A-1.

- Have you ever received a mental health evaluation while in prison?
- How many more months or years do you have left to serve?

We also realized as we began to work with the survey questions themselves that our original framing had been limited at times. For example, some of the age-and-sentence length categories overlapped with starting and ending points. Therefore, we may have produced some inaccuracies in understanding exactly how old people were or how long their sentences were. Having greater delineation in these numbers could have assisted us with being clearer about potential relationships between age and health concerns, for example, or disability and sentence length.

III. FINDING WORKING DEFINITIONS FOR DISABILITY AND HEALTH

Given that the survey results showed a women inmate population that was highly disabled, several questions emerge: Why are there more inmates with experiences of disability than we might expect in the general population? Do existing theories explain the survey results? At what point does a health concern become disabling and, in what social, as well as mental and physical, ways? These questions go beyond an intuitive process; they force both pragmatic and ideological issues to the forefront, such as how health can be restored, what adjustments to society might be needed to assist with disability access, and how people are valued—or not—based on their health statuses. Fundamentally, they lengthen the timeline of considering what crime is—from the precipitating events for convictions to a longer inquiry into where these women first had experiences of poor mental or physical health and what could have been done to better both the health and criminal outcomes. In this Part of the Article, we explore how three existing working definitions of disability and health do not serve adequately as a comprehensive theoretical lens for this population and suggest how a fourth approach—epidemiological criminology—might prove to be a way forward for understanding the connection between health and crime for women inmates.

While there are as many approaches to defining health as ways of experiencing it, four major approaches have attempted to place experiences of health and disability in a social context. The first three—the World Health Organization, the Americans with Disabilities Act, and vulnerability theory—do not operate specifically at this intersection of crime and health but do lend critical perspectives on

health as multifaceted and environmentally situated. For example, the World Health Organization approaches health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁵⁷ The organization links disability and poverty and suggests that disability is the result of a person’s interactions with the environment.⁵⁸ The Americans with Disabilities Act contributes to our understanding of disability and health by focusing on providing protections across society to people with disabilities in such areas as employment, transportation, government services and programs, and places of public accommodation.⁵⁹ The Act does not specifically define health, but it does take a medicalized approach to defining disability—and therefore, carving out who is protected by the Act and who is not.⁶⁰ Its approach largely focuses on thinking about the effects of impairment on major life activities, such as “caring for oneself,” “seeing,” “hearing,” “eating,” “sleeping,” “concentrating,” “learning,” “reading,” and “working.”⁶¹ Vulnerability theory—a third common approach to understanding disability and health—revolves around recognizing that vulnerability to physical or mental illness, injury, and decline is a shared experience. For example, Professor Martha Fineman, the field’s prominent theorist, is interested in understanding how “our common vulnerabilities” fit in society—what institutions, for example, rise up to support them and which ones squelch our hopes for a “more substantive vision of equality.”⁶²

A fourth approach—epidemiological criminology—combines the strengths of these context-driven perspectives on health and disability and applies them to understand the interaction of health (or lack thereof) and crime.⁶³ This emerging field, which forms the framework of this Article’s analysis, places its foothold directly in the intersection of public health and criminology, weaving together fields such as

57. *Constitution of the World Health Organization*, in U.S. DELEGATION TO THE INT’L HEALTH CONFERENCE, REPORT OF THE UNITED STATES DELEGATION INCLUDING THE FINAL ACT AND RELATED DOCUMENTS 8, 8 (1946).

58. *Disability and Health, Fact Sheet No. 352*, WORLD HEALTH ORGANIZATION (Dec. 2014), <http://www.who.int/mediacentre/factsheets/fs352/en/>.

59. See Americans with Disabilities Act, 42 U.S.C. § 2101 et seq. (2012).

60. Disability, under the ADA, means: “(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.” § 2102(1).

61. § 2102(2)(A).

62. Martha Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J.L. & FEMINISM 1, 1 (2008).

63. See TIMOTHY A. AKERS ET AL., EPIDEMIOLOGICAL CRIMINOLOGY: A PUBLIC HEALTH APPROACH TO CRIME AND VIOLENCE, at liv (2012).

psychology, epidemiology, sociology, and urban planning.⁶⁴ For purposes of our study, this desire to draw upon multiple fields to begin to ask interdisciplinary questions is what is most exciting and fruitful, yet it has been underexplored in the law review literature.

Notably, the field creates a framework in which health is an important part of understanding both adherence to and violation of the law. It is not simply that risk, health, and crime are dependent on one another but rather that they are correlated:

Perceived and real risks of infectious disease help to create labels of persons and groups as deviant and potentially dangerous. Groups with enough social power to enact legislation can . . . attempt to control the behaviors and groups they believe are practicing behaviors that threaten the health and safety of the general public. These definitions, and particularly criminalization, reinforce perceptions of risk and danger across groups.⁶⁵

Therefore, epidemiological criminology struggles with the issue of how certain behaviors are likely to yield both criminal offenses and poor health status, as well as a position of social deviance—perceived or actual.⁶⁶ This “paradigm integrates the biomedical and behavioral constructs of disparities and operationalizes them according to their unique assumptions, measures, data characteristics, theories, and scales.”⁶⁷ It tries to bring together best practices from fields such as public health, psychology, and sociology to support individuals, communities, and institutions to improve health outcomes and to address perceptions of deviance and criminality.⁶⁸

Scholars working at this intersection are concerned about environmental factors and the individual’s interaction with that environment, such as the effects of stress, chronic strain, and discrimination on health and behavior.⁶⁹ For example, scholars have emphasized how unsafe neighborhoods affect health by decreasing the likelihood that lower income people will exercise.⁷⁰ Furthermore, the increased rate of disability among racial minority groups, particularly

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.* at 70.

68. *Id.* at 70, 74.

69. *Id.* at 86–88.

70. Carlos F. Mendes de Leon & Thomas A. Glass, *The Role of Social and Personal Resources in Ethnic Disparities in Late-Life Health*, in *CRITICAL PERSPECTIVES ON RACIAL AND ETHNIC DIFFERENCES IN HEALTH IN LATE LIFE* 353, 353–405 (Norman Anderson et al. eds., 2004).

black men, might be a function of living in these kinds of environments.⁷¹ However, epidemiological criminologists are interested in being critical about the “units of analysis”—to understand what happens at the micro, meso, and macro levels to individuals, communities, and society.⁷² They see environment as important, as noted, but also recognize that social problems are “the product of collective definition” in which complex power dynamics and resource disparities play out to label certain individuals as being out of compliance with morality and social codes.⁷³ Health and disability, therefore, are states of being that are both physically and socially determined; they affect the body and the mind, as well as one’s place in society.

This way of approaching the questions that plague both criminology and epidemiology fits well with our efforts to understand why disability is rampant and more complex than the correctional system expected at the beginning of our survey. Epidemiological criminology would recognize, for example, that disability has both an actual impairment component as well as a socially stigmatizing effect, particularly if the disability is one associated with morally condemned behavior, such as drug use or promiscuity. The social effects of health conditions can exacerbate those conditions as well as produce new ones and new barriers to support in the community. Epidemiological criminology encourages us to draw from fields outside of law to make sense of the results. We will now turn to some examples of applying this theoretical lens to four examples of disability concerns—stigma, trauma, comorbidity, and agency—that the survey revealed.

IV. DISABILITY IN THE INMATE POPULATION THROUGH AN EPIDEMIOLOGICAL LENS

Existing research suggests that several factors increase a young woman’s chance of entry into the prison system: “[E]arly puberty, sexual abuse, depression and anxiety, conflict with parents and involvement with delinquent (and often older) male partners.”⁷⁴ This

71. See AKERS ET AL., *supra* note 63, at 68.

72. *Id.* Macro levels of analysis look at trends at the population or global level (e.g., nation, society, civilization), while meso analysis happens at the intermediary or middle level, such as within towns, communities, or formal organizations. Micro levels of analysis occur within a small group or at the individual level, such as within households, individuals, or families.

73. *Id.* at 323.

74. Jane K. Steinberg, Christine E. Grella & Melina R. Boudov, *Risky Sexual Behavior and Negative Health Consequences Among Incarcerated Female Adolescents: Implications for Public Health Policy and Practice*, in CRIME, HIV, AND HEALTH, *supra* note 8, at 63, 65. See

list is a valid starting point for research involving women inmates, but we suspected from the outset of the study that it was not as inclusive and multifaceted as it needed to be. The following four examples—mental health, abuse, hypertension, and a sense of impaired agency—illustrate how health issues fuse with social effects (e.g., stigma, trauma, comorbidity, and social exclusion) to reinforce the complexities of responding to the issues that these women face. This kind of insight is epidemiological criminology in action. Each subsection begins with a theoretical overview of the problem, situating it within general statistics about the health issue, and then we apply and contrast that knowledge with the survey results.

A. *Mental Health: Disability as Stigma*

1. Mental Health from an Epidemiological Criminology Perspective

From an epidemiological criminology perspective that fuses public health with criminology perspectives, we already know that women interacting with the prison system have higher rates of mental illness, particularly depression and anxiety, as noted, and complex health issues. They also have higher rates of welfare use and poverty, in general; one effect of the cycle of poverty is limited access to health care and community support but also increased exposure to stigma.⁷⁵ Stereotypes and biases surrounding poverty, crime, and mental illness perpetuate disparities in safe housing, employment, and community integration.⁷⁶ Crime and mental illness share some key defining characteristics—such as the overlay of societal blameworthiness for each, the air of moral responsibility, and the notion of personal defectiveness.⁷⁷ Essentially, stigma acts to convert mental illness from a health experience to something that one is, just as it serves to shape commonly held ideas that “a criminal” is something that someone is or

generally M. A. Zahn et al., U.S. Dep't of Justice, *Causes and Correlates of Girls' Delinquency*, GIRLS STUDY GROUP (Apr. 2010), www.ncjrs.gov/pdffiles/ojdp/226358.pdf (presenting the findings of a study on the patterns of delinquency in adolescent girls).

75. See generally Jennifer E. DeVoe et al., *Insurance Plus Access Does Not Equal Health Care: Typology of Barriers to Health Care Access for Low-Income Families*, 5 ANNALS FAM. MED. 511 (2007) (noting that even with insurance, poverty may still inhibit access to health care).

76. See Patrick W. Corrigan, *Mental Health Stigma as Social Attribution: Implications for Research Methods and Attitude Change*, 7 CLINICAL PSYCHOL.: SCI. & PRAC. 48, 48 (2000); Herbert J. Gans, *The Challenge of Multigenerational Poverty*, 54 CHALLENGE 70, 70–81 (2011); Ben Geiger, *The Case for Treating Ex-Offenders as a Suspect Class*, 94 CALIF. L. REV. 1191, 1191–93 (2006); Eris F. Perese, *Stigma, Poverty, and Victimization: Roadblocks to Recovery for Individuals with Severe Mental Illness*, 13 J. AM. PSYCHIATRIC NURSES ASS'N 285, 285 (2007).

77. See JILL PEAY, MENTAL HEALTH AND CRIME, at xvi (2011).

becomes.⁷⁸ One potential explanation, therefore, for the connection between poverty and incarceration could be that people living in poverty are judged even more harshly for their mental illness experiences or criminal or deviant activities and, therefore, end up in prison at higher rates than people with greater resources.⁷⁹ This kind of bias limits advances in treatment and prevention programs because it locates the problem within the individual's failures. Therefore, policymakers and practitioners come to see treatment not as rooted in community but as requiring individual transformation and even moral reform. People living with mental illness become individual risks to control and subdue.

This preoccupation with the criminal potential of "the mentally ill" is an exaggerated endeavor. Mental illness does not necessarily beget crime or violence. As Jill Peay and John Monahan have elucidated, being a young male from a poor background poses a greater risk of engaging in violence than being mentally ill.⁸⁰ And as Monahan explains, "[C]ompared to the magnitude of risk associated with alcoholism and other drug use, the risk associated with 'major' mental disorders such as schizophrenia and affective disorder is modest indeed."⁸¹ This shared societal fear about the risk of people living with mental illness becomes the basis for discrimination that looks like the reclassification of mental illness as criminality.

As Jill Peay elucidates the tensions so clearly:

First, issues of discrimination are central to the argument about the nature of risk and whether those with mental illness are primarily the objects or the subjects of risk. The disproportionate representation of the mentally disordered among penal populations has been one such source of methodological confusion and public angst. And secondly, the

78. *Id.*

79. Jason Schnittker & Andrea John, *Enduring Stigma: The Long-Term Effects of Incarceration on Health*, 48 J. HEALTH & SOC. BEHAV. 115, 116–17 (2007) (noting that inmates can be selected on the basis of various risks, including mental illness, unemployment, drug and alcohol use, poor health, homelessness, and disadvantaged upbringing); see also Athena Mutua, *Why Retire the Feminization of Poverty Construct?*, 78 DENV. U. L. REV. 1179, 1180–83 (2001) (arguing for the replacement of the feminization of poverty concept with gendered poverty to redress essentialist constructions of poverty).

80. PEAY, *supra* note 77, at 5; John Monahan, *Clinical and Actuarial Predictions of Violence*, in MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 103, 146 (David. L. Faigman et al. eds., 2007).

81. Monahan, *supra* note 80, at 146.

process of visible 'othering' of the mentally disordered is intimately tied up with the criminalization of the mentally ill.⁸²

In focusing on risk and acting on fear, we miss opportunities to support people with mental illness to live independently and successfully in the community. The best place would be to start with inmates.

Indeed, mental illness is a common experience among inmates, one that far exceeds the general population's experience of it; more than half of all inmates report symptoms of mental illness.⁸³ The rate of mental illness is anywhere from two to four times that of nonincarcerated individuals.⁸⁴ People with psychiatric disabilities are more likely to be in prison than in mental health facilities.⁸⁵ While the deinstitutionalization of people with mental illness was a laudable step in community inclusion, released individuals were not provided with the kinds of community support to increase the likelihood of successful integration and independence.⁸⁶ Additionally, behaviors related to psychiatric disabilities are often stigmatized and misunderstood as criminality, thereby increasing the likelihood that an individual will be directed toward punishment and not therapeutic treatment.⁸⁷ Behavioral issues have become triggering issues for imprisonment; jails and prisons perpetuate a cycle of relapse and punishment.⁸⁸ Even more troubling is that once incarcerated, individuals with psychiatric disabilities are eight times more likely to be abused than inmates without such concerns.⁸⁹

It is difficult to pinpoint the beginning of mental illness experiences for any individual, let alone inmates, where the prison environment itself can cause feelings of depression, anxiety, hopelessness, and despair. Imprisonment is a traumatic experience that can exacerbate existing struggles and create new ones, but it is also often the first place that inmates are diagnosed.⁹⁰ While more than 90% of correctional facilities offer mental health services, sometimes

82. PEAY, *supra* note 77, at 41.

83. Sanders et al., *supra* note 13, at 3.

84. *Id.* at 6.

85. *Id.* at 5-6.

86. William B. Lawson & Anthony Lawson, *Disparities in Mental Health Diagnosis and Treatment Among African Americans: Implications for the Correctional Systems*, in CRIME, HIV, AND HEALTH, *supra* note 8, at 81, 82.

87. *Id.* at 86.

88. *Id.* at 82.

89. *Id.* at 86.

90. Sanders et al., *supra* note 13, at 6.

those services do not meet the needs of inmates.⁹¹ Being in prison can damage an individual's mental health, as well as physical well-being.⁹² Prison makes perceived villains vulnerable.

Even when delivered, mental health services are often racially skewed and culturally biased. For example, African Americans are often over-diagnosed with uncommon disorders, such as schizophrenia, and under-diagnosed with more prevalent conditions, such as depression and anxiety.⁹³ Stereotype-driven fears about race and poverty trickle into identification and treatment.⁹⁴

Lost in the narratives about mental illness as violence, deviance, and criminality is the recognition of the vulnerability of offenders with psychiatric disabilities to becoming victims themselves. People living with mental illness are just as likely to be victims as perpetrators, and some studies have shown that they are even more likely to be victims than perpetrators.⁹⁵ In a survey of discharged patients from a psychiatric hospital, one researcher found that 71% had been victims of violence in the past two years, with 22% reporting having been physically assaulted.⁹⁶ Other studies have teased out the nuances of these victimization experiences, finding that most people with psychiatric disabilities are assaulted—physically, sexually, or emotionally—at much higher rates than the general population of people without mental illness and by people familiar to them—such as family members, caretakers, romantic partners, and friends.⁹⁷ The nature of these ongoing relationships means that the potential for recurring violence is great.⁹⁸ The results of this survey support this conclusion, as the women were most vulnerable to, and violated by, the people closest to them; this risk continues upon reentry, particularly where formerly incarcerated people face homelessness unless they find shelter with friends or family members.⁹⁹

Mental illness, as it relates to incarceration, therefore, has a longer timeline than the date of arrest or the date of release. Partly, these continuing effects are related to the collateral consequences of incarceration, such as exclusion from employment, public assistance

91. *Id.*

92. PEAY, *supra* note 77, at 123–24.

93. Lawson & Lawson, *supra* note 86, at 81.

94. *Id.* at 85.

95. PEAY, *supra* note 77, at 34.

96. *Id.* at 35.

97. *Id.*

98. *Id.*

99. See Sanders et al., *supra* note 13, at 3.

programs, subsidized housing, and community health services.¹⁰⁰ Even where effective treatment programs are available in prison and after it, former offenders struggle to avoid relapsing because of such factors as poor community support and the costs of treatment.¹⁰¹

2. Survey Results

Consistent with existing research about prison health issues,¹⁰² our results showed high rates of mental illness, particularly as part of a constellation of health and social issues: 561 of the 989 inmates identified themselves as having mental health issues. These experiences cut across education, race, and age lines. For example, while women aged twenty-five to thirty-five years old were the largest group reporting mental health concerns (38% of all women with this concern), 9.3% of women younger than twenty-five, 29.6% of women aged thirty-five to forty-five, 18.5% of women aged forty-five to fifty-five, 4.3% of women aged fifty-five to sixty-five, and 0.4% of women older than sixty-five, identified mental health as a concern; see Chart G. Over 61% of women with mental health concerns were white, 22.6% were black, 10.2% were multiracial, 3% were Native American, and the remainder were Arab American, Asian American, Hispanic, or other; see Chart H. This population was educated largely at the high school or college level; 38.1% of these women had graduated high school and 43.1% had some college. Over 6% had a bachelor's degree; see Chart I.

100. Lawson & Lawson, *supra* note 86, at 86.

101. *Id.*

102. In 2006, the Bureau of Justice Statistics estimated that 705,600 people with mental illness were living in state prisons. JAMES & GLAZE, *supra* note 12, at 1. See generally Holly M. Harner & Suzanne Riley, *The Impact of Incarceration on Women's Mental Health: Responses from Women in a Maximum-Security Prison*, 23 QUALITATIVE HEALTH RES. 26 (2013) (finding that women's health in prison might worsen, improve, or remain the same while incarcerated and highlighting the extent to which women enter prison with significant mental health concerns and need support for their experiences of trauma).

Chart G. Rate of Mental Health Concerns by Age

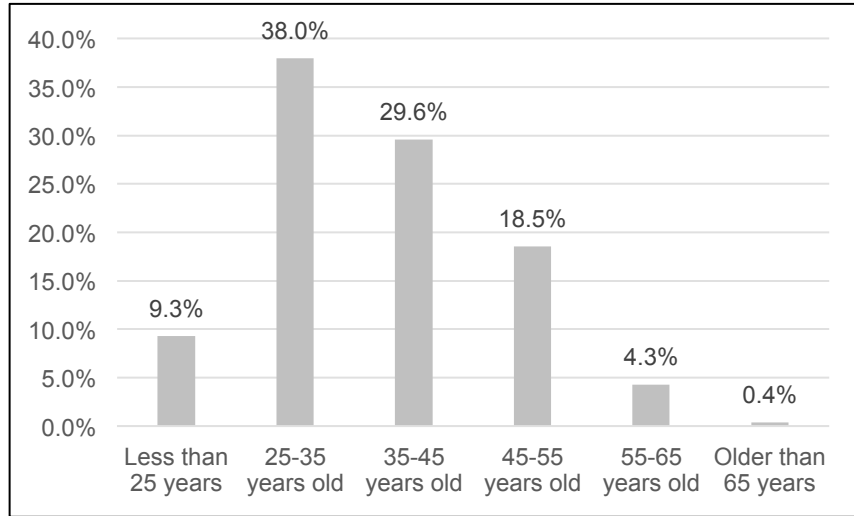


Chart H. Rate of Mental Health Concerns by Race

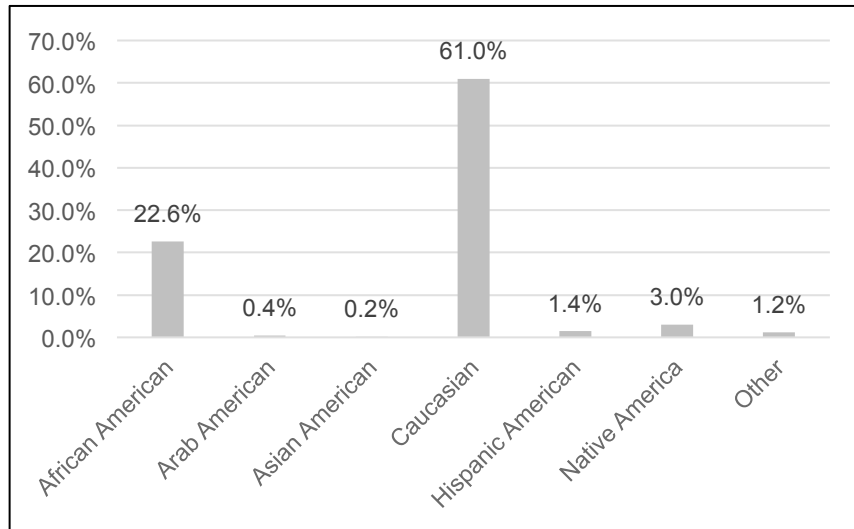
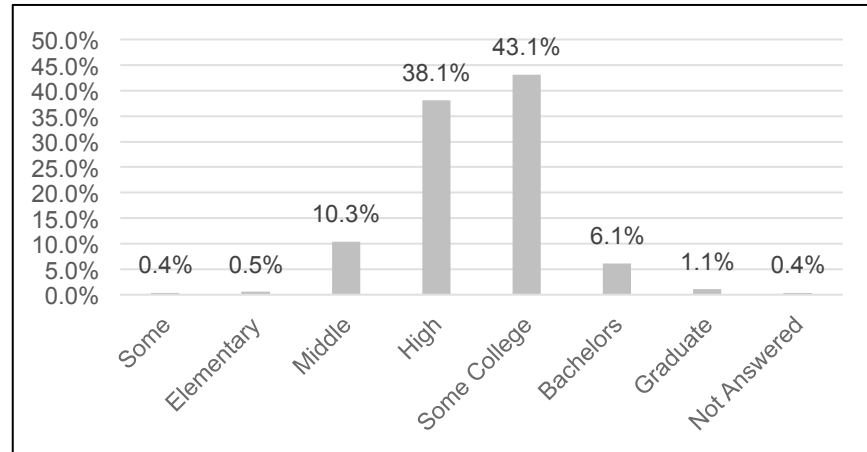


Chart I. Rate of Mental Health Concerns by Education Level

By employing the lens of epidemiological criminology, we began to ask several questions about these preliminary results showing rampant mental health concerns among women inmates. Are women inmates receiving support and care for mental health? To what extent has stigma been a factor in their life experiences? We do not claim to have ready answers to these questions but find that further unpacking the survey data helps to develop a robust picture of what the lives of women inmates with psychiatric disabilities looks like.

Strikingly, respondents with this health concern were often poor, had multiple health issues, and did not always have their basic needs met—despite relatively average or high levels of education. This connection between poverty and mental health concerns reflected the literature in the field. While poverty was a consistent theme in the lives of the women respondents, even those without mental health concerns, those inmates with such health concerns had higher rates of welfare use, for example. Among the 561 women identifying themselves as having mental health concerns, 438 had received welfare (78.1%). Four hundred and twenty-eight women identified themselves as not having mental health concerns. Of these women, 290 received welfare (67.7%) and 129 did not.

The results also raised questions about what other issues women were managing in the face of limited resources. The data showed that mental health was women's highest individual health concern and also their highest health concern when multiple issues were present. Women experiencing mental health concerns often relayed concerns about

hypertension (21.5%) and vision impairments (27.1%), for example. Therefore, managing several health issues was common for women with psychiatric disabilities, yet they were forced to do so with highly constrained resources and the additional stress of managing multiple conditions.

Poverty issues additionally raise questions about how these women access mental health care services, if at all. Approximately 83% of women who identified mental health as a concern had mental health services before entering prison, while only 77.2% of these women had such services in prison. This decrease in services is not optimal given the additional stresses of incarceration.

We also found that while women may have used mental health-care services while in prison or before being incarcerated, participation did not always mean that they identified as having mental health concerns. For example, of the 607 inmates who had mental health services before going to prison, only 469 identified mental health as a current concern. And of the 561 inmates who had mental health services in prison, only 433 identified mental health as a current concern. Perhaps, they were simply using mental health services to deal with life concerns and stressors, while not identifying as having a specific mental health problem. This distinction could have been driven by perceived and internalized stigma about mental illness.

The effects of stigma on the experience of disability as well as access to resources and the process of incarceration are difficult to distinguish. But it is not necessary to separate them from one another. Rather, new conceptions of disability and health dictate that we be aware of the effects of stigma on generating categories of “the mentally ill,” “the poor,” and “criminals” and be responsive to dismantling stereotypes and their disabling effects on both the physical and social levels.

B. Frequent Physical Abuse: Disability as Trauma

1. Abuse from an Epidemiological Criminology Perspective

In the general overview of the survey results, we noted that the women in our study had been subjected to high levels of physical and sexual abuse. Adopting an epidemiological criminology focus, we are interested in considering the life trajectories of these women—from where they started in childhood to where they might be postincarceration—specifically to understand how abuse is a form of

trauma, and a disabling experience, even after the physical or sexual violence has ended.¹⁰³ Given the frequency of the abuse that the women experienced, we start the examination of that life trajectory influenced by trauma by looking at the literature surrounding childhood.

Young women in the justice system have shared family trauma histories, ranging from parental substance abuse to physical assault, parental incarceration to homelessness.¹⁰⁴ In a 2006 study, researchers examining the family and risk issues of incarcerated girls in California and Florida, for example, found that more than 40% of them had been taken from their homes by social services, 77% were chronic runaways, and 48% to 88% had experienced sexual, physical, or emotional abuse.¹⁰⁵ Over half of them had an incarcerated parent, 29% had a former pregnancy, and 75% reported using drugs or alcohol regularly.¹⁰⁶ Other studies have found correlations between childhood abuse and chronic fatigue syndrome, gastrointestinal diseases, and fibromyalgia, among other conditions.¹⁰⁷ Trauma is also associated with making higher-risk health decisions, such as smoking, drinking alcohol, using drugs, and having unsafe sex.¹⁰⁸ The more trauma exposures, the greater the likelihood there is of adulthood health concerns, and this calculus only increases when risky health behaviors are considered.¹⁰⁹

Abuse has profound physical and emotional effects beyond the tangible psychological anguish that it causes. Sexual assault, for example, has been correlated with poor overall health, as well as chronic health conditions that are telling of the nature of the violence itself—such as sexual dysfunction, painful intercourse, and irregular menses.¹¹⁰ A study

103. See generally Bessel van der Kolk, *Posttraumatic Stress Disorder and the Nature of Trauma*, 2 DIALOGUES IN CLINICAL NEUROSCIENCE 7 (2000) (discussing the effects of PTSD on the brain, body, and emotions).

104. Steinberg et al., *supra* note 74, at 72.

105. *Id.* at 73; LESLIE ACOCA & KELLY DEDEL, THE NATIONAL COUNCIL ON CRIME AND DELINQUENCY, NO PLACE TO HIDE: UNDERSTANDING AND MEETING THE NEEDS OF GIRLS IN THE CALIFORNIA JUVENILE JUSTICE SYSTEM 49–63 (1998), available at <http://justiceforallgirls.org/resources/No%20Place%20To%20Hide.pdf>; VANESSA PATINO ET AL., NATIONAL COUNCIL ON CRIME AND DELINQUENCY, A RALLYING CRY FOR CHANGE: CHARTING A NEW DIRECTION IN THE STATE OF FLORIDA'S RESPONSE TO GIRLS IN JUVENILE JUSTICE 9, 23–25 (2006).

106. Steinberg et al., *supra* note 74, at 73.

107. See Charles C. Engel, Jr., *Somatization and Multiple Idiopathic Physical Symptoms: Relationship to Traumatic Events and Posttraumatic Stress Disorder*, in TRAUMA AND HEALTH, *supra* note 21, at 199–202 (discussing contemporary studies of trauma, abuse, and physical health effects).

108. Alyssa A. Rheingold et al., *Trauma, Posttraumatic Stress Disorder, and Health Risk Behaviors*, in TRAUMA AND HEALTH, *supra* note 21, at 191, 217.

109. *Id.* at 218.

110. Green & Kimerling, *supra* note 22, at 16.

of over 100 women in their sixties and beyond found that a background of exposure to interpersonal violence led to greater chronic physical conditions and increased use of medication to alleviate those symptoms.¹¹¹ The effects of this form of trauma can be cumulative.

Trauma and vulnerability to abuse are further compounded by socioeconomic status. For example, black women are more likely to be victims of partner violence than white women and for that violence to be more severe.¹¹² Domestic violence occurs at similar rates in the LGBTQ community, as in the heterosexual community, yet these numbers might be underestimated because of the underreporting of these incidents to authorities due to fears of “outing” or child removal.¹¹³ Women with disabilities are at great risk for physical abuse, particularly before and during pregnancy.¹¹⁴ More than 50% of welfare recipients have experienced physical abuse.¹¹⁵

2. Survey Results

For the women in our study, physical and sexual violence happened most frequently at the hands of family members and romantic partners. While 2012 rates of domestic violence committed by intimate partners, for example, were three victims for every 1,000 persons aged twelve or older and about one victim for every 1,000 persons when the perpetrator was an intimate family member, our survey results demonstrate even higher levels of physical abuse among respondents.¹¹⁶ Similarly, these women experienced higher rates of sexual abuse than other women in North Carolina—64.5% of respondents versus a lifetime expected rate of 19% of women in the state.¹¹⁷ These disparities potentially highlight how past experiences place these women at greater risk of being re-

111. *Id.* at 16–17.

112. CALLIE M. RENNISON & SARAH WELCHANS, U.S. DEP’T OF JUSTICE, NCJ 178247, INTIMATE PARTNER VIOLENCE 2 (2000), available at <http://www.ojp.usdoj.gov/bjs/pub/ascii/ipv.txt>.

113. CTR. FOR AM. PROGRESS, DOMESTIC VIOLENCE IN THE LGBT COMMUNITY 2 (2011), available at <http://www.americanprogress.org/issues/lgbt/news/2011/06/14/9850/domestic-violence-in-the-lgbt-community/>.

114. Monika Mitra, *Physical Abuse Around the Time of Pregnancy Among Women with Disabilities*, 16 MATERNAL CHILD HEALTH J. 802, 802 (2012).

115. Richard Tolman & Jody Raphael, *A Review of the Research on Welfare and Domestic Violence*, 56 J. SOC. ISSUES 655, 660 (2000).

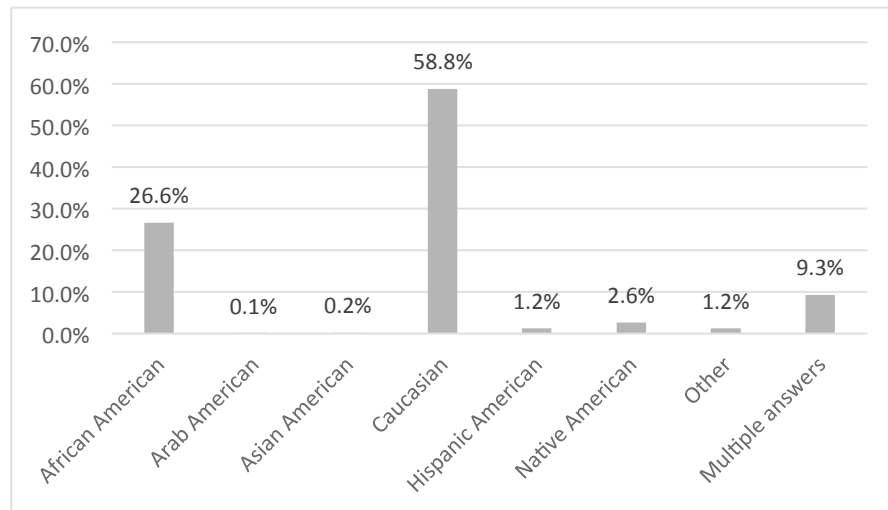
116. JENNIFER L. TRUMAN & RACHEL E. MORGAN, BUREAU OF JUSTICE STATISTICS, OFFICE OF JUSTICE PROGRAMS, U.S. DEP’T OF JUSTICE, SPECIAL REPORT: NON-FATAL DOMESTIC VIOLENCE 2003–2012, at 11 (2014), available at <http://www.bjs.gov/content/pub/pdf/ndv0312.pdf>; see also Suzanne Cloutier et al., *Sexual Assault Among North Carolina Women: Prevalence and Health Risk Factors*, 56 J. EPIDEMIOLOGY & COMMUNITY HEALTH 265, 267 (2002) (finding that women in North Carolina have a 19% lifetime risk of sexual assault and that women with poor physical and mental health were at greater risk for sexual assault).

117. *Id.*

traumatized upon reentry or unable to find appropriate community supports to meet their needs. We also glean from the high levels of health concerns faced by these respondents that they have multiple vulnerabilities in their communities, as well as in prison. These vulnerabilities include disability, health concerns, and histories of abuse, thus compounding their current and future experiences of trauma and its effects on their health.¹¹⁸

Respondents reporting physical or sexual abuse, or both, were largely young inmates (36.1% between twenty-five and thirty-five years old), white (58.8%) or black (26.6%), heterosexual (55.6%) or bisexual (31.9%) and living with multiple health concerns (44%); see Chart J. Approximately 66% of the women had received mental health care before prison, while only 60% received such services while incarcerated. Over 37% of the women reported using drugs eleven or more times a week before prison, while about 25% them either did not drink alcohol or had eleven or more drinks each week.

Chart J. Experience of Abuse by Women's Race



118. See generally *WOMEN WITH DISABILITIES: ESSAYS IN PSYCHOLOGY, CULTURE, AND POLITICS* (Michelle Fine & Adrienne Asch eds., 1988) (discussing the interaction of being female and having a disability).

Over 11% had been in special education at some point in their lives. Most of these women had completed high school as their highest level of educational achievement (40.3%) and 43.3% had taken some college coursework. Like other inmates, women who had been abused (45%) worried most about finding a job after incarceration.

These general trends show both physical and sexual abuse as common experiences in the lives of the women participants. However, what became most striking to us as we delved into the data was the extent to which *frequent* physical abuse was also a shared life experience among the women. For the remainder of this section, we explore some of the trends within the population of women who were physically abused eleven or more times in their lives. Indeed, inmates were more likely to have been abused—and to have been abused frequently—than to never have experienced such trauma. Over 82% of the respondents had been physically abused. Of the 353 women who had been abused eleven or more times in their lifetimes, most were between twenty-five and forty-five years old. They were largely high school graduates (38%) or women with some college experience (46%) as their maximum educational attainment. Women with histories of being in special education were more likely to have been frequently abused physically than to have never been abused.

Of the population of women that had been physically abused eleven or more times, white women were 61% and black women were 23%. Women selecting multiple answers for race were 10%. African American women, by contrast, constituted 36% of the population that had never been abused and white women were 51%; women with multiple racial/ethnic identities were 8%. White women in our sample, therefore, are the most likely to experience frequent abuse as well as the most likely to have never been abused.

Bisexual women (31%) and lesbian women (8%) were a significant portion of this group in ways that exceeded their representation in the overall survey. Heterosexual women were 57% of the respondents that reported experiencing abuse eleven or more times. On the flip side, heterosexual women were 69% of the women reporting that they had never experienced physical abuse, while bisexual and lesbian women were only 27% combined. Therefore, physical abuse—in a range of frequencies as captured by the other survey answers—was more common among women who did not identify as being straight.

Women who had experienced frequent abuse were also more likely than women who had never been abused to be managing multiple health concerns. Only 17% of the women who had

experienced frequent physical abuse identified as having no health concerns. Interestingly, 48% of the women experiencing frequent abuse chose multiple health concerns. Women who had been physically abused eleven or more times had higher rates of all disabilities, except multiple sclerosis, than women who had not been abused. Strikingly, women experiencing such frequent abuse were more than twice as likely to identify mental health concerns in their lives as women who had not been abused.

Given an epidemiological approach to health and disability, we also considered other community and environmental factors in understanding the health challenges of women who had been frequently abused. For example, of the women experiencing frequent physical abuse, 16% had been in foster care, while only 6% of the women who had not been abused had a history of being in foster care. Of the women experiencing frequent physical abuse, 80% had received welfare support.¹¹⁹ In contrast, only 55% of the women who had not been abused had been on welfare. Poverty and interactions with the social services system seemed to be more common experiences of women who had been frequently abused physically than those who had not.

Victims of abuse might also seek methods of self-medicating and escaping the reliving of trauma. As part of the survey results, we considered drug and alcohol use as it related to frequency of abuse. Among the women who had been abused eleven or more times, drug use eleven or more times a week was common (42%), while among women who had never been abused, drug use was less common.¹²⁰ Similarly, 31% of women with histories of such frequent abuse consumed alcohol eleven or more times a week, while women who had not been abused were more likely to abstain from alcohol consumption entirely.

Women with histories of frequent physical abuse seemed to have longer sentences, especially for crimes involving sex, assault, or drug

119. Researchers have linked frequent physical abuse, particularly in the home or from the woman's mother growing up, to a greater likelihood of having unintended first pregnancies, homelessness, unstable romantic partners, illegal sex work, and risk for HIV infection. See Rheingold et al., *supra* note 108, at 229. Our question about welfare did not tease out why the support was needed.

120. These findings bear out in studies conducted by other researchers as well. Childhood abuse, for example, leads to greater use of "hard drugs," even among college-educated women. Among adolescents who have witnessed abuse or been abused, drug use is 1.5 to 3 times higher than people with no history of violence. *Id.* at 224–25. Drug use also increases women's likelihood of being assaulted; this risk further increases if the women have histories of assault. *Id.* at 226.

charges. They also seemed to have longer sentences than women without these abuse experiences. For example, more than 33% of women in this group had sentences of longer than ten years, while only 19% of women with no history of abuse had sentences of longer than ten years. We can only begin to theorize about these sentencing patterns but suggest that further study is needed into potential relationships and causal links between trauma and the kinds of crimes committed by women.

C. *High Blood Pressure: Disability as Comorbidity*

1. High Blood Pressure from an Epidemiological Criminology Perspective

The third health issue that captured our attention was high blood pressure or hypertension. The existing health literature on hypertension reveals that about 32% of women across all age groups have this health issue, with black and Hispanic women reporting higher rates than men, for example.¹²¹ Age, diabetes, obesity, alcohol use, sodium consumption, lack of exercise, and family history are all risk factors for developing the condition.¹²² The effects of high blood pressure can be profound. High blood pressure increases the likelihood of heart attack, stroke, chronic heart failure, and kidney disease.¹²³

One of the greatest challenges that health policymakers and providers face is grappling with disability and health issues that are comorbid because such strategies need to be multifaceted and creative.¹²⁴ Hypertension is one of those challenges,¹²⁵ particularly among women living in prison—where the etiology of stress might be difficult to trace, but nutrition and exercise are more predictable than in the community. In prisons, these kinds of comorbid or co-occurring disorders, such as hypertension, exacerbate the rate of poor health and health recidivism because they make diagnosis and treatment more complex and they pose strains on previously incarcerated women as

121. *High Blood Pressure Facts*, CENTER FOR DISEASE CONTROL (Feb. 19, 2015), <http://www.cdc.gov/bloodpressure/facts.htm>.

122. *Minority Women's Health: High Blood Pressure*, WOMENSHEALTH.GOV (May 18, 2010), <http://womenshealth.gov/minority-health/african-americans/high-blood-pressure.html>.

123. *High Blood Pressure Facts*, *supra* note 121.

124. Jose M. Valderas et al., *Defining Comorbidity: Implications for Understanding Health and Health Services*, 7 ANNALS FAM. MED. 357, 357–58 (2009).

125. Evelyn P. Davila & WayWay M. Hlaing, *Comorbidities of Patients with Hypertension Admitted to Emergency Departments in Florida Hospitals*, 5 FLA. PUB. HEALTH REV. 84, 84 (2008).

they try to find health supports in the community.¹²⁶ This kind of complicated picture of the individual and her needs is not something that prisons do well, historically.¹²⁷ Treating illnesses individually also downplays the connections between the illness and environmental and personal stressors, such as restricted activity levels, intrusive thoughts about trauma or the crime committed, infrequent opportunities for family and peer support, depression and anxiety, and other health issues that limit overall feelings of wellness. To begin to analyze the data from this study, we will need to draw a parallel between a studied area of comorbidity—substance abuse and mental health—and the results showing hypertension as a comorbid experience.

While rigorous study of comorbid health concerns is still underway, some progress has been made in looking at substance abuse and mental health. Scholars working at this intersection have connected physical and psychological well-being by recognizing disturbances in one area as disrupting the other. In the field of drug abuse, for example, researchers have recognized that drugs can affect the brain and nervous system in ways similar to mental illness.¹²⁸ Drug abuse can often exacerbate mental illness, or even disguise it as simply an effect of the drugs.¹²⁹ Similarly, we might think of hypertension as being caused by, and affecting, other health conditions—and like the tie between drug abuse and mental illness, being responsive to environmental factors, such as stress and community.

In fact, researchers are making emerging connections between hypertension, mood, addiction, and environment. Mental health seems to be strongly correlated to heart health. A 1997 study found that anxiety and depression increased the risk of developing hypertension two-fold.¹³⁰ Furthermore, increased use of alcohol (more than two to three drinks a day) is predictive of experiencing problems with hypertension later in life.¹³¹ Finally, exposure to discrimination can lead to such stress-regulating behaviors that increase the likelihood of damage to the cardiovascular system.¹³²

126. Lawson & Lawson, *supra* note 86, at 88; D.E. McNeil et al., *Incarceration Associated with Homelessness, Mental Disorder, and Co-Occurring Substance Abuse*, 56 PSYCHIATRIC SERVS. 840, 845 (2005).

127. Lawson & Lawson, *supra* note 86, at 88.

128. *Id.* at 88.

129. *Id.*

130. Daniel E. Ford, *Depression, Trauma, and Cardiovascular Health*, in TRAUMA AND HEALTH, *supra* note 21, at 73, 85.

131. *Id.*

132. AKERS ET AL., *supra* note 63, at 88–89.

One compelling example of the connection between high blood pressure and environment comes from outside the prison walls, but might begin to give us better insights into why these issues are common among inmates. Living in areas of high crime and violence creates detrimental health effects, such as high blood pressure.¹³³ These environments might also curtail people's exercise patterns and access to health care, as individuals in the community feel safer remaining in their homes and avoiding victimization or conflict.¹³⁴ This explanation makes sense intuitively—people stay home when they fear being outside, and the stress of living in constant danger strains the heart.

Stress, however, takes more than a psychological toll and affects more than just individual choices about exercise and diet. Public health efforts to address hypertension among African Americans, for example, have focused on primary prevention and early diagnosis.¹³⁵ This approach, while laudable in its desire to tackle health disparities, might fall short of fully understanding what disability as comorbidity looks like because it continues to locate the health problem within individuals themselves and not in the context of individuals in their environment. Recently, researchers have begun to ask: Do spikes in crime create inflammatory cardiovascular responses, specifically elevations in C-reactive protein ("CRP")? Sociologists Christopher Browning, Kathleen Cagney, and James Iveniuk attempted to tease out this connection by examining data from the Dallas Heart Study (2000–2002) and comparing that heart health information to census-tract-level burglary rates.¹³⁶ The connection they found was compelling; for example, when burglaries are greater than four per 1,000 people, just one more burglary increase in the short-term burglary rate correlates with a 9% increase in CRP, even when problematic factors such as individual health, neighborhood characteristics, and time of year are controlled for.¹³⁷ Perhaps the most striking insight of this study is that understanding the effects of environment means both grasping short-

133. Sanders et al., *supra* note 13, at 4.

134. *Id.*

135. Julie C. Will & Paula W. Yoon, *Preventable Hospitalizations for Hypertension: Establishing a Baseline for Monitoring Racial Differences in Rates*, PREVENTING CHRONIC DISEASE (Feb. 14, 2013), http://www.cdc.gov/pcd/issues/2013/12_0165.htm.

136. Christopher R. Browning, Kathleen A. Cagney & James Iveniuk, *Crime Rates, Crime Spikes, and Cardiovascular Health in an Urban Population*, in *CRIME, HIV, AND HEALTH*, *supra* note 8, at 187, 191.

137. *Id.* at 198.

term changes, such as crime spikes, as well as long-term conditions, such as structural disadvantage.¹³⁸

Inmates, because of their life trajectories before and after prison, are not immune to the impact of environment either; they are people foremost, people susceptible to the barometric changes of trying lives. Rather than viewing their health and disability issues as insular, we should attempt to understand how pieces fit together and how disturbances in one context have effects on others. Therefore, one of the most valuable lessons from the survey results is embracing how disability and health must be viewed as a totality of experience, rather than singular diagnoses. Hypertension, therefore, is a fine example of the complexities of addressing both prevention and treatment. Given its multiple avenues to developing as well as the factors that can exacerbate its intensity, high blood pressure forces treatment providers and policymakers to consider overall health, inclusive of mental well-being, structural discrimination, and community safety.

2. Survey Results

Given the constraints of prison nutrition and exercise, as well as a substantial population of women of color in prison and shared experiences of stress, we expected that both lifestyle and biological factors would show high rates of this health concern.¹³⁹ At first glance, the survey data revealed that high blood pressure, or hypertension, was not a common area of concern for the respondents (3.6%). However, that conclusion was flawed because it only considered high blood pressure as a singular issue—not when the answer choice was buried among other health issues that we had originally collapsed into one category of “multiple health issues” in our first round of coding. Thus, if a respondent selected several different health concerns individually, we had summarized those responses under a new coding category in our first round of working with the data. While convenient, that category became a grab-all for interesting data that required further analysis. Once we began to unpack the “multiple health issues” category, we realized the prevalence of hypertension as a health concern (21% of inmates). Of the women with hypertension, almost 30% were between thirty-five and forty-five years old and another 35% were between forty-five and fifty-five years old. Almost 32% of

138. *Id.* at 188–89; Robert J. Sampson, *Neighborhood-Level Context and Health: Lessons from Sociology: Neighborhood-Level Context and Health: Lessons from Sociology*, in *NEIGHBORHOODS AND HEALTH* 132, 139–40 (Ichiro Kawachi & Lisa F. Berkman eds., 2003).

139. ARLENE SPARK, *NUTRITION IN PUBLIC HEALTH: PRINCIPLES, POLICIES, AND PRACTICE* 230–31 (2007); *Minority Women's Health: High Blood Pressure*, *supra* note 122.

them were black and 55% were white. Drug crimes (25.1%), murder (19.4%), and robbery (18%) were common bases for conviction.

Hypertension makes an interesting example of disability because of its tendency to be clustered with other health conditions. In our study, it was frequently paired with mental health concerns, followed by comorbidity with vision impairments, hearing impairments, mobility impairments, and learning disabilities. High blood pressure, then, is something that becomes part of a constellation of health issues for these women, rather than a standalone health issue. This is precisely the error that we had made in initially thinking that hypertension rates were low among inmates. Not until we unpacked the data did we see that hypertension was a condition that happened in conjunction with other health concerns, thereby complicating its management. The nature of these experiences raises compelling questions about comorbidity and its relationship to environment and stress.

D. Concerns About the Future: Disability as a Barrier to Agency

1. Impaired Agency from an Epidemiological Criminology Perspective

In examining the respondents' overall picture of health and disability, we were apprehensive about its toll when the women returned to the community. We, therefore, decided to carefully examine their responses to the final question of the survey regarding their own concerns for the future. One's outlook about the future and its possibilities might serve as a barometer of health, both physical and emotional. Health and disability are both opportunities and obstacles. If we view health as multifaceted and a continuum, then understanding respondents' concerns about the future is crucial to not only setting pathways for success in those returns to the community, but also heading off situations and skills gaps that might lead to both health and criminal recidivism.

Here, recognizing disability broadly—as encompassing being currently or formerly incarcerated and facing physical and mental health issues—also means acknowledging its effects on how successful any one individual can be in fully actualizing her success.¹⁴⁰ Disability

140. Liat Ben-Moshe, *Disabling Incarceration: Connecting Disability to Divergent Confinements in the USA*, 39 *CRITICAL SOC.* 385, 399 (2013) (noting that “incarceration is understood as . . . an institutional matrix in which disability is a core component, not simply an added category of analysis”).

is an issue of agency—both internally and externally constrained.¹⁴¹ These women might complete processes of self-growth while incarcerated only to find that the environments to which they return hinder and dismantle that progress and trigger old strategies for survival.¹⁴² In envisioning the future, inmates might be relying on a series of copying strategies, ranging from problem-oriented coping (e.g., identifying a problem, tackling a problem) to emotion-based coping (e.g., avoidance, withdrawal), social-based coping (e.g., finding family support, relying on a faith community) to cognitive reframing (e.g., looking for meaning in the experience of imprisonment, remaining positive).¹⁴³ Out of all these strategies, the least effective is seeking social support; research has shown that it can lead to negative consequences.¹⁴⁴ The emphasis here is on the active process of looking for help. This phenomenon is not well understood, but it might be the result of negative reactions to this kind of outreach or to the lack of a strong network in the beginning.¹⁴⁵

According to recent research, formerly incarcerated people struggle with finding sources of emotional and social sustenance upon return to their communities.¹⁴⁶ The process of searching for that safety can be a destabilizing reminder of the isolation that they have felt previously. Relationship stability, for example, is a significant barrier, as romantic relationships erode because of separation and as family members grow estranged.¹⁴⁷ Very few people experience improvements in their lives postincarceration when compared to preincarceration.¹⁴⁸ This situation is especially true with multiple periods of incarceration or returns to prison; each disruption further

141. See, e.g., Janet S. Sauer, "Look at Me:" *Portraiture and Agency*, 32 *DISABILITY STUD. Q.*, no. 4, 2012, <http://dsq-sds.org/article/view/1736/3180> (suggesting that an important component of understanding the relationship between disability and agency is understanding "awareness of and resistance toward the oppressive nature of social contexts").

142. See generally ANDREA M. LEVERENTZ, *THE EX-PRISONER'S DILEMMA: HOW WOMEN NEGOTIATE COMPETING NARRATIVES OF REENTRY AND DESISTANCE* (2014) (exploring the process of desisting in criminal activity, negotiating social institutions upon reentry, and constructing new narratives of self).

143. Carolyn M. Aldwin & Loriena A. Yancura, *Coping and Health: A Comparison of the Stress and Trauma Literatures*, in *TRAUMA AND HEALTH*, *supra* note 21, at 99, 101–02.

144. *Id.* at 102.

145. *Id.*

146. ANNIE E. CASEY FOUNDATION, *REENTRY: HELPING FORMER PRISONERS RETURN TO COMMUNITIES* 57 (2005), available at <http://www.aecf.org/resources/reentry-helping-former-prisoners-return-to-communities/>.

147. Blankenship & Smoyer, *supra* note 11, at 215.

148. *Id.*

erodes the social support system.¹⁴⁹ However, such resources as supported housing, disability benefits, meaningful work, and faith communities can provide beneficial outcomes—on a modest scale—and deserve further research.¹⁵⁰

2. Survey Results

Respondents did, indeed, demonstrate concerns about their agency postincarceration, but the relationship to their health and disability issues is not always explicit. The survey results show that respondents were most concerned about finding jobs (44.8%) and then expressed a range of concerns not captured by the survey choices alone (24.2% of respondents selected “other”). The third most common answer was stress about potentially returning to prison because of problems that the women might encounter when reentering the community (8.6%). While experiences of abuse were common among the respondents, only 1% of respondents identified that as a concern.

Respondents choosing “other” often wrote notes on the survey. Their comments, as well as the range of concerns identified, reveal underlying fears about how they will support themselves in the future. Disability, viewed from this perspective, raises concerns about individuals’ agency, even when they were not explicitly framed in that way.¹⁵¹ While many inmates identified in their comments that they understood their crimes and were committed to never returning to prison, they also recognized that there were tangible barriers to embarking on “new lives.” This kind of anxiety encompasses both the financial-material aspect of surviving in the community as well as the individual health and wellness piece. The fact that respondents chose to write their own answers is telling in many ways because the answer choices did not capture the full range of their experiences. The comments touched on issues of housing, a combination of worries, the lack of support systems and acceptance (primarily, family and partners), and improving or maintaining health (including gaining access to health care that was never provided in prison). Here are just a few of the words from the women in this study:

149. *Id.* See generally N.C. PRISONER LEGAL SERV., FORMERLY INCARCERATED PERSON PACKET, available at <https://www.ncpls.org/FIP%20packet.pdf> (providing resources for reentry).

150. Blankenship & Smoyer, *supra* note 11, at 215.

151. See Hanock Livneh & Randall M. Parker, *Psychological Adaptation to Disability: Perspectives from Chaos and Complexity Theory*, 49 REHABILITATION COUNSELING BULL. 17, 23 (2005) (describing the nonlinear nature of disability and its continuous unfolding as a navigation of internal and environmental factors).

- “My husband is dead after 37 years. Now I will be alone to start over.”
- “I just made a mistake. I have a great family support system. I am not the average prisoner.”
- “Housing? Where am I going? Halfway houses cost money . . . what we know how to do—whatever we have to to survive. I’ve been here five years and seen MASSES of women come back for just that and equal amounts have died.”
- “I’m afraid that I may never leave, and when I do, be too old to worry about anything and I can only give my testimony to others as my way of benefiting my community.”
- “I have a 4 year old little girl and I am scared that I will not be able to take care of her because I have to pay the state a \$250,000 fine.”
- “I have the Other—Death Penalty. I will never be released till I’m dead.”
- “Homeless.”
- “I need legal help desperately over medical indifference and maltreatment. Please help—I have cancer.”

Taken holistically, respondents were worried about their individual health as well as the abilities of their communities to be receptive to them and to provide opportunities for flourishing and integration.

CONCLUSION

The preliminary results of our study of the experiences of women inmates in North Carolina’s state system demonstrate the need for greater collaboration and creativity in approaching health and disability issues. The first step is to recognize the size of the problem, as well as the complexities of the experiences. This study was a modest step toward that goal.

The field of epidemiological criminology recognizes the important interaction of health and crime. Its strength is that it highlights the importance of interdisciplinary collaboration, but like any perspective on such complicated and long-term social issues, it poses just as many

questions as it attempts to answer.¹⁵² Our goal with this study was to avoid making a claim to having simple solutions to problems so embedded in social and moral systems. The survey results suggest rather plainly that we have gravely underestimated the role of disability in the criminal justice system—and that innovation in treatment, care, and support will have to extend beyond merely assessing health risks.¹⁵³ Health and crime are more than matters of risks and harms to be managed; the lives of these women illustrate the complexities of each.¹⁵⁴ As disability studies scholar Kate Kaul suggests, “[V]iolence is another response to vulnerability.”¹⁵⁵

State prisons and jails present opportunities to improve health outcomes and to tackle circumstances that lead to criminal recidivism.¹⁵⁶ However, these kinds of collaborative efforts in looking at both health and criminal recidivism cannot stop upon release because gains made in prison can be easily lost in both areas when the sentence is finished.¹⁵⁷ While it might be dramatic to depict chronic health issues as “life sentences” of sorts, they pose ongoing maintenance and support issues in the same ways that the circumstances that lead to incarceration do.¹⁵⁸ The failure to address health and disability—and their management—as part of imprisonment and community reintegration is shortsighted.

Any attempts to respond to health and disability coherently in prison require backing up a few steps to redefine disability and health. Chronic health issues are ones that touch upon stigma, poverty, trauma, comorbidity, and the complexities of managing those kinds of situations. They are embedded in crumbling social supports and limited material resources. Yet, most medical school or criminal justice programs provide very little training about trauma and its physical and

152. See AKERS ET AL., *supra* note 63, at 97 (comparing public health and criminal justice approaches to violence behavior and prevention).

153. See *id.* at 324–25 (arguing for greater awareness in these fields about the effects of trying to control the behavior of individuals or groups).

154. See Kate Kaul, *Vulnerability, for Example: Disability Theory as Extraordinary Demand*, 25 CAN. J. WOMEN & L. 81, 105 (2013) (encouraging disability studies scholars to address the perception of disability as harm and risk and to emphasize both its physical and social dimensions).

155. *Id.* at 106.

156. AKERS ET AL., *supra* note 63, at 206.

157. See *id.* at 207 (discussing HIV-positive inmates’ failure to comply with treatment strategies after release and the possible sources for it).

158. *Id.* at 208 (“Chronic diseases are more accurately conceptualized as life sentences.”).

psychological effects.¹⁵⁹ Even fewer consider the complexities of disability and the potential that it has for greater self-awareness as well as systemic reform.¹⁶⁰

Rather than seeing disability as an isolated event in prison or as a situation affecting a limited number of inmates, this study and its results call for recognition that addressing prison health and future recidivism means going beyond a limited set of issues and contending with the longer timeline in these women's lives. Disability is a shared experience among these inmates yet one that is not recognized as such. Race, gender, specific health experiences, welfare status, and other markers complicate it, but it is pervasive. Addressing "disability issues" extends beyond legal compliance with the Americans with Disabilities Act, for example, and pushes for conceptual reimagining of where chronic health conditions begin, how they affect the community, and what opportunities exist to embrace them as stable features of the criminal justice system. We are grateful for the candor of the women in the North Carolina system and hope that their experiences begin to inform policies and practice to improve outcomes in their own lives, as well as the prison pipeline, community health strategies, and disability justice.

159. Paula P. Schnurr & Bonnie L. Green, *Understanding Relationships Among Trauma, Posttraumatic Stress Disorder, and Health Outcomes*, in *TRAUMA AND HEALTH*, *supra* note 21, at 247, 259.

160. Erinn Gilson, *Vulnerability, Ignorance, and Oppression*, 26 *HYPATIA* 308, 322 (2011).

APPENDIX A. INFORMED CONSENT LETTER¹⁶¹**Study: Women Inmates in State Facilities in North Carolina**

June 30, 2011

Dear Woman Inmate:

I am a visiting assistant professor at the University of North Carolina School of Law, who is concerned about the experiences of women inmates in North Carolina. I am conducting a study of your experiences to be able to gain some insights and to make some recommendations about how to improve prevention, prison, and postincarceration community programs. You were randomly selected from a mailing list given to me by the state prison system of North Carolina. However, staff of the Department of Corrections are not conducting this research project. A total of 2,000 women inmates have been chosen to participate in this study. Your participation in this study is completely up to you; you do not have to do it.

To participate in the study, you would complete the enclosed anonymous, multiple-choice survey and return it to me in the enclosed postage-paid envelope. Returning your completed survey means that you have given your consent to be a participant in this study. This survey deals with such topics as your background and demographic information, your health issues, and your concerns about life after prison. Completion of the survey should take no longer than 30 minutes. Some of the questions are about sensitive issues. You are free to answer or not answer any particular question and do not have to finish answering the questions once you begin. If you decide to skip questions, but still want to participate, please return the survey—as much as you've finished—to me in the enclosed envelope.

Your participation is anonymous. Your sentence or parole will not change if you take part in this study, or if you do not take part in this study. You are asked not to put any identifying information on the survey or the envelope. To make sure that the survey is confidential and anonymous, please do not send any notes or other mail to me in the survey envelope. All data obtained in this study will be reported as

161. This letter has been modified from its original format in order to accommodate law review formatting conventions. However, the content of the letter is identical to the original letter sent to survey participants.

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group data. No individual can be or will be identified. I plan on publishing the results of this research in social science and law journals, and making presentations to community and academic audiences. I will be the only person with access to your survey data before I combine it with everyone else's responses. (In the rare event that a question in the survey triggers an upsetting memory for you, you can use the prison system's healthcare to seek counseling or treatment.)

There are no risks or benefits to you from participating in the study; there is also no cost to you for participating. However, I hope the study will produce information that ultimately can improve our understanding of the challenges faced by women inmates in North Carolina and lead to better programs and policies here and nationally.

All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject you may contact, anonymously if you wish, the Institutional Review Board at 919-966-3113 or by email to IRB_subjects@unc.edu.

Thank you for considering participation in this study. I hope to use your response to help shape recommendations for improving the lives of women inmates. I really appreciate your time and help. You may contact me with any questions at (918) 949-1977 or by letter (address above).

Sincerely,

Carrie Griffin Basas, Visiting Assistant Professor

APPENDIX B. SURVEY OF WOMEN INMATES IN NORTH CAROLINA FACILITIES¹⁶²

Thank you for agreeing to participate in this survey of women prisoners conducted by Prof. Carrie Basas of the University of North Carolina School of Law (UNC). Your answers will be anonymous and confidential and will help us to understand the concerns of women inmates in North Carolina. If you do not feel comfortable answering any of these questions, feel free to skip them, but please answer as many questions as you can. **Please return this survey in the enclosed envelope by August 15, 2011.** It has postage on it already to return it to me at UNC. Please do not put any identifying information (like your name, inmate number, etc.) on this survey or on or in the return envelope. If you choose to stop taking the survey at any point, but you want to share the answers you have completed, please return your survey by mail anyway.

PLEASE CIRCLE YOUR ANSWER.

- 1) How old are you?
 - a. Less than 25 years old
 - b. 25–35 years old
 - c. 35–45 years old
 - d. 45–55 years old
 - e. 55–65 years old
 - f. Older than 65 years of age

- 2) With which of the following races do you identify? You may choose more than one.
 - a. Black/African-American
 - b. White/Caucasian, not of Hispanic descent
 - c. Hispanic/Latina
 - d. Asian American or Pacific Islander
 - e. Arab American/Middle Eastern
 - f. Native American/American Indian
 - g. Other

162. This survey has been modified from its original format in order to accommodate law review formatting conventions. However, the content of the survey is identical to the survey presented to survey participants.

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3) Do you currently have or have you ever had any of the following health issues? Choose as many as apply.

- a. Hearing impairment or deafness
- b. Vision-impairment, low vision, or blindness
- c. Learning disability (such as dyslexia, difficulties reading or processing words)
- d. Mental health concerns (such as depression, anxiety, bipolar disorder, schizophrenia, personality disorder, paranoia)
- e. HIV or AIDS
- f. Cancer
- g. Diabetes
- h. Hypertension (high blood pressure)
- i. Mobility impairment (something that limits your physical mobility or abilities)
- j. Multiple sclerosis
- k. Other neurological disorder
- l. Another serious health condition that seriously limits your ability to work, care for yourself, or perform some of the daily activities of living. (Survey continues . . .)

4) What is your sexual orientation and identity? Choose as many as apply.

- a. Lesbian
- b. Bisexual
- c. Transgender/transsexual
- d. Heterosexual/straight

5) What is the highest level of education that you have completed?

- a. Some elementary school
- b. Elementary school
- c. Middle school
- d. High school (graduated from HS or attained a GED)
- e. Some college
- f. Bachelor's degree from a college or university
- g. Graduate degree from a college or university (an advanced degree beyond a bachelor's)

6) Were you ever in special education as a child?

- a. Yes
- b. No
- c. Not sure

7) Were you ever diagnosed with a learning disability as a child?

- a. Yes
- b. No
- c. Not sure

8) Were you ever in the foster care system as a child?

- a. Yes
- b. No
- c. Not sure

9) Have you ever received welfare or public assistance?

- a. Yes
- b. No
- c. Not sure

10) Have you ever received Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) (disability-based assistance from Social Security)?

- a. Yes
- b. No
- c. Not sure

11) Have you ever been physically assaulted or physically abused?

- a. Yes
- b. No
- c. Not sure

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12) If your answer to #11 is Yes, which of the following people physically assaulted or abused you? Choose as many as apply.

- a. A caregiver (examples: a babysitter, teacher, hospital attendant, nurse, doctor, etc.)
- b. Stranger
- c. Another prisoner
- d. Family member
- e. Friend, but not a romantic partner
- f. Romantic partner (examples: boyfriend, girlfriend, husband, wife, lover, spouse)
- g. Member of the prison staff
- h. Unknown

13) Have you ever been sexually assaulted or abused?

- a. Yes
- b. No
- c. Not sure

14) If your answer to #13 is Yes, which of the following people sexually assaulted or abused you? Choose as many as apply.

- a. A caregiver (examples: a babysitter, teacher, hospital attendant, nurse, doctor, etc.)
- b. Stranger
- c. Another prisoner
- d. Family member
- e. Friend, but not a romantic partner
- f. Romantic partner (examples: boyfriend, girlfriend, husband, wife, lover, spouse)
- g. Member of the prison staff
- h. Unknown

15) How many times, over the course of your life, have you been physically assaulted or abused? Please choose one answer below.

- a. Never
- b. 1-2 times
- c. 3-5 times
- d. 6-10 times
- e. 11 or more times
- f. Can't recall

16) How many times, over the course of your life, have you been sexually assaulted or abused?

- a. Never
- b. 1-2 times
- c. 3-5 times
- d. 6-10 times
- e. 11 or more times
- f. Can't recall

17) Have you ever received mental health care services before entering prison?

- a. Yes
- b. No
- c. Not sure

18) Have you received mental health care services since entering prison?

- a. Yes
- b. No
- c. Not sure

19) If your answer to #18 is No or Not Sure, please answer the following question: Do you think you could benefit from mental health care services in prison?

- a. Yes
- b. No
- c. Not sure

20) Before being incarcerated, how often did you use illegal drugs, on average, when you used drugs the most frequently?

- a. Never
- b. 1-2 times/week
- c. 3-5 times/week
- d. 6-10 times/week
- e. 11 or more times/week
- f. Not sure

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21) Before being incarcerated, how many alcoholic beverages a week did you drink, on average, during the period when you drank the most frequently? (As a guideline, a drink is generally 4 oz. wine, 12 oz. beer, 12 oz. wine cooler, or 1 oz. hard liquor/spirits.)

- a. Never
- b. 1-2 drinks/week
- c. 3-5 drinks/week
- d. 6-10 drinks/week
- e. 11 or more drinks/week
- f. Not sure

22) Do you receive any accommodations in the prison system related to the Americans with Disabilities Act (ADA) or a disability that you have?

- a. Yes
- b. No
- c. Not sure

23) Do you need any accommodations or special assistance related to a disability that you have that affects you in prison?

- a. Yes
- b. No
- c. Not sure

24) How long is your current total prison sentence?

- a. Less than one year
- b. 1-3 years
- c. 3-4 years
- d. 4-6 years
- e. 6-8 years
- f. 8-10 years
- g. 10-12 years
- h. 12-15 years
- i. 15-18 years
- j. More than 18 years, but less than life
- k. Life

25) For what kind(s) of crimes are you incarcerated? Please choose as many as apply to you.

- a. Robbery, forgery, or theft
- b. Assault or battery
- c. Drug conviction
- d. Weapon conviction
- e. Kidnapping
- f. Murder/homicide or manslaughter
- g. Attempted murder or attempted manslaughter
- h. Sex-related crime (such as rape, sexual assault, sexual abuse)
- i. Other

26) Have you ever been disciplined while you have been in prison for violating prison rules?

- a. Yes
- b. No
- c. Not sure

27) If your answer to #26 is Yes, please select the reason(s) why you were disciplined. You may choose more than one reason.

- a. I was accused of physically abusing or assaulting a prison staff member.
- b. I was accused of physically abusing or assaulting another prisoner.
- c. I was accused of sexually abusing or assaulting a prison staff member.
- d. I was accused of sexually abusing or assaulting another prisoner.
- e. I was accused of having a banned ("contraband") item in prison.
- f. I was accused of violating another prison rule.

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28) What is your biggest concern about what your life will be like when you are released from prison? Please choose only ONE answer.

- a. I will not be able to find a job.
- b. People will not accept me into the community because I have been in prison. It will be difficult to make friends and fit into the community.
- c. I will not be able to find appropriate health care or health services once I am no longer in prison.
- d. I will not be able to live independently after living in prison.
- e. The problems that led me to prison may lead me back to prison.
- f. I worry that I will become dependent on others and be sexually and/or physically abused by them.
- g. Other.

THE END OF THE SURVEY

The survey is finished. Thank you for completing the survey. Your responses are important to the project. Please return this survey by August 15, 2011. I have enclosed a return envelope. You do not need a stamp.

