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### The Louisa Van Wezel Schwartz Symposium on Mental Health Issues in Correctional Institutions - Proceedings

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**THE LOUISA VAN WEZEL SCHWARTZ  
SYMPOSIUM ON MENTAL HEALTH ISSUES  
IN CORRECTIONAL INSTITUTIONS**

**PROCEEDINGS**

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*Comments of*  
**MS. BRENDA SMITH**

*Associate Professor at Washington College of Law at American University*

Now, you would think that I was as old as dirt after listening to that introduction. Well, the truth is, I am as old as dirt. And I told Paul Quander that we are both as old as dirt.

First, I want to thank Arlene for inviting me. Many, many months ago Arlene called and asked me if I would speak at this symposium on mental health in correctional institutions.

At that time I was fairly fresh into a new school year and had every intention of saying "no". However, as most of you know, Arlene is not a person that you can turn down. And she is determined, she is resolute, and she will find a way to sweep away any objections that you have. So I really couldn't argue that time was an objection because I'm really not that important yet that my schedule is booked six months ahead of time.

I tried to give her sort of the struggling, untenured person who needs to present argument. So I told her, I said, "Look, I can't do this unless there is a publication opportunity." So hence those of you who spoke and who ended up having to present a paper, you can thank me for that.

Then I told her that I needed to speak about a topic that I was beginning to write about. And so that's why I'm going to be talking about intimacy, sexuality, and fertility in prisons.

You may be wondering because everybody else has mental health somewhere in their title how that fits into a symposium about mental health in corrections. What I would like to say is that I'm using that particular blueprint to collapse my broader project and to use it to speak to the unmet needs for mental health services for women in the criminal justice system.

One of the things that also is really a privilege of going last is that everybody else has done your presentation for you. And so what I'm going to try to do is limit my comments, so that we can have an opportunity for some dialogue. You already have my background. And I'll just say a couple of things, just four points about what brings me to this place talking about these issues of mental health and women in the criminal justice system.

There are many, many connections here. I have worked with the Public Defender Service where Olinda Moyd, our first speaker, is currently employed. And actually when I did the Women in Prison Project, which was actually just a way to use all of the expertise that's in the District, Olinda was one of the standard speakers there, as was Erias Hyman when he was at the Board of Parole and also during the brief period of time that he was head of corrections. I think he had a dual appointment at one point.

I spent about — not eight years, but about ten years running a program at the minimum security annex addressing issues that women had raised as important in that setting.

And it was a very simple sort of theory. My theory was that there were so many experts in D.C. and you know that any time you leave D.C. and go more than thirty minutes and you speak fifteen minutes, then you become an expert. So I figured that what I would do is I would have a very simple thing and I would say to all these people, if you are an expert, come in — only two or three of you can come at a time — and you have to speak on issues that women have identified as priorities.

And the other thing is that you have to agree to take phone calls and resolve these women's issues when they call you. Because these are also women who are in the population that you are dealing with. So if you are a parole person, these are women who are going to need parole services. If you are an abuse and neglect judge, then the reason you didn't see this person at the hearing was because they were locked up. So that was the basic theory.

And then I guess the last thing that I want to talk about in terms of what brings me here is that around 1993 I was involved in some fairly contentious and public litigation addressing staff sexual misconduct against women in D.C. prisons. And at that time the District — I sued the D.C. Department of Corrections for a pattern and practice of sexual abuse of women in D.C. prisons. And I was successful in that litigation. And the court ruled that staff sexual misconduct against women inmates is a violation of the eighth amendment. And so that's sort of my background.

I want to start my discussion today with a little bit of a narrative that relates to some extent to that litigation. The litigation was settled — not settled, but we won the litigation in 1994. And, of course, there were two years of appeals. But in the fall of 1995, I received a phone call from a local newspaper reporter informing me that she had heard that two women at a local prison had become pregnant while incarcerated. Well, having done this litigation, I knew that was actually a fairly common occurrence in D.C. prisons.

While she did not have the women's names, she did have their prison ID numbers, and she wanted me to identify the women for her. I told her that I would contact the women, and, if they wanted to speak with her, they could.

I also told her that I would be advising them that under no circumstances should they speak to her. As it turned out, I had assisted one of the women, Allison, with a parole matter several years before. And this isn't the person's real name, but we'll call her "Allison".

Allison was serving a long prison sentence for killing one of her kids. Before the incident, she had never been incarcerated; she had no prior arrests or convictions. And because of the incident, she became childless. Her parental rights were terminated as to her surviving children. I had helped Allison by convincing the parole board to consider her for parole every three years instead of every five years. And Margaret and Erias are laughing because they all have stories of people that I have come in and lobbied very seriously on their behalf for parole relief.

And they talk about all of the trouble that I have gotten them into in the past. I made an appointment to see Allison at the prison. And when I saw her in the prison visiting room, I told her about the phone call from the reporter. Allison didn't plan to speak to the reporter, and she was unconcerned about her pregnancy being discovered. In her mind, she had beaten the system.

First, she had embarrassed the prison system by exposing one of its weaknesses. Security is so poor that she could conceive while incarcerated. Second, she had thwarted efforts by the courts and the foster care system to deprive her of motherhood. She had conceived a child who, to her, was safe from the system. And third, Allison had gained someone's attention. It would be hard for other women and for the prison system to ignore her needs at this point.

While Allison's story is disturbing, it's a story that plays out every day in correctional institutions. Of course, not every woman is there for having killed her kids or harmed her kids. In fact, most women are in the system for parole violations, as I'm going to talk about, for drug offenses and other nonviolent offenses. There are those who — like Allison — who are in prison for violent offenses, but more often than not their first convictions were for nonviolent offenses.

While the factual circumstance that brought these women to prisons differ greatly, they often have past histories that are very similar. And that, I think, Ms. Cropsey talked about. Many have past histories of physical and sexual abuse. The Bureau of Justice Statistics, in its report on women offenders in 1999, estimates about forty percent of women were physically or sexually abused — and/or sexually abused prior to eighteen years old.

Angela Brown, who wrote a book called *Battered Women Who Kill*, did a long-term study at a maximum-security prison for women in New York and found that over ninety percent of those women had past histories of physical and sexual abuse.

These women also share mental health issues, including depression, that were untreated prior to coming into the system and that remain untreated while they are in the system. They also have significant substance abuse issues, which are

also part of the DSM vernacular, but again, which were untreated in the community and continue to be untreated when they go into prison.

There is actually some very interesting data, which is the drug use forecasting data, which looks at rates of substance abuse in twenty-four major cities. And consistently women have higher rates of drug abuse for serious drugs, while men have higher rates of drug abuse for marijuana and less serious drugs. Women also have higher rates of intravenous drug use.

Another thing that these women share is very serious trauma that they have often suffered before, and often during, incarceration. And when I talk about trauma, I'm talking about physical trauma: hitting, abuse, inappropriate use of restraints, inappropriate and excessive use of force.

These women also bring to the institutions huge issues about loss. In particular, issues about the loss of their children. So that's what I mean in terms of intimacy and talking about fertility, the loss of the opportunity to parent, a stigma related to imprisonment. Any of you who have worked with women before know that there is a tremendous stigma for women around being in prison and the fact that they are not doing what they are supposed to do and to some extent they have stepped out of the roles that we have defined for them. Tremendous grief and loss about the opportunities for intimacy and the opportunity to form close relationships with other people.

One of the things that — I think one of the most defining features of prisons is the isolation and the lack of touch and the lack of physical contact that people can have as between prisoners and also with staff. And also for an increasing number of women, particularly those who are serving long sentences, the loss of an opportunity to bear children, hence the discussion about fertility.

And I think, finally, one of the issues that really goes unresolved is a lot of anger. Anger about how they ended up in the system and why nobody addressed their needs before they got there, and also why their needs continue to go unaddressed in the system.

While I'm discussing this issue for women through the prism of intimacy, sexuality, and fertility, what I'm really talking about is their need to be in relation. I think that Ann talked about that some, which is the fact that you are talking about juveniles. What we are talking about is a need for people to develop relationships and to have relationships. And those opportunities just don't present themselves in a correctional environment. And while I'm talking about women here, this is a human need, and it is also a need for men, as well.

My contention is that prison and other institutions' policies, practices, and realities deny these needs and thereby create larger problems, and importantly, for purposes of this conference, don't meet the needs of women.

So, I have outlined three policies that I think sort of lead to some of the isolation, vulnerability, and mental health problems that people have.

Limitations on contact visits. We have already talked about the need for intimacy, for contacts and about how having that contact can decrease depression. Yet there are limitations on contact visits. There are limitations on the frequency of those visits.

Another area where I'm going, because I'm talking about intimacy, sexuality and fertility: conjugal visits. Whenever we talk about conjugal visits, people think we are talking about sex. But a study of conjugal visits in Florida talks about the fact that men use conjugal visits to see women, while women use conjugal visits to see family and children.

Third, termination of parental rights of parents who are in prison, and failure to devote sufficient resources to assessing whether reunification is possible or practical.

I believe that the D.C. Prisoners' Legal Services project is going to be doing a project where they are working with child and family services specifically to deal with that issue and to deal with trying to create communication between people in prison and kids who are in foster care.

Practices that I think are important to look at: the placement of inmates in facilities far from home. While that has typically been a situation that's particularly affected women because there are so few facilities, if we look at the situation and D.C. prisoners in general, that's a feature for all of the prisoners in D.C., and I think that it increases the mental health issues that they face. It also creates isolation again and vulnerability.

None of those things are good in terms of the long-term outcomes for this particular population. The other thing that happens in a place where inmates are far from home is there is nobody who was invested in them. If you are in Suffolk, Virginia, or Ohio, or New Mexico, or wherever, there is nobody there who you can even attach to in terms of having some sort of information about where you grew up or your home.

The lack of consistent — again, another practice that I think contributes to some of the mental health difficulties in prisons, the lack of consistent commitment to mental health services and groups. For example, NA & AA have trouble getting into institutions because of poor planning. These groups are not mental health, but they provide support which can help people get into treatment, whether that is substance abuse, pharmacological treatment or talk treatment.

A second practice: when cuts are made in budgets, medical education and mental health are often the first to go. These are the people and facilities that can actually, by policy, touch prisoners. Medical and mental health touch bodies and they touch minds. And while corrections people may feel that the primary mission of corrections is security, the best security is inmates whose needs are met. And, as we all know from very difficult experiences, in many pieces of litigation, these needs will get met one way or the other.

Finally, the lack of assessment tools to assess people's needs upon entering facilities. We sort of have a don't ask/don't tell policy, and we have no idea of the kind of baggage and trauma that people are carrying into facilities, and how that has an impact on their adjustment.

The reality is that correctional institutions are pretty sick environments. Much of what goes on on a routine basis is contrary to good mental health practice: the use of restraints, over-medication, administrative segregation, violence and social isolation for people with mental health problems.

I want to take two minutes and talk about a woman that I recently saw over at CTF who was pregnant and who had serious mental health problems. She was in administrative segregation and had been in segregation for many, many weeks. And she had been there because they weren't giving her medication because she was pregnant. And the medication — she really needed the medication to be able to control her behavior. But no one had made a phone call to her physician at St. Elizabeth's to try to figure out how that medication could be handled so that she could get out of administrative segregation.

I also want to talk about the realities of limited resources for mental health services. And also, finally, another reality of prison is the stigma, fear and antipathy toward inmates with mental health problems. Often, staff talk about how they set up inmates with mental health problems so that they will end up in administrative segregation so they won't have to deal with their needs.

Finally, the point that I want to make and how it relates to my initial topic: I found that the expression of the need for intimacy, fertility and sexuality are natural and appropriate among women and, indeed, anybody. We all have those needs; however, those needs become problematic when there are not appropriate outlets for them.

Appropriate mental health services could begin to address some of these needs. Grief counseling would have helped Allison, the woman that I talked about in the beginning, to deal with the anger and grief that she had about having killed her child, about having lost custody and having actually lost any right to contact with the two remaining children. And the actions that she took, I believe, were really focused out of depression and anger.

Appropriate diagnosis and medications and counseling to address depression and other mental health issues, I think, is really needed. Groups to address shared experiences of women related to physical and sexual abuse—that would also be something that would be really needed but that is often not provided.

And the need to create a healthier environment in prison so that people are not re-traumatized while they are there, and that includes protection against sexual and physical violence while people are in prison.

And finally, the point that I want to make is that the connections to and collaborations with institutions that can meet the needs of women both inside and outside of prisons is a good thing to do. Not only is it a good thing to do because

we are required to do that and should do that as a constitutional matter, but I believe that it is a good thing to do as a correctional policy matter as well.

Thank you.