invited. Other inmates would play guitar and sing. The nursing staff kept the secret as the young woman went from one to the other saying, "Does anyone know about a party? Did you know my birthday is coming?" Finally the hour arrived. She was invited to visit another patient's room; while they talked, a room was decorated with banners and party favors made by the volunteers. When she was led into the room, her face reflected her joy as her lips moved to the words of "Happy Birthday" being sung by all.

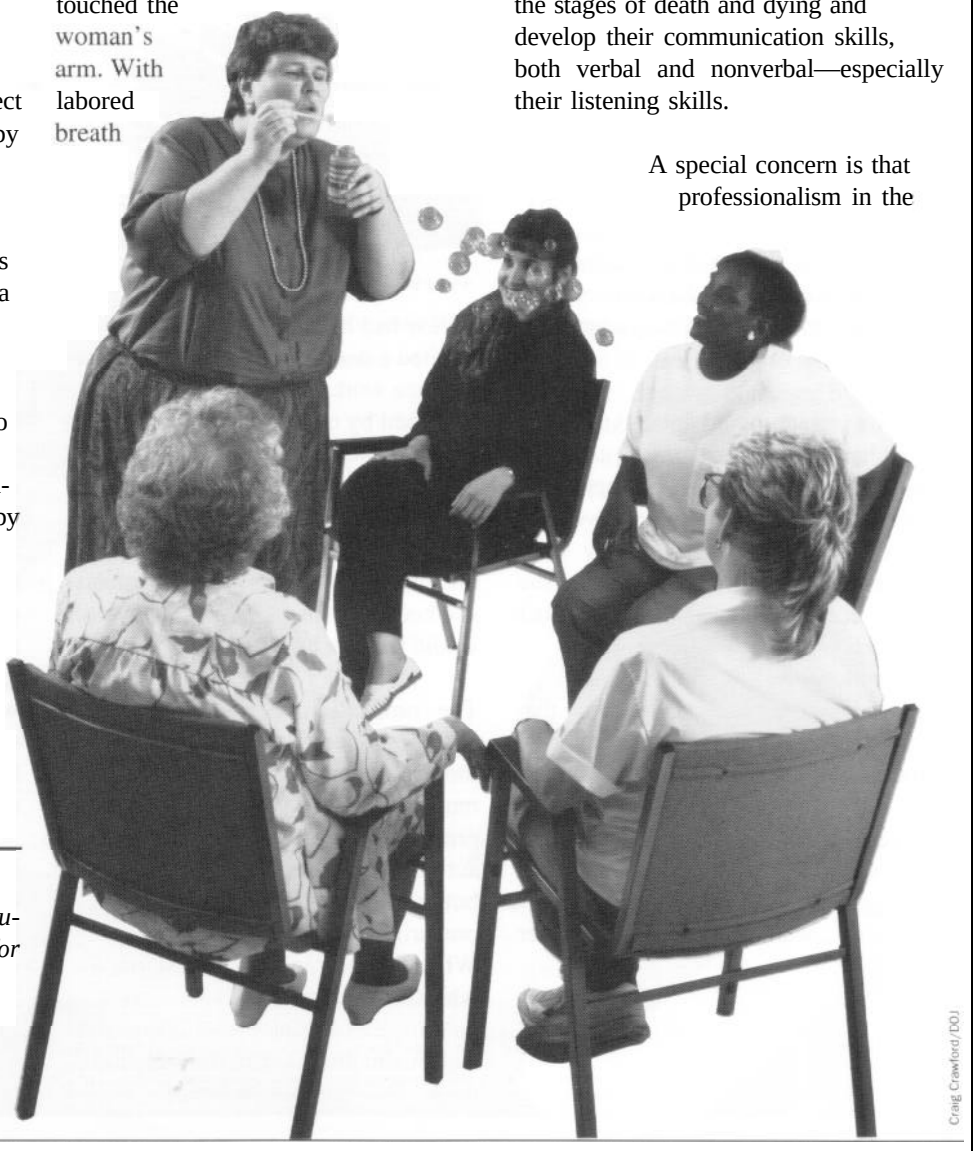
When the volunteers met later to reflect on the celebration, they were moved by the knowledge that this might be this woman's last birthday celebration. "There was a feeling of happiness," said one volunteer, "and there was this insurmountable sadness too. She had a wonderful birthday and I'm glad we had a part in making it special."

Another patient had turned her back to her door and faced the wall. She seemed to have given up. The community volunteer noticed a sack of yarn by her bed; she had ordered it to make a sweater for her husband. "It's no use now," she said, "I know I'm going to die and it'll never be knitted." The volunteer asked if she could do it for her. The woman rolled over to face her—"You would do that for me?" Patterns appeared and the two women put their heads together to choose the right kind of sweater. Much of the work was done by the volunteer in her home, but she often brought the pieces and sat in the woman's room knitting.

When the woman was taken to the local hospital outside the prison, she was close to death. The volunteer came to her one day and roused her. She pulled from a shopping bag a sweater of earth tones. "Finished!" she exclaimed as she touched the woman's arm. With labored breath the patient smiled and said, "Beautiful! Please send it to him and tell him I love him." After she died the sweater was sent from the prison chapel with a note explaining how it was made. By return mail came thanks and a box full of yarn that might be used for others.

It's necessary for Hospice volunteers and staff alike to come to grips with their own mortality and feelings about death. They must learn to understand the stages of death and dying and develop their communication skills, both verbal and nonverbal—especially their listening skills.

A special concern is that professionalism in the



Craig Crawford/DOJ

The author (left), with Hospice volunteers—both inmates and community members. Games are important for the Hospice workers as well as the patients.

correctional setting, and the "distancing" between staff and inmates that it implies, at times makes it difficult for staff to show the compassion they feel. Without a way to express these feelings, staff who have close, prolonged contact with dying inmates risk burnout.

The duties of the Hospice volunteers are varied. They commit to visiting the patient at least twice a week—more if needed. They are on call for emergency situations. They help by writing letters, reading, playing games, and listening. One volunteer gives manicures to help the patients feel better about their appearance. One volunteer arranged to have a photograph taken so a patient could send it to her children. The volunteer was there before the photographer arrived to help the woman fix her appearance for her first picture to be sent home in years.

When a patient would not leave her room her Hospice worker was called by the nursing staff. She lay depressed and saddened that her children were far away—voicing the guilt so many mothers in prison feel: Why should she leave her room when she had been such a failure as a mother? Her Hospice companion was able to listen and respond; before the end of the visit they were walking hand in hand up and down the hospital corridor.

Sometimes, an inmate will be granted a compassionate release to spend her last days at home with her family. Maria was such a woman. The request for her release had been submitted and she awaited a decision. As she waited, the Hospice workers stood with her; her life sustained by oxygen tubes and the will to see her sister in another country one last time. Volunteers were called repeatedly to sit by her side during the long nights; she would hallucinate and imagine herself home. The volunteers soothed her with the hope that soon she would be with her family.

The compassionate release was granted. A surge of hope caused Maria to draw inner strength. Her hair, makeup, nails, must be done; her sweatsuit must be pressed. The Hospice workers leapt into action. There was joy in the preparation, but the workers also knew they were preparing her for her final journey. When the morning arrived, Maria, a wheelchair, portable oxygen, an entourage of Hospice volunteers, and staff made their way to the sallyport door.

She made the flight to her homeland without incident. When the plane touched down she checked her appearance, then asked the nurse to remove the oxygen tubing; she walked unassisted into the arms of her family. Two months later she died peacefully at home. "When I watched her go through that sallyport door it was as if part of me went with her," said one of the inmate volunteers. "I had been given the great privilege of knowing a woman of strength and faith. Her life touched mine. The facts of compassion I shared with her are small compared to the lessons she taught me."

Death is never easy to deal with. For those in prison it is even more difficult due to their isolation. The Hospice group gives the women in prison an

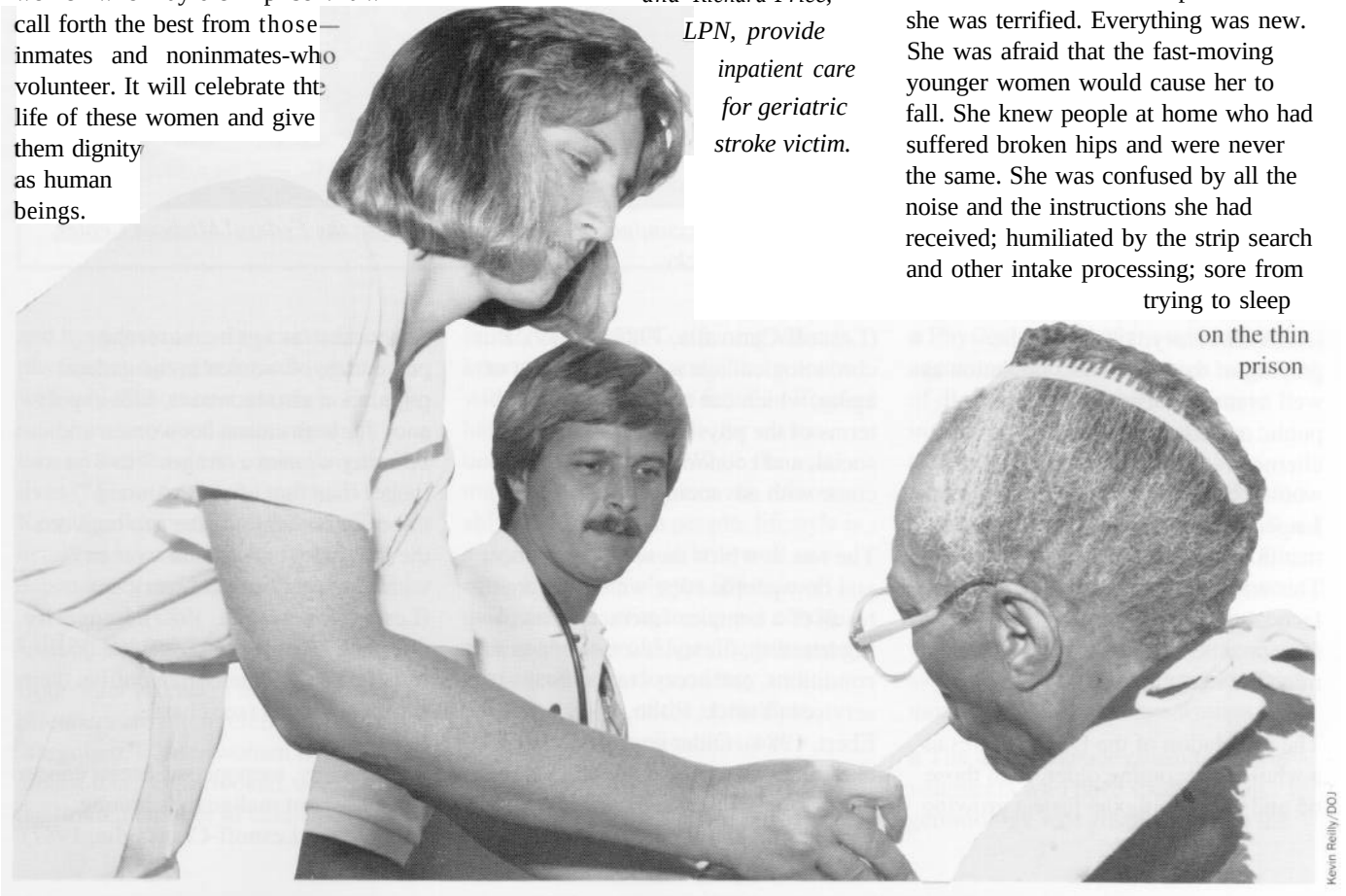
opportunity to say "goodbye" by means of a memorial service. On one occasion 20 white helium-filled balloons representing those who had died were suspended over the altar in the Chapel. At the end of the service 150 women filed into a courtyard in the pouring rain and watched as the balloons were released. The wind and rain threatened to whip them to the ground, but they began to rise, higher and higher, until one woman cried, "Look, they're over the wall! They're free."

The seed of Hospice is taking root at the Federal Correctional Institution in Lexington. As it flourishes it will ensure compassionate concern for women who may die in prison. It will call forth the best from those—inmates and noninmates-who volunteer. It will celebrate the life of these women and give them dignity as human beings. They will not die alone, but will be embraced by a group of caring individuals who bring a commitment to meeting the needs of others.

"I was scared at first," says one of the volunteers, "scared that I would say the wrong thing, do the wrong thing, act the wrong way. But now I look forward to being with these women. They teach me more about life than about death."

Angela Church is a chaplain at the Federal Correctional Institution, Lexington,

Mary Joe Powers, Registered Nurse, and Richard Price, LPN, provide inpatient care for geriatric stroke victim.



Kevin Reilly/DOJ

The Older Female Offender: Suggestions for Correctional Policymakers

Joann B. Morton

Being old, being female, or being an offender can all have negative implications in our society. Combined, they provide challenges for corrections now and in the future. Consider the following:

■ "Annie," 72, a small, frail woman with scraggly white hair, crouched against the wall as a group of boisterous young women came down the hall. This was her first week in prison and she was terrified. Everything was new. She was afraid that the fast-moving younger women would cause her to fall. She knew people at home who had suffered broken hips and were never the same. She was confused by all the noise and the instructions she had received; humiliated by the strip search and other intake processing; sore from trying to sleep on the thin prison

mattress; upset because she had trouble finding her room and had been reprimanded by an officer. Above all, she had an overwhelming dread of dying in this stark, friendless place.

■The warden read the incident report and put it down with a sigh. What were they going to do with "Mary"? Mary had been in and out of mental hospitals and prisons most of her adult life. She had a long history of assaultive behavior and at 60 showed no signs of mellowing. According to the report, this time she had hit her roommate with her cane and threatened to kill the officer who intervened.

These two cases illustrate the extremes correctional personnel face in dealing with older female offenders. They do not represent isolated instances. According to a recent study, women 50 years of age and older make up some 4 percent of the female inmates in this country (American Correctional Association [ACA], 1990). In 1990, the number of women 55 and older in State and Federal prisons was less than 1,000 (ACA *Directory, 1991),* but the graying of the American population as well as mandatory sentencing, harsh public attitudes, lack of community alternatives, increasing numbers of women being incarcerated, and the longer lifespan of women will ensure that this number continues to grow. This article will review some relevant facts about aging and women as well as factors to be considered in programming for incarcerated older women.

The population of the United States as a whole is becoming older, with those 65 and older being the fastest growing age group (Feldman and Humphrey, 1989). By the year 2030 forecasters expect 65 million people aged 65 and older.

One way to define aging is chronological. Using years, aging persons can be defined as: "older," 55 and older; "elderly," 65 and older; "aged," 75 and older; and "very old," 85 and over (Lesnoff-Caravalia, 1987, p. 379). But chronological age is only one facet of aging, which can also be defined in terms of the physical, emotional, social, and economic changes that come with advancing years.

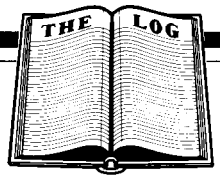
The rate at which these changes occur and how people cope with them are the result of a complex interaction involving heredity, lifestyle, socioeconomic conditions, and access to medical services (Yurick, Robb, Spier, and Ebert, 1984). Older people are an extremely diverse group with widely varying needs. Compare the level of functioning of your elderly relatives with other older people you know and you will have some idea of the diversity among older people.

Older women

Within the 65 and older age group the number of women is growing faster than the number of men (Kart, Metress, and Metress, 1988). Older women make up some 60 percent of older Americans; as age increases the percentage of women in the general population also increases. Life expectancy for both Caucasian women and minority women averages 7 to 8 years longer than that of men. Among minority populations the gap between the longevity of men and women is widest among Native Americans (Lesnoff-Caravaglia, 1987). Longevity does not, however, increase the *quality* of life; older women often outlive their support systems (see chart).

Additionally, menopause, breast cancer (the prevalent malignancy among women; see Lesnoff-Caravaglia, 1987),

Native Americans conduct a "sweat ceremony" at the Federal Medical Center, Lexington, Kentucky.



Older women compared with older men

- Older women are more likely to live alone and have limited family support.
- More older women—particularly minority women—live below the poverty level.
- Older women often "fall through the cracks" of medical and financial support programs, as well as private insurance programs.
- Older minority women are more likely to be ill and need medical care.
- Older women make up three-fourths of all nursing home residents.
- Older women have a higher incidence of certain debilitating diseases, including strokes, visual impairments, hypertension, and diabetes.
- Osteoporosis, a degenerative bone condition, causes women to be three to five times more likely to suffer from hip, back, and spine impairments.
- Older women are portrayed more negatively than older men, categorized by stereotypes such as unattractive, ineffectual, unhealthy, asexual, and sedentary.
- Middle-aged women find it more difficult to enter or reenter the workplace; they are viewed as "over the hill" at an earlier age than are men.
- Although older women outnumber older men, most research on older people has focused on the impact of aging on men and ignored older women.

Sources: Lesnoff-Caravaglia, 1987; Kane, Evans, and Macfadyen, 1990; Yuric, et al., 1984; Mummah and Smith, 1981):

and hysterectomies can cause dramatic physical and psychological upheavals with which women must cope. Finally, many women need encouragement to take an active role in controlling their lives ("*Fighting for the rights,*" 1991). Keeping older women active and involved is critical in preventing dependency and helplessness.

Older women in prison

Both older offenders and women offenders are often referred to as "forgotten." Older women in prison are almost totally overlooked, even among the limited number of studies on female offenders. Combining what is known about aging and older women with issues relevant to female offenders has serious implications for correctional programming. While the vast majority of older women are reasonably healthy, active people, lifestyle is a significant factor in how well one ages. Unfortunately the lifestyle of many female offenders is not conducive to a viable old age. Incarceration also encourages dependency and passivity. Some of the immediate programmatic implications are:

- Staff selection and training are critical. Awareness of medical and other factors involving older women, as well as sensitivity in dealing with them, will help overcome some of the debilitating aspects of prison for older women. All staff—particularly medical staff—who work with this population should have training in gerontological health issues. Staffing patterns should also reflect that supervising older women is often more time-consuming for a variety of reasons, including visual and muscular impairments that slow them down. Staff must also confront their own fears of aging and prejudices about older women. Not everyone can work effectively with this group.

- Programming and supervision will have to be individualized to meet the broad range of needs of this diverse group. Individual program planning is particularly critical in prerelease preparation—women's needs vary, as do community resources. Additional lead time will be necessary in prerelease planning for older women, to help with placement in residential facilities for the elderly or in nursing homes, if needed.

- Physical plant designs will need to accommodate persons with a range of disabilities (this applies to male institutions as well). Wheelchair access, color distinctions between floors, walls, and doorframes, comfortable places to sit, and handrails will aid those who have limited mobility. Older women need privacy and quiet space as much as or more than do younger women. Vulnerable older women, such as "Annie," may need protection from more aggressive younger women.

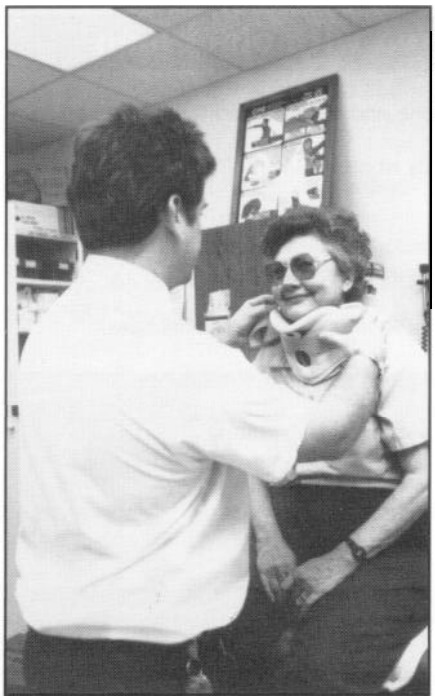
- The use of outside consultants and volunteers who have specialties in gerontology will greatly enhance the

ability of correctional personnel to deal constructively with older women in prison, as well as assist their transition to the community. The network of service providers for the elderly, such as local Councils on Aging, can be invaluable in improving services for older women.

■ Creativity in modifying work and other activities to accommodate the interests, needs, and capabilities of older women will also be necessary. Work and other programs—which are not only critical to feelings of self-worth but also, in many systems, mean time off of one's sentence for participation—must be accessible to the elderly.

■ Internal systems of rewards and punishments must be reevaluated in light of what is effective for older female offenders and their long-term well-being. The use of traditional lockups and loss of privileges may be counterproductive. Yet the "Marys" in this group must be handled as effectively as possible under the circumstances. Flexibility and creativity are essential.

■ Medical services should not only be gender-sensitive but be planned to meet the needs of older women. This includes special diets, as well as physical therapy to counter osteoporosis and other potentially debilitating conditions. Regular mammograms, pap smears, and other diagnostic work should be conducted in accordance with prevailing community standards. An "ounce of prevention" will have long-term benefits. Many older women are reluctant to assert themselves with medical staff, or will simply agree with instructions received without clearly understanding what is happening. Staff must be aware that it is all too easy to attribute symptoms of illness to old age and ignore serious medical problems. Continuity of medical care upon release will require additional effort. Liaison with community health providers will ensure accessibility to medications and other services that some older women will need.



Physician Assistant Charles Glass (left), Federal Correctional Institution, Marianna, Florida.

■ Issues of loss, including death, also must be considered when working with this age group. Women will need legal assistance with matters such as wills and living wills, as well as spiritual guidance and solace. When a death does occur, it can be traumatic for both staff and other inmates who may have worked closely with the older woman. Counseling, crisis intervention, and closure in the form of a funeral or memorial service can be helpful.

The list above is only a beginning. Older female offenders, even in small numbers, pose many challenges for correctional personnel. Now is the time to start addressing them, as well as considering alternative sanctions or timely release of those who pose no threat to themselves or the community. Acting now may avoid a costly correctional crisis in the future.

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A Journey to Understanding and Change

Ann d'Auteuil Bartolo

I have had a unique opportunity these last 2 years, as Chief of the Female Offender Section, to visit local, State, and Federal facilities housing females, and speak to many practitioners involved in their administration. I have listened to the concerns of dedicated and knowledgeable administrators and line staff, as well as women offenders. By making use of their shared knowledge and experiences, the Bureau has improved programs and services for the women in its custody. I would like to outline briefly some of the areas in which women offenders' needs differ from those of men.

■ One of the most significant differences in the management of male and female inmates involves medical needs. Women have different medical needs and concerns than men, the most obvious being gynecological care. Given the differences in diagnostic procedures, medical care is clearly more expensive and time-consuming for women—and there are the added issues of care for pregnant inmates and placement of newborns. We must train medical staff in female health care by providing orientation and refresher training and hiring staff who specialize in obstetrics and gynecology.

■ Women tend to react differently to their incarceration than men, and thus require different psychological services. The woman offender is more prone to depression—commonly related to separation from her children, guilt over her incarceration, poor self-esteem, and a history of abuse or neglect. A large number of women offenders have a history of alcohol and substance abuse.

It is important that we provide a female-designed therapeutic model within the prison setting that addresses these issues, as well as a community support group that assists women leaving prison.

■ Educational and vocational programs must be staffed and equipped comparably to those in male facilities. Most female offenders are high school dropouts; most have poor employment histories and lack skills that enable them to support themselves and their children. Life skills classes, parenting classes, and "reunification" programs for women prior to their return to the community need to be high priorities.

■ Recreational programs are important tension-relievers at all facilities, but female inmates have different preferences and tend to use different exercise equipment. We must provide orientation and refresher training to recreational staff and hire staff who specialize in female recreation—providing aerobics and exercise classes geared to women's interests, and walking and jogging programs that encourage them to release tension and control their weight.

■ The average female offender is more receptive than the average male offender to programs and services offered by the chaplaincy staff. We must ensure that chaplains assigned to female facilities are open to an all-inclusive spirituality and provide family-oriented services in which women can join with their children in worship.

■ More than 80 percent of women inmates are single parents. The children are ordinarily cared for by the inmate's mother. The construction of facilities reasonably close to where most inmates live will help maintain family ties.

These are a few of the issues surrounding the care and custody of women offenders—a population that is increasing at a faster rate than is the male population. The following articles, written from several different perspectives—the academic community's, corrections professionals', and the women's themselves—do not "solve" these issues, but I believe they will inspire both thought and action. ■

Ann d'Auteuil Bartolo is Chief of the Female Offender Section, Federal Bureau of Prisons, and Guest Editor of this issue of the Federal Prisons Journal.

Equality or Difference?

Nicole Hahn Rafter

Over time, women in U.S. jails and prisons have been incarcerated under enormously varied conditions. However, one question has remained constant: whether these women should be treated like male prisoners or differently.

The current situation is complicated, however, by the growing realization that outwardly "equal" treatment often means less adequate care for women. It does so because the standard is set on male terms that overlook important gender differences. Today, we are seeing a search for new policies that can achieve equality while taking gender differences into account. The chart at right shows broad historical shifts in policies.

First period

Let me clarify some of the problems inherent in the first period's straightforward equal-treatment approach. When the first State prisons were founded at the end of the 18th century, there were (as there are today) many fewer female than male convicts. With only 1, 3, or 10 female prisoners, States had no need for a separate women's institution. They began by operating just one prison or penitentiary to which all felons were sent, regardless of sex. In these early institutions, women were often celled next door to men. Outwardly, they received the same treatment. But this ostensible equality in fact meant more difficult circumstances for women, as three examples will illustrate:

Stages of care governing incarcerated women

- The first stage began about 1790, when the very first State prisons were founded, and continued to about 1870. During this period, women were subjected to essentially the same conditions as male inmates.
- The second period covered the century from 1870 to 1970, during which the emphasis fell on differential treatment—on providing care designed to meet what were thought to be the special needs of women.
- The third period began in 1970 and continues into the present. It has been characterized by a reaction against differential treatment and a swing back toward the idea of equal treatment.

- My first example concerns *isolation.* Alone in a sea of men, the women were surrounded by members of the opposite sex. This created privacy problems, and meant that they were more lonely than their male counterparts. It also made women more vulnerable to sexual exploitation by "guards" and male prisoners.

- A second example, concerning *prison personnel,* also shows how apparent equality created harsher conditions for the few women in these early institutions. All the staff were male—not only the guards but the physicians and chaplains. Visitors from the outside, like the guards on the inside, identified more closely with the male than the female convicts. For visiting physicians and chaplains, as for members of their broader culture, women belonged on a pedestal; thus, if a women "fell," she fell farther than any man, and must consequently be far more depraved. Physicians and chaplains therefore often steered clear of the women, giving more attention to the male convicts.

- My third example concerns *pregnancy and birthing.* If a female convict in one of these early prisons was pregnant, she had to deliver the baby alone, in her cell. Predictably, infant death rates were very high. Male convicts did not have to contend with such problems.

As the decades passed and more female prisoners accumulated, they were removed to separate quarters, perhaps a small cell block in a corner of the prison yard or—toward the middle of the 19th century—to a separate unit just outside the wall. Removal brought some advantages. The women convicts were no longer so isolated from other members of their own sex, and they were less vulnerable to sexual exploitation.

But removal also took a toll. The further the women were located from the center of the prison, the less access they had to whatever opportunities were available to the male convicts, such as medical advice and services, religious services, and opportunities to exercise in the yard. The isolated women's units had no kitchens. Food was carried to them from the men's quarters, often just once a day, usually cold. And if the warden did not hire a matron to supervise the women's quarters, female inmates had no protection from one another. There are records of some wild fights in these early women's units.

In sum, during this first stage in women's prison history, from roughly 1790 to 1870, the policy was to treat female and male convicts alike. But because the norms were set by male officers with reference to the needs of the far larger

number of male convicts, outward equality in fact produced inferior conditions for incarcerated women.

Second period

This situation began to change about 1870, as the ideal of rehabilitating prisoners took hold. Interest grew in reforming female as well as male convicts. However, due to the "separate spheres" doctrine—according to which men are best fit for public work, while women are inherently better at dealing with domestic tasks, children, and other women—the job of reforming female criminals was relegated to other women: middle—class reformers.

This task was welcomed by late 19th-century feminists, who threw themselves into the task of establishing separate women's reformatories. These middle-class feminists succeeded in the often very difficult job of persuading all-male legislatures to fund separate reformatory prisons for women. When the new reformatories opened, these reformers frequently became the administrators.

The reformers established the principle that women in prison must be treated entirely differently than male prisoners. Copying the mode1 of the juvenile reformatory, they built the new women's prisons on the cottage plan. Inmates lived in relatively small "cottages," or individual units, where they could be supervised by motherly matrons.

Programmatically, the new women's reformatories were designed to rehabilitate by inculcating domesticity. While the programs included outdoor work, inmates were mainly trained to sew, cook, and wait on tables. At parole, they were sent to positions as domestic servants, where they could be supervised by yet other middle-class women.


National Archives

Inmates at work at Alderson in the 1940's.

In short, the regimen of the first separate penal institutions for women was infantilizing: inmates were treated as wayward children rather than responsible adults who, after release, would have to live independently. The reformers did not face the fact that most of their charges would have to support themselves. Alderson—the first Federal women's prison—was built during this period. Like its State counterparts, Alderson adhered to the principle that women should be treated differently than men.

Differential treatment manifested itself in sentencing practices as well as in architecture and programs. The reformers who founded the State reformatories for women had little interest in dealing with felons—serious offenders who were also often black. The reformers preferred to direct their rehabilitative efforts toward minor offenders with whom they could identify—white women found guilty of misdemeanors or (more frequently) offenses against chastity. The new women's reformatories held these minor offenders on long sentences—terms equivalent to those imposed on felons in the State penitentiaries.

Thus, differential treatment carried its own set of liabilities:

- Women imprisoned in female reformatories were forced into a "true woman" mold of domesticity that infantilized and ill-prepared them for self-support in an industrializing society.
- Moreover, minor female offenders were now held on very long sentences—much longer than those to which male misdemeanants were subjected.
- And, of course, males were never sent to State prisons for violations of chastity. The women's prison system became a means of enforcing the double standard of sexual morality.

Third period

The ideal of differential treatment of male and female prisoners prevailed through the 1960's, a persistence illustrated by a 1960's recommendation that a certain women's prison develop a dairy industry. Milking cows, the formulator of this policy argued, is an excellent activity for women prisoners, since women have a natural affinity for udders!

The women's movement of the late 1960's brought a reaction against such talk, however, and renewed demands for equal treatment of male and female inmates. The tide began to turn against

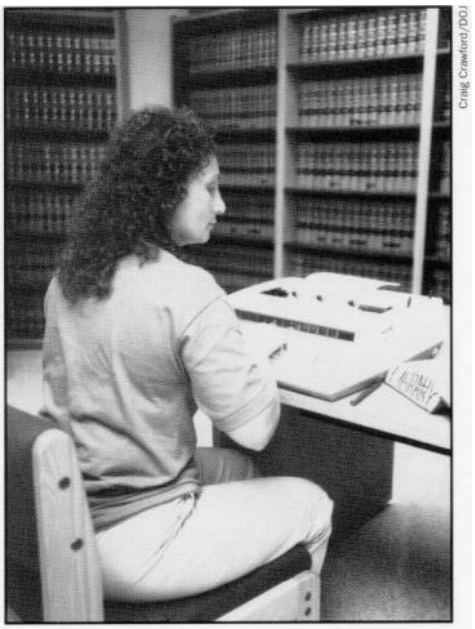
domestic training. Instead, advocates insisted on programs that would prepare released women for real-world jobs and self-support.

Another signal of the shift back to the ideal of equal treatment was a wave of litigation against differential care. For example, in the 1960's female inmates began using the courts to challenge sentencing laws that made them liable to longer terms than men who had similar records and conviction offenses.

We are all familiar with aspects of this drive toward equal treatment. But many people are unaware that it has been accompanied by a growing perception that equal treatment usually means less adequate treatment. Inferior care is the rule because today, as in the first stage, the ideal of equality does not take gender differences into account. Two examples illustrate this new awareness:

■ One concerns *law libraries.* Incarcerated women are finally being given law libraries as adequate as those available to incarcerated men. But because women have no tradition of "jailhouse lawyering," they are less skilled in using legal resources. Thus, several recent court decisions have ordered not only adequate law libraries, but legal training for female prisoners, so that their level of access to the courts will *in fact* equal that of males. These decisions recognize that equality involves parity—actual as well as apparent equivalence.

■ A second, very different, example of the need to recognize gender differences concerns *children.* Unlike incarcerated men, most women in prison leave behind children who are solely dependent on them. Every study of this matter concludes that separation from children



Law library, Federal Correctional Institution, Marianna. Florida.

constitutes the major hardship for incarcerated women. The studies show that separation is also devastating for the children, who must keep in contact with their primary parent if they are not to suffer severe psychological damage. Thus, although male and female prisoners are both separated from their children, this situation affects them differently and has different social consequences.

Beyond the models

Today, the two major historical themes of equal and differential treatment are flowing together. Those involved with planning for female prisoners are trying to deal with both considerations simultaneously.

This confluence signals an awareness that neither approach works well on its own. Outwardly even-handed treatment produces inferior treatment for incarcerated women because the norm is still set by male administrators, working with male needs uppermost in mind. Deliberately differential treatment, alone, also spells inferior treatment, for it reinforces the gender division of labor.

Today, policymakers are seeking ways to go beyond both the equality and difference models. I want to stress "beyond." The move is emphatically not toward merely combining the two approaches, for the result would be to compound their individual disadvantages. Rather, the search is for a way, or ways, to transcend the traditional approaches by developing a new model.

This new model will no doubt borrow the best elements of the two older approaches. But it will also have to find ways of avoiding their inherent drawbacks. As yet we do not know what the new model will look like. We do know that merely extending the older approaches will perpetuate a tradition that began to form on the day the first State prison received its first female convict. That tradition, whether based on the idea of similar treatment or different treatment, has been one of automatically condemning incarcerated women to inferior care. ■

Nicole Hahn Rafter is a professor in the College of Criminal Justice, Northeastern University, and is the author of Partial Justice: Women, Prisons, and Social Control *(Transaction Publishers, 1990, 2nd edition). A version of this article was presented at a Federal Bureau of Prisons "Issues Forum" in June 1991.*