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Behind the Wall of Indifference: Prisoner Voices about the Realities of Prison Health Care

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Abstract: While most Americans never see or become ensnared in the nation's vast correctional system, there are unprecedented costs—economic, social, and ethical—that are being paid, one way or another, by everyone in this country. It is no secret that prison inmates face health threats behind bars that equal anything they face in the streets. Violent assault, rape, or the outbreak of highly infectious diseases are much more common in correctional facilities than in the general population. Prison conditions can easily fan the spread of disease through overcrowding, poor ventilation, and late or inadequate medical care. Effectively protected from public scrutiny, the prison health care system has almost zero accountability, thus escaping outside attention to serious failures of care. If you want to know about the practice of health care in prison settings, ask someone who has been "in" the system. Prisoners have a story to tell and this article gives voice to the experiences of those who have been directly impacted by the provision of health care in the prison system.

Keywords: prisoner voices about healthcare; prison healthcare; need for prison healthcare reform

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1. Introduction

Over the past four decades, United States criminal justice policies have undergone a period of intense and harsh transformation. Draconian sentencing laws and get-tough correctional policies were the central tactics of the "war on drugs" and created an unprecedented increase in jail and prison populations as noted in the number of people sentenced to imprisonment as well as the average length of their sentences (Bureau of Justice Statistics 2015). While America continues to outstrip every other nation in the world in the number of people it puts in its prisons (Walmsley 2018), a byproduct of the "confinement eras" within criminal justice is the influx of ill and generally unhealthy offenders into this nation's correctional institutions. As a result, correctional health care services represents a critical issue confronting correctional managers, correctional health service administrators, and all people housed in such institutions.

The provision of health care in prisons has mushroomed into a large, often ignored, global issue of concern (United Nations Human Rights Office of the High Commissioner 2018). While prisoners are secured behind high fences wired with electronic sensors and cameras or brick or stone barriers, locked doors and barred windows, and cells encased in thick concrete, the probability of developing an illness or disease while incarcerated is quite high (Slade 2018). Prison overcrowding, a universal problem, is an instant recipe for spread of disease both within the confines of the prison as well as to the outside population (MacDonald 2018). For example, in New York City in 1989, an outbreak of multi-drug-resistant tuberculosis (MDR-TB) was later linked to prisons that had given inadequate treatment. More recently, while testing procedures vary by state, approximately 200,000 prisoners and 46,000 prison staff tested positive for COVID-19 (Marshall Project 2020). Indeed, the public health implications of the provision of inadequate health and medical care in prisons are potentially serious as inmates transferred to other facilities or

released back to the community more often than not have communicable diseases such as TB, HIV/AIDS, hepatitis C, and COVID-19.

In a most powerful essay on prison health care in the United States, Ridgeway (2014) shared a few examples of correspondence with prisoners that bear repeating for those not "in the know":

> I reported on a case of a woman in prison for a $11 nonviolent robbery who had received two consecutive life sentences. She was suffering from end stage renal disease. The subcontractor which provided health care to Mississippi prisons brought in a dialysis machine which broke down during treatment. Her condition eventually deteriorated and she was sent to a city hospital where the doctor warned the prison she would die if taken back. The prison put her back in the cell anyway. Eventually after pressure from the National Association for the Advancement of Colored People (NAACP), this woman and her sister, who was also in prison, were released by the governor on grounds that the healthy sister gives a kidney to her sister. (Ridgeway 2014, p. 1)

In another case that did not result in a positive outcome:

> A man, 71, was locked up in solitary in Louisiana for 41 years. Over five years ago, he was diagnosed with hepatitis C. He complained of stomach cramps and weakness. He was seen by a prison doctor who said he had a stomach fungus and administered an antibiotic. A short time later, having lost 50 pounds, still living in his tiny cell where the temperature was 96 degrees, he became so sick he was taken to a hospital outside the prison where he was diagnosed with terminal liver cancer. His friends and lawyers requested that the state grant him compassionate release and allow the man to spend his final days with family and friends. And, indeed, shortly before his death, a federal judge in Louisiana, disregarding the state's opposition, set him free. Sadly, he spent two days as a free man before he succumbed to the cancer. (Ridgeway 2014, p. 1)

Because the prison health care system is protected from public scrutiny, there is little to no accountability with respect to the failures of the care provided. A recent assessment by the Justice Department's Civil Rights Division released a summary of its findings on the state of Alabama's prisons that attest to the horrific conditions and treatment of those in their care and custody. "Two years in the making, the federal investigation of men's prisons in Alabama found them plagued with 'severe, systemic, and exacerbated' violations of prisoners' Eighth Amendment rights. In fact, one prisoner had been lying dead for so long that his face was flattened" (Ford 2019, p. 1). The problem, however, is not isolated. Four hundred and twenty-eight prisoners died in Florida's prisons in 2017, amounting to a 20 percent leap over previous years. In Mississippi, 16 prisoners died in the state's custody last August alone. Some of them may have died from natural causes or unpreventable problems, but that is not always the case. Arizona regulators testified that multiple prisoners in state facilities had died from inadequate healthcare services by a private provider. Perhaps the most famous death in recent years was Sandra Bland, a 28-year-old woman who committed suicide in a Texas jail after she was arrested during a routine traffic stop in 2015. Bland warned officials during her intake procedure that she had made suicide attempts in the past, but they took no extraordinary measures. (Ford 2019). The clear message here is that there are multiple interpretations of the situations and facts as presented by those who are the spokespersons for those facilities and, moreover, like many prison-related issues, not all health-related events are disclosed to the public.

Sentenced to "life without parole" when he was 16 years old, the coauthor of this article has been living that sentence for 24 years. Our chance meeting during a prison tour resulted in a long-term friendship and we continue to collaborate on a variety of projects that address prison-related issues. At the time that we were working on this article, he and a few other men who were incarcerated at the same prison, wanted to share their experience(s) and so their collective experiences inform the section on Prisoner Voices.

This article adds to the literature and knowledge about prison health care by providing an overview on the provision of health care to those incarcerated not only by policy and legal standards but also through the voices and experiences of male prisoners in a North Carolina prison as well as the descriptions provided by others who are or were imprisoned in the United States' correctional system and who have been directly impacted by the provision of (or lack of) health care in a prison setting.

2. Overview of Prisoner Health Conditions

The spectrum of health problems in correctional facilities is significant. Inmate health and medical conditions range the gamut from minor (colds or viruses) to the significant (HIV/AIDS and TB). In addition to communicable diseases, the prevalence of mental health and psychiatric diseases and substance abuse is higher among the prison population than the general population. As noted by Smith (2013), "When it comes to what we do know about inmate health, a gloomy picture is often painted. Due to circumstances that occur before, during, and after incarceration, prisoners are often at an increased risk for poor health outcomes (Binswanger et al. 2009). Compared to the general public, the prison population is more likely to have experienced disadvantaged backgrounds; to have low levels of education; to have a history of smoking, drinking, and illegal drug use; to have poor nutrition and limited physical activity; to have mental health and neurological disorders; to have been exposed to infectious diseases; to have high levels of stress, anxiety, sleep deprivation, and depression; and, to have low levels of self-efficacy (Condon et al. 2007; Mumola 1999; Massoglia and Remster 2019; Fazel and Danesh 2002; Baillargeon et al. 2002). Studies have further found that released prisoners often have worse health and higher risks for death than those in the general public. Such findings indicate that the existence of chronic condition may be higher in inmate populations than amongst the general public (Binswanger et al. 2007; Farrell and Marsden 2008; Loeb and AbuDagga 2006).

In fact, research does suggest that chronic conditions are more prevalent in prisons than in the outside world. Binswanger et al. (2009) quantified the difference in the occurrence of major medical conditions among inmates within the noninstitutionalized U.S. adult population. Even after controlling for various sociodemographic factors and alcohol consumption, prison inmates were found to be more likely to suffer from hypertension, arthritis, asthma, cancer, and hepatitis. Similarly, Wilper et al. (2009) also evaluated inmate health. Results of their research indicated that of the over 1.35 million state and federal inmates in their study, over 570,000 inmates reported suffering from at least one chronic health condition; these inmates had higher rates of diabetes, hypertension, myocardial infarction, persistent asthma, and HIV than the general U.S. population. More recent studies provide evidence that these medical conditions continue to be common within incarcerated populations (Bronson et al. 2017; Maruschak et al. 2016; Bronson and Berzofsky 2017). As Binswanger et al. (2009) as well as Wilper et al. (2009) attest, we need to learn more about prison populations if we are to properly address this group's growing needs" (Smith 2013).

In an effort to begin to address prisoner health care needs, it is useful to start by examining the demographic and epidemiological features of the incarcerated population. A number of social determinants are strongly associated with poor health. In the United States, being nonwhite, low-income, undereducated, homeless, and uninsured are among the strongest predictors. When compared with the general population, individuals in jails and prisons exhibit these predictors of poor health disproportionately. As a result, the population of inmates typically shares a number of health profile characteristics, including mental health disorders, drug dependence, infectious disease, and chronic conditions. Moreover, some groups pose unique challenges to correctional health care, examined here in order in the following sections.

2.1. Mental Health Disorders

In the 1970s, psychiatric hospitals across the nation began to be deinstitutionalized with the intention of shifting patients to more humane care within their communities. However, insufficient funding for community-based mental health programs left many patients without access to care altogether. As a consequence, people with undiagnosed, untreated, or inadequately treated mental health disorders experienced heightened risks of incarceration. Indeed, there are now more people with serious mental health disorders in Chicago's Cook County Jail, New York's Riker's Island, or the Los Angeles County Jail than there are in any single psychiatric hospital in the nation (Macmadu and Rich 2015). As noted by District Court Judge Joe Buckner, who pioneered the use of mental health courts in North Carolina, "we don't have the space for the mentally ill in jails, but that's where they're going" (Hoban 2014, p. 1). Housing inmates with known mental health problems with those who do not creates dangerous living conditions, results in sleep deprivation for other inmates, and creates sanitation issues. There have been instances in North Carolina prisons where mentally ill inmates refuse to take showers or clean their living area, flood their cells, bang on doors or windows during the night, and even throw human waste or urine at staff members or other inmates.

Estimates of the number of inmates who have symptoms of a psychiatric disorder—as specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)—vary widely but often exceed half of the incarceration population. In contrast, approximately one in ten people in the general population has symptoms of a psychiatric disorder by the same criteria. Additionally, an estimated 10% to 25% suffers from serious mental health problems, such as schizophrenia or major affective disorders; by comparison, an estimated 5% of the general population suffers from a serious mental illness (Macmadu and Rich 2015).

2.2. Drug Dependence

Given the role of the war on drugs in mass incarceration, high rates of drug dependence among inmates are not surprising. Over 50% of all inmates meet the diagnostic criteria for drug dependence or abuse, and one in five state prisoners has a history of injection drug use. Up to a third of all heroin users—an estimated 200,000 people—pass through U.S. prisons and jails each year. The comorbidity of substance abuse and mental illness among inmates is strikingly high. Among those who have a serious mental illness, over 70% also have a co-occurring substance abuse disorder; in the general population, the corresponding percentage is about 25% (Macmadu and Rich 2015).

2.3. Infectious Disease

Contagious diseases such as tuberculosis (TB), sexually transmitted infections (STIs), HIV, and hepatitis C (HCV) are prevalent in correctional facilities. In 2002, it was estimated that jails and prisons, respectively, had a 17 and four times greater prevalence of TB than the general population. Although the prevalence of TB in correctional facilities appears to have declined in more recent years, outbreaks are still possible, as poorly ventilated, enclosed, densely populated dwellings are highly conducive to the spread of TB (Macmadu and Rich 2015).

Although the true prevalence of STIs in correctional facilities is difficult to estimate due to differences in screening procedures (most specifically, universal opt-out vs opt-in screening), studies consistently report that the prevalence of chlamydia, gonorrhea, and syphilis are higher in correctional populations, particularly jails, than in the general population. The prevalence of STIs is also especially high among female inmates, who are more likely to have a history of sex work than their male counterparts (Macmadu and Rich 2015).

The prevalence of diagnosed HIV in correctional facilities has recently declined, but remains four to five times higher among inmates than in the general population. Correctional facilities, which are increasingly adopting routine screening procedures, have played an important role in diagnosing those who would not otherwise seek testing.

Because injection drug use is a common route of transmission for both HIV and HCV, coinfections of these diseases are common. HCV is estimated to be nine to ten times more prevalent among inmates than in the general population, and over half of prisoners with HIV are estimated to also have HCV (Macmadu and Rich 2015).

2.4. Chronic Conditions

Chronic health conditions, such as diabetes, hypertension, and asthma, now comprise a growing proportion of correctional health care needs. This increasing prevalence comes as the result of two trends: the aging prison population and the nation's general obesity epidemic. About 40% of all inmates are estimated to have at least one chronic health condition. With a few exceptions, nearly all chronic health conditions are more prevalent among inmates than in the general population (Macmadu and Rich 2015).

2.5. Special Populations

Certain populations pose a unique challenge to correctional health care; these include women, juveniles, and aging populations.

1. Female inmates, while comprising only 10% of the incarcerated population, have a greater burden of disease than their male counterparts. Post-traumatic stress disorder is particularly common among incarcerated women, about a third of whom experienced physical abuse and a third of whom experienced sexual abuse prior to incarceration. An estimated 5% to 6% of incarcerated women are pregnant upon entry to jail or prison, and the prevalence of STIs among female inmates is at least twice that of the incarcerated male population (Macmadu and Rich 2015).

2. Incarcerated juveniles also have a higher burden of disease than their nonincarcerated peers. Dental decay, injury, and substance use are common, and many were subject to abuse prior to incarceration. Twenty percent of incarcerated juveniles are parents or expecting, and STIs are highly prevalent among incarcerated juveniles. Although incarcerated juveniles are typically held in facilities separate from adults, about 10% are held in adult prisons; in both settings, this population is highly vulnerable to disease and abuse (Macmadu and Rich 2015).

3. The imposition of longer sentences in the 1980s and 1990s produced a dramatic increase in the number of older adults in corrections. From 1990 to 2012, the number of inmates aged 55 or older increased by 550% as the prison population doubled. Older inmates, as in the general population, have higher rates of chronic health condition; geriatric syndromes, such as cognitive impairment or dementia; and disabilities, compared with younger inmates. Given the aging incarcerated population, prisons and jails—which were designed to hold young and healthy inmates—are increasingly becoming a site for nursing home-level care and treatment for chronic conditions (Macmadu and Rich 2015). "The National Institute of Corrections pegged the annual cost of incarcerating prisoners age 55 and older with chronic and terminal illnesses at, on average, two to three times that of the expense for all other inmates, particularly younger ones" (The Pew Charitable Trusts 2014, p. 9). "In 1981, there were 8853 prisoners aged 55 and over; this number increased to 144,500 in 2013. The trend is expected to continue as the number of prisoners in this age group is expected to reach an estimated 400,000 by 2030" (Chari et al. 2016, p. 1).

3. Prison Health Challenges

Those who are incarcerated in correctional facilities face multiple challenges to conducting their daily lives. These include limited access to health care, poor diets, bad food, lack of communication, negative attitudes toward them from the public and from other inmates, toxic environment, restrictions on travel and outside communication, threats to their safety by predator inmates and others, constant noise and bright lights, minimal to no privacy, unexplained punishments, humiliating strip searches, endless loneliness, heartbreaking homesickness, and loss of control over even minor decisions. Prison conditions

can easily fan the spread of disease through overcrowding, poor ventilation, and late or inadequate medical care (Finkel 2011).

Incarceration can be especially challenging for disabled inmates. To qualify as a disability, an impairment must be one that "substantially limits one or more major life activities" (Boston and Manville 2010). Some examples include being limited in caring for themselves, walking, breathing, speaking, learning, sleeping, hearing, and seeing to name a few. A North Carolina inmate who was completely blind, faced these challenges. Upon his incarceration there were no immediate provisions made to accommodate his disability. He did not have a designated person assigned to help him function. As a result, since he could not keep track of time, he missed numerous meals and appointments, had no one to read his mail to him, and had his possessions stolen by those pretending to help him. After three months of complaining to staff members about his neglect, he was given a watch with audio and was assigned an inmate orderly to ensure he arrived to his appointments and meals, read his letters to him, and reduced the likelihood that his possessions would be stolen by other inmates. The end result was satisfactory but it should not have taken so long to address his needs (personal communication with the inmate, 2017).

The provision of health care in prison depends on the state. At best, it is about as good as a low-income health plan. At worst, it is almost nonexistent. In general, when a prisoner gets sick or wishes to be seen by a physician or other medical staff, they must fill out a sick call form and place it in the special box for consideration so that an appointment with the prison's in-house medical staff may be scheduled. To handle emergencies, most prisons have a nurse on duty 24 hours a day. The majority of ailments are treated on-site, but inmates who are gravely ill can be taken to the nearest hospital. Sick prisoners must make a nominal copayment for each visit to the doctor—usually $5 or so—which is taken from a daily or, in some cases, an hourly wage. Since most facilities are cashless, a debit to the person's prison account is noted and when money appears in the account, it is quickly removed to pay for the service(s) provided. Costs above the initial visit may be covered by the state (Bertram 2019).

In the United States, all prisoners are supposed to be screened for suicide risk and medical and dental history (including diagnostic blood tests and HIV and TB testing) at admission to most correctional facilities. However, far fewer prisoners receive postadmission medical exams and diagnostic blood tests and when they do, they may not receive their medical results in a timely fashion. Moreover, when prison inmates develop health conditions that require intervention by prison health providers (e.g., cancer), those challenges may be amplified by feelings of social abandonment, fear, anxiety, hopelessness, and other existential distress as they generally have little access to a second medical opinion and limited opportunity to weigh their treatment options with health care professionals (personal communication with prisoners in several North Carolina prisons, 2015–2019). Few data are collected on whether the appropriate treatment is provided once a prisoner is diagnosed with a condition, and so the conflict between theory (what is written policy and/or law) and reality (the actual operational practice of and/or application of the law) emerges.

Prison policy is not always acted upon especially when addressing health care of prisoners. In practice, many prison systems are so overcrowded that prisoners have to wait days to see a doctor, even in emergency situations. Moreover, the quality of care also depends on the security level of the prison. In some maximum security prisons, for example, an inmate may be taken to see the doctor in arm and leg chains, and left to wait in a cage. In contrast, those who are elderly or chronically ill might qualify for a special treatment facility, like Pennsylvania's Laurel Highlands, where inmates receive constant care but such facilities are not uniformly available in all states. Finally, it should be noted that insurance companies sometimes fail to provide medication and treatment to needy prisoners, and inmate medical records get misplaced regularly (SEE: New York Times' investigative series on insurance giant Prison Health Services, James 2005). The problems

associated with the delivery of quality health care to incarcerated populations have been identified as diverse, complex, and pressing.

Even with the research findings reported here along with available aggregate agency-based information from departments of correction about prison health care services, questions about the accuracy, quality, and actual provision of those services remain. What follows are the prison health care experiences of five men as shared by the men themselves. We believe it will provide scholar and layperson alike with an honest account of some of the health-related challenges associated with living in prison and we hope that the care and risk they took to share their lived experience(s) will be considered by policy makers and others who will act to reform health care in prisons nationwide.

4. Prisoner Voices on Health Care

4.1. Anthony

I agree with Binswanger et al. (2009) as well as Wilper et al. (2009) because I believe that one of the most effective ways to learn about prison populations is to speak to those who are daily living this reality. By giving an ear to the voices of those whose cries usually go unheard, the neglect and inadequate medical care that inmates are exposed to becomes evident. I know firsthand what it is like to experience the frustration that many inmates experience from our medical staff. It is my objective to refrain from going to medical unless it is absolutely necessary. Over the years, my medical record should indicate that if I submit a sick call request, it is something that I am seriously concerned about.

The day we were sentenced to prison, we were placed in the care of the North Carolina Department of Public Safety (NCDPS). As days turn into years, it becomes more evident that our lives and, ultimately, our fate are literally in the hands of administration, custody, and medical staff. At any point, we may get injured or sick and must rely on communication between Administration and Medical to ensure our needs are properly tended to. This isn't as easy or effective as one may hope. Incarcerated individuals don't have medical insurance nor can we request a second opinion. We are a "ward of the state" and the medical care at our prison is the only medical care we have unless we get a rare special approval from the Utilization Review (UR) Board to go to Central Prison (the only prison in the state with a hospital for men) for further treatment or to a hospital in the free world for the rarest and most severe circumstances.

One thing that those with lengthy sentences fear is getting sick while in prison. By being incarcerated for the past 24 years, I've been forced to accept the diagnosis of our medical staff. We could be given an erroneous diagnosis and we would never know until we are reevaluated upon release or get severely ill as has occurred to others that I've known over the years. It grieves my heart to witness and/or hear of men who endure 20+ years of prison only to be conquered by a hidden sickness that suddenly takes their lives while on the brink of being released or when a terminal illness was discovered soon after they are released. It naturally causes worry in the minds of the other inmates who also have lengthy sentences of what our fate could be. We are unsure if it is the processed food that we are forced to eat for decades, the water, the unsanitary environment or simply the poor medical treatment that we are limited to.

During my incarceration, I've interacted with and slept next to men who've experienced unimaginable suffering, pain, and some even died due to inadequate medical care. Although we've made bad decisions, these men who were full of dreams and healthy upon entering prison became maimed, terminally ill, while some never made it home. It is sad to learn of the many lives that have ended prematurely without ever being able to redeem themselves or make a positive contribution to society.

It's true that offenders enter prison in a state that reflects the lives they lived. Many didn't have health insurance and rarely visited the doctor. Others were drug or alcohol users, or smoked cigarettes, which significantly impacted their health. Some received injuries from crimes such as being shot, stabbed, burned, or paralyzed and now NCDPS must care for them.

As a prisoner, I understand that I am incarcerated as a punishment. Therefore, I don't expect to be catered to or given special treatment. I expect my prison conditions to be restrictive in some capacity but not to the extent that the few rights that I am legally entitled to be stripped away. My wrestling match with Medical has primarily been regarding obtaining proper procedures regarding blood work, obtaining blood work results, and issues with our staff nutritionist. Since diabetes runs in my family, I am attempting to be proactive by periodically requesting to have my sugar level checked. On numerous occasions, I have requested to have a fasting lab only to have those request(s) ignored and to be called soon after I have eaten. When I inquired why I wasn't notified that I was scheduled to have blood work taken to ensure I wouldn't eat, medical staff would respond by saying that it didn't matter if I ate or not because they would factor that in on my results. I could argue with them but ultimately they will do whatever they want and if there would be any consequences, the only person who would suffer would be me.

It is normal for staff to wake us up around 3:30 am when we are to have a fasting lab conducted. We are always told that if we are not contacted regarding our blood work results, then that means that our results are fine. This has caused men to live with illnesses that their test results clearly indicated but the medical staff simply failed to notify the inmate. This almost happened to me on one occasion, but, rather than assuming that my blood work results were normal, like I was instructed, after a few weeks I submitted a request stating that I wanted to know what my lab results were. I'm glad I did because my results were not normal and further tests were needed. I was simply overlooked and if I wouldn't have acted, I likely would have never known.

After this diagnosis, I submitted a request to speak to our staff nutritionist to learn about various foods with minimal sugar, starches, etc., which are best to eat. My goal was to attempt to take preventive measures to ensure I remain as healthy as possible throughout my incarceration. I would have thought that medical staff would be pleased that someone was genuinely interested in maintaining their health and wanted to learn of ways to do this, but my request was denied. The staff nutritionist sent me a message stating that she couldn't speak to me regarding these issues because I was not a diabetic. But she stated that once I became a diabetic, then she would speak with me. Still today that doesn't make any sense to me. A medical professional wants my health to begin to fail before they would attempt to help me. How is this logical? So, I have attempted to read articles on these issues myself. What is the purpose of medical staff if they are not willing to provide patients with proper information to prevent future sicknesses?

Since prisoners cannot obtain their own medical services, the constitution requires prison authorities to provide them with "reasonably adequate" medical services as "services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards," and at "a level of health services reasonably designed to meet routine and emergency medical, dental and psychological or psychiatric care" (Boston and Manville 2010, pp. 36, 92).

The constitution requires that correctional officials provide medical care only for "serious medical needs." Generally, a medical need is serious if it "has been diagnosed by a physician as mandating treatment or . . . is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." Conditions are also considered to be serious if they "cause pain, discomfort, or are a threat to good health" (Rold 2008, p. 16).

When my coauthor and I decided to pursue writing an article about the quality and provision of health care to men in prison, I was able to sit down and listen to a few fellow inmates share their stories about the neglect and unprofessional care they experienced from the medical staff and custody officers while housed in the infirmary unit. The infirmary is where those with serious medical issues are housed so they can be in a 24-hour medically supervised area. If these men experienced inadequate medical care in an environment that supposedly receives constant medical attention, it becomes clearer that the type and quality of medical care provided to the rest of the inmate population is questionable at best and

requires oversight by community groups. Sadly, one of these three men has passed away during the course of preparing this article.

> [EPILOGUE: He is coauthor of this paper and still resides in prison though he has been resentenced since his "juvenile life without parole" sentence and has earned a custody reduction that resulted in a transfer to a minimum security prison.]

4.2. Roger

Roger has been diagnosed with epilepsy since he was a baby. Before coming to prison he would experience approximately two to three seizures a year. Since his incarceration, he now experiences one to three seizures a month due to the inadequate medical care he has been given. After he had a severe seizure in the restroom and was left unattended and helpless due to the lack of supervision, he was moved to the infirmary unit so he could be closer to medical staff. One would think this would result in better medical care and attention but this assumption is far from accurate. At this time, the medical staff still hasn't determined what his Dilantin level is. This alone prevents medical staff from knowing the appropriate dosage needed to manage his seizures. He has waited over one year for an MRI that is necessary to determine where his port-a-cath should be installed. This device will allow him to be given a shot quicker to end his seizures.

In the past year he had a seizure so severe that his heart stopped and had to receive CPR to be revived and was later placed on a breathing machine because he couldn't breathe on his own. Another instance when he had a seizure, he bit into his cheek so hard that he shredded the flesh inside his mouth and shattered three of his back teeth. Rather than the nursing staff rolling him on his side during this seizure, they stuck a wooden tongue depressor into his mouth which caused his mouth to be covered with tiny splinters. As he regained consciousness, the doctor at the hospital was using a small light as he worked tirelessly to remove each splinter that was imbedded throughout his mouth.

> [EPILOGUE: He was released October 2016.]

4.3. Shawdna

Shawdna is 29 years old and has been confined to the infirmary for two years due to a gunshot wound that he suffered in 2012 leaving him paralyzed from the waist down. At the time of his incarceration, he was in physical therapy to help strengthen his legs to possibly allow him to be able to walk again. Through these sessions he regained feeling in his legs and could move them minimally.

In 2014, as he came to prison in a wheelchair his nightmare began. He quickly discovered that the pain medication that was prescribed to him in the "free" world was not permitted inside of prison. The medication that the prison medical staff prescribed as a substitute, in his words, "doesn't work." Even after months of requesting a different medicine, his cries have gone unheard.

In 2014, while attempting to lift himself out of the shower into his wheelchair, he fell and broke his left leg. The nurses refused to treat him because they claimed he wouldn't know if his leg was broken or not due to his paralysis. They literally laughed and said he couldn't feel it. After enduring six days of excruciating pain, he went back to medical and refused to leave until he received treatment. He requested to see the captain in charge of that shift and once he heard the issue, the captain literally forced the medical staff to take an x-ray of his leg. Medical complied and it was confirmed that his leg was, in fact, broken. That same night, he was coincidentally transferred in the middle of the night to another prison facility, in his opinion, in order to remove the burden and possible malpractice claims from them and placing the responsibility on another prison. He was immediately placed in the infirmary and eventually was scheduled to see the orthopedic staff where he was given a leg brace for his leg to heal naturally.

While in the infirmary, he experienced a torturous degree of neglect as well as having to endure broken equipment designed for his safety. His disability causes him to feel like he is a burden to the medical staff. There are times when he requests assistance from nurses

assigned to oversee him and they respond to him with an attitude, barking "what do you want? I'm busy." Since his room doesn't have a working call button he was given a metal bell to ring in case of an emergency. His leg prevents him from getting up to walk and it isn't safe for him to attempt to get out of the bed by himself. There have been a number of times when he has been in pain and his calls for help and the sound of his bell have gone unanswered. Later the nurses often claim they didn't hear the bell or his screams but other inmate patients told him they heard him very clearly as far as 40–50 feet away, so he believes the nurses directly across the hallway should have heard his cries for help. A few times weren't necessarily an emergency but they wouldn't know if they don't ever show up. He held onto the hope of receiving adequate medical care upon his release.

[EPILOGUE: He was released from prison in November 2017.]

4.4. Vernon

Vernon has lived in the infirmary for the past two years and this is his testimony: There are so many issues going on with medical like nurses not knowing what to do in an emergency and other times we end up with the wrong medication. I am diagnosed with Chronic Obstructive Pulmonary Disease (COPD), heart problems, I'm a diabetic, and I have cancer in my lungs. If I or any other patient fall and get hurt, we have no emergency call button to use, we can only wait and hope someone comes by to find us. We have trouble getting outside appointments to see doctors due to the Utilization Review (UR) Board. Also, there have been times when our health care provider has ordered for us to do certain physical activities such as walking the hallway for a certain length of time since several of the infirmary patients aren't physically able to walk to the recreation yard but we are prevented from doing this because the custody officers keep us confined to our rooms, thus disregarding doctor's orders. We are allowed to come out of our rooms for two hours each morning to go to the recreation yard but besides this, we are locked in our rooms. We are usually refused to come out of our rooms to get cold/hot water, use the microwave to heat up food, to use the telephone, and even to take a shower. There are designated inmate-orderlies assigned to clean our rooms and it is nearly impossible to have this done if certain custody staff are working because they say they don't want to be bothered. Each day when we are served our meals, they are usually cold. We are supposed to be served the same food as the other inmates who are in the regular population but we are not. I am grateful to have food to eat but why can't I be given the same treatment as everyone else who isn't in the infirmary? I don't understand why we are being punished because we are sick.

[EPILOGUE: He died in prison in June 2016 before compassionate release was granted.]

4.5. Jamie

Jamie was an inmate orderly in the infirmary unit from May 2015 until February 2016. During that time he witnessed several incidents and inadequate medical conditions regarding the patients in their care. This is his testimony:

When I was initially hired as an orderly I wasn't given any type of training other than a brief verbal orientation. But during that time, I noticed that certain things didn't work any longer. There are emergency lights placed outside of each patient room that are designed to flash in the event of an emergency. These lights are supposed to be connected to emergency devices in the bathroom, the shower, and alarms at their bedside but none of the emergency call buttons are functional. Instead, some of the patients are issued a small silver bell that they can ring in the event of an emergency, but only a few actually work properly. The ring tone is so low that if the nurses are in the nurse's station as they usually are, they can't hear the bell at all. I've witnessed times when a nurse has been in the vicinity of a patient while he was ringing his bell attempting to get the nurse's attention and he was simply ignored.

In other situations I've witnessed the poor ventilation in the patients' rooms. Each room is either too hot or too cold. The inmate janitor is permitted to use very strong cleaning supplies around patients with breathing problems. One day a patient had a seizure while in the bathroom and fell in an awkward position and even though the nurse couldn't tell if he had a neck or back injury, they continued to try to move him to the bed without stabilizing him in any way. Because the patient was too heavy, they gave me a direct order to pick him up over my shoulders like a sack of potatoes. I reluctantly complied and fortunately he wasn't paralyzed or injured further due to being improperly lifted and moved without proper stabilization.

The patients are locked in their rooms and aren't permitted to come out unless they are going to the recreation yard or to take a shower. Not long ago, one of the patients suddenly died and I observed and overheard the nurses working together to rewrite their statements of the events to cover their mistakes.

[EPILOGUE: He still resides in prison but was transferred to another facility.]

5. Examples of the Female Experience

It would not be fair to say that imprisonment is worse for women than it is for men, but, imprisonment is qualitatively different for women. There is a need to extrapolate precisely how institutional policies contribute to the continuation of the disadvantaged status of female prisoners. After all, women's prisons increase women's dependency, stress women's domestic rather than employment role, aggravate women's emotional and physical isolation, can destroy family and other relationships, engender a sense of injustice (because they are denied many of the opportunities and legal protections available to male prisoners) and may indirectly intensify the pains of imprisonment. Nowhere is this more evident than in the provision of health care to imprisoned women (Pelligrino et al. 2016; Lanier 2006).

> At 5 a.m. on June 12, 2012, lying on a mat in a locked jail cell, without a doctor, Nicole Guerrero gave birth. Guerrero was eight and a half months pregnant when she arrived 10 days earlier at Texas' Wichita County Jail. The medical malpractice lawsuit Guerrero has filed—against the county, the jail's healthcare contractor, Correctional Healthcare Management, and one of the jail's nurses, LaDonna Anderson—claims she began experiencing lower back pain, cramps, heavy vaginal discharge and bleeding on June 11. The nurse on duty told her there was no cause for concern until she had bled through two sanitary napkins. Several painful hours later, Guerrero pushed the medical emergency button in her cell. At 3:30 a.m., more than four hours later, Guerrero was finally taken to the nurse's station. Guerrero says she showed Anderson her used sanitary pads filled with blood and fluids, but was not examined. Instead, she was taken to a one-person holding cell with no toilet, sink or emergency call button, known as the "cage." At 5 a.m., her water broke. She called out to Anderson, but, Guerrero says, Anderson refused to check on her. Shortly after, Guerrero felt her daughters head breach. A passing guard stopped to assist her, and Guerrero, unable to keep from pushing, gave birth on a blood and pus-covered mattress.
>
> The baby was dark purple and unresponsive, with the umbilical cord wrapped around her neck. When Anderson arrived minutes later, she did not attempt to revive the baby, Guerrero says. The Emergency Medical Technicians (EMTs) got there after 20 minutes and rushed the baby to the hospital. Guerrero remained in the cage, where she delivered the placenta. At 6:30 a.m., the baby was pronounced dead. (Law 2015, p. 1)

In another case, Kena Spurgeon was diagnosed with advanced cancer in jail. She needed so much care she was ultimately moved to the Tennessee Prison for Women. What happened there has her family and a doctor at Vanderbilt raising questions if her pleas for help were ignored. Even though her cancer was incurable, Kena Spurgeon wanted to fight.

She was due to be released from prison on Dec. 30. But then, her family started getting letters from Kena Spurgeon saying she was not being taken to her medical appointments at Vanderbilt. Even Kena Spurgeon's doctor, Dr. Vicki Keedy, wrote that she was missing important appointments; that Keedy's nurse experienced difficulty communicating with the facility; and that Kena Spurgeon was in need of more frequent appointments, which had been difficult to orchestrate with the prison facility. The next month, after her doctor wrote she needed more appointments, Kena Spurgeon died. (Finley 2014, p. 1)

The mentally ill in prison, as in the world outside prison, suffer from a wide array of mental disorders serious enough to require psychiatric treatment. But, the use of psychotropic drugs in combination with locking people in segregation units (Zaitzow 2010) only serves to make matters worse for the prisoner:

> R.M. was twenty years old when Human Rights Watch interviewed her at Chittendon where she was being held in an administrative segregation cell. Inside the facility, R.M., who is a heroin addict and who was severely sexually abused as a child, hurts herself on a regular basis. Her arms are criss-crossed with raw, red cuts. One of her legs . . . had a big, bloody, open wound. R.M. stated that she jabs pencils into her limbs, that she cuts herself with razors, and that she sticks staples, retrieved from the bindings of magazines, into her open wounds. She also smashes her head against the walls of her cell when she gets agitated. Ill with serious diabetes, R.M. confided her desire to kill herself by depriving herself of needed diabetes medications. "I'm going to kill myself here and they don't care . . . I know how to do it. I can. I swallowed a pencil the other day . . . That was fun. I shove things in my legs all the time and they don't care." R.M. expressed a desire to return to the state mental hospital. "I wish I could," she says, pouting like a child. "They don't have enough staff. It's ok. If they don't take me, I'm going to kill myself." (Human Rights Watch 2002, p. 1)

While women represent approximately ten percent of the entire correctional population, they have a number of special needs that differ from their male counterparts. Women in custody have an increased incidence of chronic health problems, including asthma, gynecological disease, nutrition problems and convulsive seizure disorders. Yet, the implementation of innovative in-house medical treatment for women has not kept pace with the diverse needs of the ever-increasing population.

Female inmates require higher levels of medical care for reproductive health, and sometimes these needs are ignored. In March 2004, for example, Kimberly Grey gave birth over a toilet after Tampa jail officers refused to transport her to a hospital (Crawley and Greenwood 2004). This case resulted in the death of Grey's infant, but the incident also underscores the treatment that some incarcerated women receive. Correctional health services have been historically delivered based on models developed from male correctional populations, who require less comprehensive physical or mental health care.

Thousands of women are dependent on correctional authorities for their health care, and correctional authorities are legally obligated to meet those needs. The reality of the situation, however, is that even when the constitution is on their side, women (and men) behind bars face special difficulties in exercising those rights and receiving the regimented treatment necessary to control medical ailments (e.g., STI and HIV/AIDS-infected prisoners). As more people become incarcerated—as more women are locked up—programmatic challenges associated with variations in prison populations' health concerns need to link public health efforts with criminal justice policy and practice. Continued indifference will have great economic and social costs to society for current and future generations.

6. Legal Obligation to Provide Health Care in Prison

Prisons and jails throughout the country are legally obligated to provide health care to inmates. This requirement comes from both federal and state law. Two supreme court

decisions—one 44 years ago and another in May 2011—are having profound impacts on how the states provide health care to their prison populations.

Forty-four years ago, in *Estelle v. Gamble*, the U.S. Supreme Court ruled that the government has an obligation to provide medical care to those whom it incarcerates, and that failure to provide such care may violate inmates' constitutional rights. In the 1976 case Estelle v. Gamble, the U.S. Supreme Court ruled that the eighth amendment (which prohibits cruel and unusual punishment of prisoners) requires that prisoners be provided with medical care. However, the two legal tests for care—that medical need is "serious" and that prison officials are not "deliberately indifferent" to that need—provide little guidance about the actual provision of care.

Correctional facility medical care is considered a condition of confinement. When conditions of confinement are extremely severe or inadequate, they can amount to cruel and unusual punishment in violation of the eighth amendment. In *Estelle*, the court held that the eighth amendment can be violated by the failure to provide necessary medical care. The court reasoned:

> An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or a lingering death," the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency. (*Estelle v. Gamble*, 429 U.S. 97, 103, 97 S. Ct. 285, 290 (1976)

While the eighth amendment's deliberate indifference standard presents a relatively demanding standard for proving liability against/by correctional staff, it does require that sufficient resources be made available to implement three basic rights: the right to access to care, the right to care that is ordered, and the right to a professional medical judgment.

In May 2011, the U.S. Supreme Court decision to order California to release tens of thousands of prison inmates (*Plata v. Brown*) is having a sobering impact on these prison systems. The California decision represents one of the largest prison releases in U.S. history and was driven by the issue of prison overcrowding which the court indicated has caused suffering and death.

7. Laws Don't Guarantee Protection of Prisoners' Health Care Needs

Examples of the Male Experience

In spite of important legal decisions and presumed safeguards for prisoners' health, in November 2012, nurses at the infirmary at St. Clair Correctional Facility in Alabama sent an inmate back to his room numerous times after he complained of pain after his dialysis treatment. A doctor had told them over the phone to give the man water and send him back to his room; they were not to hospitalize the inmate and not to bother the doctor with another phone call about his complaints. The next morning, the inmate died. Additional reports of medical neglect and abuse in Alabama prisons include a case where an inmate on suicide watch was burned on his legs by a flaming cloth other prisoners threw at him. The correctional officers put out the fire but refused for more than 24 h to take the inmate to the infirmary because the burns "were nothing." Finally, in another case, another inmate who complained of sore, swollen testicles for five days, was only given ice for the swelling. He ended up having gangrene and had to have his testicle removed. These are just a few examples cited in a report, released by Southern Poverty Law Center and the Alabama Disabilities Advocacy Program, of inmates in need of medical care who were ignored, misdiagnosed or forced to wait long periods of time before getting treatment (Kachmar 2014).

Such medical horror stories occur in other states as well. In Illinois, a patient at Menard Correctional Center (MCC), a downstate maximum-security facility which houses some 3750 inmates, had his insulin discontinued by a doctor untrained in primary care after his

blood sugar levels were found to be normal while on insulin. The report states a "failure to identify and appropriately manage a common primary care condition (diabetic foot ulcer) led to actual harm of the patient (amputation)." Meanwhile, at Illinois River Correctional Center (IRCC), an inmate coughing up blood upon arrival was given a container for it by a nurse and told to call if the amount increased. For months, the 55-year-old man had a family history of lung cancer and smoked more than 40 packs a year, exhibited classic and worsening signs of lung cancer. He died just nine days after being properly diagnosed and given treatment.

The numerous examples of medical neglect and abuse are too many to list here. Suffice it to say that there are not enough qualified medical professionals to handle the crush of cases. There is inadequate record-keeping. There are unanswered questions about the outsourcing use of private companies. There is no courageous leadership, and, as a result of all of that, ailing inmates who have eighth amendment rights must attempt to survive in unsanitary conditions that prison officials attempt to hide or attempt to block the release of or downplay the conclusions of reports that portray horrific treatment of human beings in the care and custody of their respective facilities.

8. Where to Now?

Prisons were never designed as facilities for the physically or mentally ill, yet that is one of their primary roles today. Many of the men and women who cannot get the medical and/or mental health treatment in the community are swept into the criminal justice system after they commit a crime. Unfortunately, prisons are ill-equipped to respond appropriately to the needs of prisoners with serious health challenges. Prison health services are all too frequently woefully deficient, crippled by understaffing, insufficient facilities, and limited programs. Many seriously ill prisoners receive little or no meaningful treatment.

When mental illnesses go untreated, a prisoner is more likely to act out and end up in segregation. "In most correctional facilities, suicidal prisoners are placed in solitary confinement and monitored by guards rather than by qualified mental health professionals in a treatment setting" (Gilna 2016). Hiding problems in a cell does not fix them. "In July 2016, state officials announced a plan to train prison employees to recognize prisoners in need of suicide intervention, with the training to begin on September 1, 2016. This was a small step toward acknowledging serious mental health issues that are a matter of life and death for prisoners including Scott Sica, Tony J. Davis, Lori Pote, Steven Hass, and Bernard Sanford, who all took their lives in North Carolina prisons" in 2016 (Alexander 2016, p. 1). One committed suicide in January, the other four followed suit all during a 17-day period. "It is extremely rare for so many inmates to commit suicide in such a short period. In the 25 years ending in 2015, 68 suicides were reported in the state's prisons—an average of about 2.7 per year" (Alexander 2016). "Elizabeth Forbes, director of the criminal justice reform group, NC-CURE, said she recently received two letters from inmates in solitary confinement who expressed suicidal thoughts. She says she also has received many complaints from inmates who say that when they request visits with mental health professionals, they often are forced to wait four to six months. Often, the best they can hope for on short notice, Forbes said, is a visit with a nurse who might not have the experience to identify serious mental health problems" (Alexander 2016).

The health care experiences of men and women in American prisons have a decades-long track record of abuse and neglect and there are questions about whether elderly and disabled prisoners should even be in prison—the idea that they are a threat to the community or need further retributive justice is hotly debated. But the lack of care they are receiving, and the callous way in which prison officials tolerate it year after year, is not just unconstitutional, it is immoral. So is the political and judicial indifference to the problem nationwide. "Many states have adopted medical or geriatric parole policies that allow the release of older, terminally ill, or incapacitated inmates who meet certain requirements." However, states have released relatively few people who meet the requirements because of narrow eligibility criteria, complicated applications, lengthy review processes, difficulty

in assessing medical suitability, and a shortage of nursing home space for these inmates. Furthermore, because many older and infirm prisoners were convicted of violent crimes or were sentenced under habitual offender laws, opposition among policy makers and the public to the concept of medical or geriatric parole has proved to be another significant obstacle" (Schiff 2014).

The mission of medical care is to diagnose, comfort, and cure; the goal of a prison or jail is to confine, punish, and, hopefully, rehabilitate. There is an inevitable collision between these two sets of goals, exacerbated because correctional facilities are inherently coercive institutions that for security reasons must exercise nearly total control over their residents' lives and the activities within their confines. Medical providers are accustomed to directing care provided according to their orders and designed to be in the best interests of the patient. In correctional settings, medical orders are often an irritant to correctional authorities who might need to reorder schedules to accommodate medical needs or augment or change diets, thus deviating from predetermined systems and rules.

Crucial to understanding the dynamic of inmate/patient compliance with a medical regimen, it is almost impossible in a correctional setting to decide between a refusal of care and a denial of care. Does the fact that an inmate was absent at the infirmary mean that he or she chose not to attend or was prevented from attending? Only a case-specific inquiry, of which there may be numerous ones every day, can distinguish between a decision made by an inmate based on individual moral agency and a decision made by a correctional officer based on clear disregard of the inmate's well-being or on disciplinary zeal.

"Because the doctor-patient relationship in a correctional facility is imposed by the state, the dissatisfied patient (or doctor, for that matter) is not free to select a different provider (or patient). The absence of freedom of choice removes the 'competitive quality controls' of the marketplace that normally influence the behavior of physicians" (Rold 2008, p. 16). This could subtly cause doctors to feel they can treat their inmate patients however they choose since they can't go anywhere else or get a second opinion. On the other hand, inmates may take a passive approach because they don't want to make this doctor angry or irritated for obvious reasons.

However, inmates are not always passive in this process. As flawed as the medical services might be, they provide one, constitutionally protected, avenue to escape boredom or deviate from a schedule. Health-care staff are trained to be compassionate, sympathetic and supportive even if these nurtured professional instincts are modified over time by frequent clashes with correctional culture. A nurse is still likely more sympathetic than a correctional officer to the actual or perceived self-identified needs of the inmate. While it would not be fair to say that going to the prison infirmary is a joyous event, sick call may provide a break from the daily monotony of prison life.

Yet, sick call can rarely address the real emotional, medical, or mental health needs of inmates who, as a part of the general correctional population—mainly poor young men of color, with little previous access to care—arrive at the institution with far more intense and more neglected medical problems than a nonincarcerated age matched cohort. Medically neglected problems of untreated hypertension and extensive tooth decay are the norm. With state and federal budgets pinched and hyperincarceration still swelling the inmate general population, underfunded and understaffed medical facilities can simply not cope with the reasonable demand for services addressing previously unmet and present needs. Faced with these realities and a rapidly growing and aging prison population, many states are scrambling for ways to provide economical and quality healthcare services that are currently eating up 10 percent of their correctional budgets and rising.

The truth is that criminal justice reform cannot simply consist of easy choices like letting petty marijuana users out of prison. It cannot be comprised of calls to reduce the impact of forfeiture laws for the benefit of property owners. It must also consist of harder choices like requiring taxpayers to pay more for basic, humane medical treatment for the men and woman we decide must stay behind bars. This means more funding for more doctors and nurses inside our prisons. It means more funding for more medicine for

inmates. And it means changing from the lowliest guard to the highest official the ugly, vicious, merciless dynamic that exists within these institutions, a dynamic whereby the ailing and ill are treated worse than animals. "It is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself" (*Spicer v. Williamson*, Supreme Court of North Carolina 1926). By helping individual prisoners regain health and improve coping skills, health treatment promotes safety and order within the prison environment and enhances community safety when prisoners are ultimately released. Change is needed now!

9. So Who Is Watching the Prison Health Care Providers?

According to the Corizon Health (n.d.) website, "As the correctional healthcare pioneer and leader for 35+ years, Corizon Health provides client partners with high quality health care and reentry services that will improve the health and safety of our patients, reduce recidivism and better the communities where we live and work" (SEE: http://www.corizonhealth.com/ (accessed on 1 Januaty 2021)). While it sounds impressive and while there are, indeed, good people who work in the health care industry who truly care about providing prisoners with the health care promised by this group, there are instances that arise that beckon for scrutiny and oversight by outside agencies that should include community members. One such incidence that was reported by an ex-Corizon employee:

Teresa Short was a patient care technician for Corizon, but lost her job in late March for refusing to go to work while suffering from a case of scabies she caught from a prisoner. Short said she thought it would be unethical to treat patients while she was still contagious. She had already infected a family member, she said, and feared her son could contract it and bring it to his high school. According to Short, Corizon and Arizona prison officials have been trying to cover up the outbreak, which now includes the original prisoner and seven staff members. The most persistent problem at Corizon, Short said, was staffing. "We have a lot of dementia patients that take time in feeding," she said, "and because of the short staff we'd have to stand there for hours to try to feed them and it was just not permitted." Sometimes, those patients would go unfed, she said. Others who were incontinent would sit for hours in their own feces, she said, and still others died. Short described one dementia patient who had a vascular catheter in his arm for dialysis treatments. He didn't understand what it was and kept playing with it, she said, so she repeatedly told senior staff he needed additional supervision. Instead, they sent him back to his cell, alone. At 5 a.m., she went in to check on him. "[I] could smell blood before I even went into the room," she said. "And when I turned on his light, it looked like somebody had been murdered. There was blood all over the room. I screamed for help." Short said the man had unplugged the catheter and quickly bled out. If Corizon had employed more staff to monitor patients, she said, he might still be alive. (Leonard and May 2014).

Although there are many conscientious and committed health professionals working in corrections, they face daunting if not insurmountable challenges to meeting the needs of their patients: impossibly large caseloads, physically unpleasant facilities, and institutional cultures that are unsympathetic to the importance of health services. Gains in health staffing, programs, and physical resources that were made in recent years have all too frequently since been swamped by the tsunami of prisoners with serious mental health needs. Overburdened staff are hard pressed to respond even to psychiatric emergencies, much less to promote recovery from serious illness and the enhancement of coping skills. Mindful of budget constraints and scant public support for investments in the treatment (as opposed to punishment) of prisoners, elected officials have been reluctant to provide the funds and leadership needed to ensure prisons have sufficient mental health resources. Without the necessary care, prisoners suffer painful symptoms and their conditions can deteriorate.

10. Policy Recommendations

Many of the problems and costs associated with overcrowded prison systems and questionable medical services are rooted in decades of choices by elected officials to close mental health institutions, impose lengthier prison sentences, and implement harsher punishments for first-time offenders, nonviolent offenders, and drug offenders. As a result, prisons have become asylums, drug treatment centers (usually without the treatment component), hospitals, and retirement homes rather than its designated function. Although the intent may have originally been to be tough on crime, time has proven that as more people are incarcerated, there is an increasing need for resources to deal with the growing numbers of people with a variety of types of illnesses. Unfortunately, quality resources and personnel are lacking and, moreover, investing limited state budgets for prisoner health care results in less program availability and opportunities in other areas of prison life.

Advocacy is needed on several fronts. First, they should use their professional weight to urge the reallocation of public funds to programs that have proved not only to provide access to treatment but also to reduce recidivism:

> *expanding access to drug courts and mental health courts, or other programs or strategies that divert people from the criminal justice system into community treatment (48, 80); *expanding linkage to care and case management services; and *ensuring that the Patient Protection and Affordable Care Act, once safely ushered through legal challenges, is used as a forum to construct alternative venues of accessing marginalized communities to forestall further reliance on correctional facilities for that access.

Second, public health practitioners should keep their eyes on the long-term agenda. The May 2011 supreme court decision (*Brown v. Plata*), which frames health care as a fundamental task of corrections, should capitalize on *Brown v. Plata*'s other function: as a warning shot to the correctional-industrial complex. Perhaps the greatest service public health practitioners could provide the incarcerated and their communities is advocacy:

> *for a drastic reduction of the largely unnecessary incarceration that has resulted from the war on drugs, including dismantling the economic incentives to target minority communities in that war; for an expansion instead of treatment programs for the mentally ill and the addicted; and for the recreation of those jobs without which such communities cannot recover.

Even though prison facilities across the United States are attempting to meet the health care needs of offenders, most are in need of attention. The following recommendations may prove helpful to prison administrators when considering health care options for those in their facilities:

1. Providing safe and appropriate health services. Health services, including gynecological and dental clinics, should be appropriately equipped, supplied and maintained. Health care service providers should be trained to follow the guidelines of universal precautions and medical practices to prevent the transmission of various diseases. Additionally, it is imperative that prison health centers provide consistent and timely medications and therapies for the specific health care need(s) of inmates.

2. Encouraging and supporting the participation of prisoners. The involvement of prisoners in developing and providing health services increases the capacity of prisons to respond to the health care needs of those in their custody. For example, health authorities in prison should encourage and support the development of peer-based education initiatives and educational materials designed and delivered by prisoners themselves. Prison authorities should also encourage the development and support of self-help and peer-support groups that raise the issues of, for example, HIV/AIDS from the perspective of the incarcerated themselves.

3. Promoting an effective national response to meet the needs of people in prison. It is essential that the correctional administrative system in any given jurisdiction work and collaborate with other relevant community groups, government agencies and national

programs for addressing the health, social and other needs of prisoners in general and, in particular, for special populations in prisons.

4. Creating better treatment and service programs outside of prison. These services should be offered on a sliding scale, accept all forms of insurance, and give payment options if they cannot afford the care. It is imperative to create better health care services, substance abuse treatment programs, therapy services, and other related services in order to provide assistance and coping skills to help with the specific health issue(s). If communities were able to provide these programs and services before incarceration there might be hope that it would lower the incarceration rate as they would be treated for the health-related issue that may have contributed to the person getting in trouble with the criminal justice system in the first place.

5. Continuity of care once released. Every inmate needs access to better services in order to help them make a successful transition back into to the community, resist relapse to substance (ab)use, and avoid a return to high-risk behaviors. This is especially true for inmates who have a variety of health challenges, who might benefit from a wide range of services, which could include continuity of health care, stable housing, drug treatment, assistance in gaining eligibility for benefits, and job training and placement services.

For decades, the U.S. health and criminal justice systems have operated in a vicious cycle that in essence punishes illness and poverty in ways that, in turn, generate further illness and poverty. Individuals in the community with under- or untreated disease, particularly addiction and mental illness, often find themselves in a cycle that is driven by criminal justice approaches instead of medical or therapeutic approaches—a cycle that exacerbates rather than alleviates the original health problems and increases risks of recidivism and unresolved health disparities.

It is understandable that many individuals are frustrated by the state of the health care system in the United States. Some might say that the system is broken and in desperate need of reform. But, those that are incarcerated do not have the ability to drive to the nearest emergency room or call for assistance when faced with a serious medical need; they must rely on prison officials in that instance. Thus, providing some measure of oversight to ensure that inmates receive basic health care access for serious illness or conditions seems reasonable.

The real public health research need is not only for understanding specific or even coexisting health conditions but also the structures of health care and prevention before, during, and after incarceration. It appears critical to understand better who is delivering care to the incarcerated and how well, which alternatives to incarceration and transitional programs have proved most effective, and which social programs may mitigate the community health effects of both incarceration and reentry.

As noted in this article, recommendations for the effective provision of health care and services in prisons are plentiful. They are found in the standards and guidelines of the American Correctional Association and the National Commission on Correctional Health Care, in court rulings, expert reports, and in a voluminous professional literature. What is lacking in prison health services is not knowledge about what to do, but the resources and commitment to do it. Compassion, common sense, fiscal prudence, and respect for human rights dictate a better approach to the treatment of persons with health care needs in U.S. prisons than is evident today.

11. Closing Remarks

Just because someone is imprisoned in a state or federal prison does not mean they should be cut off from basic human rights. Unfortunately, inmate health care tends to fall toward the bottom of the priority list at budget meetings. A study published in the American Journal of Public Health (Kouyoumdjian et al. 2015) found that providing prisoners with adequate health care while behind bars and when they are released can also help improve public health. “Improving health in people in jails and prisons can also improve the health of the general population, improve the safety of our communities, and

decrease health care costs," Dr. Fiona Kouyoumdjian, a postdoctoral fellow with the Centre for Research on Inner City Health of St. Michael's Hospital, said in a statement. "For example, treating infectious diseases can prevent ongoing transmission, treating people with mental illness can decrease crime, and providing access to primary care can cut down on expensive emergency department use."

There is no doubt that the provision of health-related services to inmates will provide increasing burdens for the nation's correctional systems. Their response to this challenge will be influenced by fiscal realities, court mandates, humanitarian concerns, and the public beliefs as to the treatment deserved by inmates. However, correctional systems cannot be expected to take full responsibility for addressing the health care problems in correctional facilities. Public health departments, educational and research institutions, community-based organizations and other service providers have critical roles to play as well and there is a need for increasing collaboration among these entities. While there are differences in philosophy and priority among these organizations, to be sure, there are also growing examples of overcoming the barriers and forging successful collaborations to provide needed services, to inmates and releasees, to benefit the public health and serve the interests of society. Why should we care about these prisoners? It must be remembered that most prisoners are released from prison and reenter the free society. Without programs to address their multifaceted health-related needs, our prisons will be returning high-risk (not in a criminal sense) individuals to the free community. We can invest now or pay later.

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