

# The Spiral of Risk: Health Care Provision to Incarcerated Women

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## **ABSTRACT**

By law, prisoners in the United States have a fundamental right to receive adequate health care. However, most prisoners in this nation face numerous obstacles when attempting to receive quality health services. This is especially true for incarcerated women, who suffer from physical and mental health disorders at rates higher than incarcerated men, yet receive fewer targeted services. The state of California leads the nation in the number of women it incarcerates, second only to Texas. The vast majority of these women are in custody for nonviolent, drug-related offenses, and few receive adequate health care.

Female offenders commonly face a wide range of serious health problems including substance abuse, infectious disease, mental illness, hypertension, asthma, and diabetes. Their health problems typically predate their involvement in the justice system, are often exacerbated while they are imprisoned, and continue to deteriorate after release. Furthermore, the majority of women in custody are racial and ethnic minorities, who receive inadequate or inappropriate health services that fail to be culturally competent.

This paper presents the results of an intensive investigation of the health care delivery system for women imprisoned in California. We characterize the current system for providing health care to incarcerated women in California and address gaps in current service provision and cultural competency. We conclude by outlining a strategy to improve quality and access of holistic health care within the system and during transition back into the community.

## INTRODUCTION

### **Rights and Legal Regulations**

By law, prisoners in the United States have a fundamental right to receive adequate health care. The Constitution is meant to protect prisoners from cruel and unusual punishment, including the unnecessary affliction of pain due to the denial of essential medical attention. When prisoners suffer because of negligence of correctional staff and low-quality medical care, their rights are clearly violated. State laws attempt to regulate provisions to health care services for inmates. In California, penal code sec 6030 states that prisoners have the right to health care, sanitary conditions, and advice from medical, dental, or mental health professionals. The California Code of Regulations Title 15 outlines emergency and basic health care services and the California Department of Corrections (CDC) Comprehensive Policies and Procedures, which is based on the Plata Settlement, provides specific health care regulations. Correctional facilities are legally responsible for making these provisions.

### **Explosion of Incarceration**

On a national scale, the rate of increase in the number of incarcerated women has consistently exceeded that of men for more than a decade (Amnesty, 1998). Much of this increase is due to “tough on crime” policies and legislation enacted as part of the War on Drugs (Casey and Wiatrowski, 1996). These policies have affected women disproportionately, because women are more likely to be incarcerated for drug-related or petty, nonviolent property crimes. Before the advent of mandatory minimums for drug sentences, these crimes would not have warranted imprisonment, but now judges usually have few options. Without judicial discretionary authority, sentencing ignores common mitigating factors for women.

California’s population of women inmates continues to grow as well. With over 10,000 incarcerated women, California has the second largest population of women prisoners in the nation—most states have less than 3,000. California prisons are overflowing with mothers (64%) and women struggling with drug problems (80-85%). However, growth in health care for women has not kept pace with the expansion in incarceration. Effective drug rehabilitation programs are rare in comparison with the explosion of drug-related sentences. Only 15.2% of women participate in the substance abuse treatment program for parolees (Little Hoover Commission, 2004). There is a growing gap between the care that women need and the care that they receive. Therefore, it is essential to address these obstacles and disparities and evaluate the effectiveness and quality of health care.

### **Nature of Women’s Crimes**

The vast majority of women prisoners are confined for drug offenses, property crimes, and public order crimes. Therefore, their sentences are relatively short, and they are soon released into the community. Women parolees released in 2003 served an average of 14 months (Little Hoover Commission, 2004). However, nearly 20% of women entering California prisons are parole violators returning to custody for technical violations of their release conditions (Little Hoover Commission, 2004). In 1998, more than half of the returns of women to prison for parole violations were for drug offenses (Hall, 2001). Women’s substance abuse problems are not being addressed in prison and, therefore, contribute to future crime. Very few programs exist to effectively reintegrate inmates into

the community. In 1997, the only federally-funded drug treatment program with an aftercare component in California was Forever Free (Bloom, 1994).

The second largest group of women returned to prison for property crimes. In comparison to men, more women were unemployed before they were arrested, and most leave prison without necessary job training. Only 40% of women had a fulltime job before they were arrested compared to 60% of men, and, while only 8% of men were on welfare, 30% of women received aid before they were incarcerated (BJS, 1999). This cyclical nature of imprisonment is not preventing crime nor protecting society, rather it is moving women in and out of prison through what is termed the “revolving doors of justice.”

## **Health Problems**

While in prison, few women receive adequate health care or treatment, and when they return to their communities their health often deteriorates. Female offenders commonly face a wide range of serious health problems including substance abuse, infectious disease, mental illness, hypertension, asthma, and diabetes. In a study of 151 women inmates, 61% required medical treatment for one or more problems and 45% required mental health treatment (Acoca and Austin, 1996). Even though both men and women experience similar rates of substance abuse problems (80-85%), women have higher rates of using drugs regularly the month prior to arrest and while the crime was committed (Little Hoover Commission, 2004). Women’s prisons in California also have a higher percentage of inmates who are HIV positive, 3.5% versus 2.2% (Little Hoover Commission, 2004). Yet, many prisons lack quality services and are unable to accommodate these health needs, so many women continue to live without necessary care (National Institute of Corrections, 2002). Moreover, health problems that are not cared for during imprisonment often get worse and continue to be untreated after release. Outside of prison, these women frequently experience extremely limited access to health care. Their health problems typically precede their involvement in the justice system, are often exacerbated while they are imprisoned, and continue to deteriorate after release.

## **Obstacles to Health Care**

Most prisoners in the United States face numerous obstacles when trying to access quality health services. First, institutional policies often deliberately limit inmates’ access to get medical assistance. Many prisons have implemented the “sick call” system, which requires inmates to stand in long lines while they wait for a doctor. This system deters prisoners who are ill or physically unable to wait in line from seeking help. Since security procedures limit prisoner’s ability to access medicine, or even basic necessities for self-care, minor problems are often left untreated, leading to more dangerous and costly health care problems (Acoca, 1998). Second, qualified doctors are less likely to work in prisons due to undesirable conditions and less pay (The Correctional Association of New York, 2000). Third, a lack of cultural competency limits the availability and quality of medical assistance to a large portion of women in prison. For example, almost 75% of incarcerated women in federal prisons are minorities. (Thirty-five percent are African American, 32% Hispanic and 4% other (BJS, 2000).) Without translation services, women who do not speak English are unable to fill out necessary forms, communicate their health problems, or fully understand the diagnosis and treatment recommendations (Stoller, 2001).

## **Disparity among Facilities**

Women are especially affected by these obstacles because they suffer from physical and mental health disorders at rates higher than incarcerated men, yet receive fewer targeted services. The percentage of women inmates who use the “sick call” system is double that of men. Similarly, women receive counseling and psychotropic medications twice as often as men (Little Hoover Commission, 2004). Women inmates represent only a small percentage of the overall prison population in the US, about 6%. They have fewer facilities, fewer programs, and fewer adequate opportunities to engage in meaningful rehabilitative activities (BJS, 2000). In a survey of 52 correctional departments nationwide, only 27 provided substance abuse treatment programs for women, only 19 had domestic violence programs, only 9 offered programs for sexual abuse victims, and only 9 had programs for women’s health education (Amnesty, 1998).

## **Unique Characteristics**

Rigid sentencing guidelines fail to recognize the inherent differences between men and women involved in the justice system. Women prisoners have unique characteristics and specific needs. The plight of incarcerated mothers is of special importance. Half of the women imprisoned in California were taking care of their children at the time of their arrest, and two-thirds of these women were single mothers (Little Hoover Commission, 2004). Incarcerated mothers experience high levels of depression during incarceration, and anxiety related to reunification during reintegration (Morton, 1998). Once released, many incarcerated women have few economic opportunities because they have limited job skills, education, or support and turn to crime as a means to provide for their children (Owen, 1995).

The separation of a woman from her children not only affects the mother but has a substantial impact on her child’s future as well. Children of inmates are five to six times more likely to become incarcerated than their peers (Bloom, 1993). Ten percent of children with incarcerated mothers are forced into the foster care system, and 11% experience at least two changes in their care givers (Dressel, 1998). Often women are sent to prisons far from their homes, making it difficult for children to visit. In the federal system, only half of the incarcerated mothers receive visits from their children (Casey, 1996). Furthermore, noisy prison environments detract from the quality of visits. These stressful and lonely places create lasting negative effects on both the mother and her child.

Another characteristic of women in prison is victimization. While only 16% of male prisoners have histories of abuse, 57% of female prisoners were physically or sexually abused before their incarceration (Little Hoover Commission, 2004). The effects of harassment in prison are often compounded when women have histories of victimization (Amnesty, 1998). Without specific treatment, issues go untended and often get worse. Hence, the prison system not only neglects to adequately treat mental health issues but exacerbates them.

## **Statement of the Problem**

The nature of female criminality is different from that of men. Incarcerated women have special needs including childcare responsibilities, long histories of victimization, and drug abuse—all of which compromise women’s health when left untreated. As the number of women entering jails and prisons continues to rise in a dramatic fashion, the need to address their unique circumstances

becomes increasingly pressing. It has never been more urgent for California to examine its current system and reform its gender-blind health care policies.



## METHOD

### **NCCD's Women and Prison Project**

One of NCCD's main areas of focus is the Women and Justice Initiative, the cornerstone project of which is The Women and Prison Project: Year One Prisoner Profile. This research is intended to focus public attention and galvanize political opinion toward meaningful prison reform for women and girls. Overall, the goals of this project are to reform sentencing laws and correctional practices, stressing community-based alternatives to incarceration.

NCCD conducted interviews with key stakeholders who have an interest in issues related to incarceration practices and health care. Stakeholders include representatives from local jails, health care providers, and community leaders, as well as formerly incarcerated women and their families. Fifty-one stakeholders were interviewed.

Findings were used to develop a strategy to sustain long-term system change surrounding the health care of incarcerated women and girls in California. It is NCCD's intention that these findings serve as a catalyst for a correctional health care movement for incarcerated women. Currently, policy makers, the media, and even social activists working on this issue are not well informed about the facts related to the health care of incarcerated women. Recommendations will be used to facilitate planning for the specific types of remedies that are needed.

### **Paper Focus and Research Objectives**

The focus of this paper is to present the findings from interviews conducted with key stakeholders who are involved in issues related to health care and incarceration.

- Characterize the current system and its provision of health care for incarcerated women in California.
- Identify and address gaps in current service provision and the lack of cultural competency in health intervention programs.
- Determine the ramifications of current practices in health care delivery to incarcerated women.
- Outline a strategy to improve quality and access of holistic health care within the system and during transition back into the community.

### **Women and Prison Advisory Panel**

To help guide our work, NCCD has convened a panel of 14 representatives from San Francisco Bay Area community-based organizations and correctional institutions, including formerly incarcerated women. Each panel member is doing tremendous work with women and girls involved in the criminal justice system. The panel met quarterly to participate in strategy discussions and to provide a critical eye to the work we produce. Specifically, NCCD wanted to ensure that the planning and data collection procedures, policy developments, and publications were guided by the panel's consensus. Their feedback has been invaluable.

## **Sample**

To determine the study's sample, an intensive literature review and internet search was conducted to identify key stakeholders working in the area of health care and the justice system in California. Referrals were also collected from NCCD's Women and Prison Advisory Panel. Key stakeholders include health care providers working both inside and outside correctional facilities; former prisoners and their families; attorneys and legal service providers; prison and health care advocates; religious, adolescent, and substance abuse service providers; policy makers; and other researchers and academics. Contact and organizational information was collected and stored in a Microsoft Access database specifically designed for the purposes of this research project. Stakeholders were selected from the database to participate in an hour-long telephone interview. Project staff mailed a letter to each stakeholder, which outlined the project and requested their participation in the study. Then, a follow-up call was made to solicit participation and schedule an interview time. Project staff interviewed a total of 51 key stakeholders.

## **Data Collection and Analysis**

To gather information specific to this project, NCCD developed the Stakeholder Interview Instrument (see appendix A). The instrument is open ended and designed to cover a range of broad topics including stakeholder's background; physical, mental and reproductive health issues of women in prison; the quality of health care service delivery and staffing; gaps and barriers to service; cultural competency and health care rights; and recommendations for improvement and model programs. The interview instrument was reviewed by NCCD research staff and by NCCD's Women and Prison Advisory Panel. Each interview took approximately 60 minutes to complete. Interviews were taped and later transcribed.

Key themes from 51 completed interviews were extracted and analyzed. Findings are presented. When necessary, information from the literature review was used to help explain key themes and supplement findings needed to develop policy recommendations.

## FINDINGS

The institutionalization of sexist, racist, and classist policies affect the fundamental structure of American society and thus, the current model for corrections, and the incarceration of women in the United States. These systemic flaws manifest themselves in destructive ways that perpetuate the status quo: the cycle of violence and incarceration, the criminalization of the mentally ill, the demonization of prisoners, a pervasive belief in punishment over rehabilitation, and the male centric model for corrections. These flaws result in the neglect of health care rights of incarcerated women. A solution to these problems begins with gradual, deliberate movement towards effective and long lasting systemic change. In keeping with this vision, NCCD seeks to identify specific problems and viable solutions to improve health care for women in California's prisons.

In the next sections, NCCD will characterize the current system of health care provision to incarcerated women and provide evidence-based recommendations for improvement.

### **I. PROCESS OF ACCESS TO HEALTH CARE**

Stakeholders describe three methods by which an inmate can access health care—the co-pay form, sick-call, and emergency care. These practices are structured to discourage utilization of services by creating unnecessary bureaucratic and financial obstacles for prisoners.

#### **Co-pay Form**

To schedule a non-emergency appointment, the inmate must fill out a co-pay form. The form requires a written explanation of patient symptoms and the reason for the request. Medical personnel collect the forms each morning for review, and after judging the relative importance of requests, schedule appointments. Women with low literacy levels and poor writing skills have serious difficulty completing co-pay forms properly. Often, they are unable to communicate the scope or nature of their symptoms, which increases the risk of potentially dangerous time-delays, and an incorrect assessment of their condition. In fact, according to stakeholders, appointments are frequently scheduled several months after inmates submit requests.

#### **Sick-call and Hot Meds**

Sick-call is a daily procedure designed to provide an inmate with same-day treatment for pressing medical issues. The process requires women to go to the medical department, sign in, and wait for hours outside, regardless of weather conditions, to receive treatment. Thus, sick women are subjected to extreme highs and lows in temperature, and pouring rain. Stakeholders also report women being wheeled to these lines in carts by fellow inmates because they were too ill to stand in line during the required waiting period. Additionally, sick-call is frequently cancelled. On these days, women who are ill and require medical documentation excusing them from work are left without recourse.

A similar policy is in place for women to receive a variety of medications—classified as Hot meds—they are not allowed to keep in their cells. Women with prescriptions for Hot meds are forced to stand in long lines two to three times a day, depending on their regimen, to receive their medicine. In some cases, these women are forced to forgo dinner and other activities while they wait in line. The structure of the hot meds policy makes it almost impossible to follow the prescribed schedule

for one's medication regimen. This can have drastic effects for serious illnesses, such as HIV/AIDS, that require very complicated and precise drug regimens, which, if not followed, greatly reduce the efficacy of treatment.

### **Emergency Care**

Emergency care is the only medical treatment available without charge. Prisoners experiencing medical emergencies, however, are not allowed to contact medical staff directly. Instead, a prisoner must convince a guard that has little or no medical training, of the seriousness of her condition. The staff member, in turn, must convince medical staff that the prisoner requires immediate medical attention. It has been reported that staff members are so convinced of malingering (fabrication of symptoms) behavior on the part of the imprisoned woman, that they ignore pleas for medical attention. Such policies of neglect have led to tremendous suffering; several stakeholders recounted deaths of women whose pleas for medical attention were ignored by prison guards.

### **Five Dollar Co-pay Charge**

Another obstacle to health care is the five dollar co-pay fee that incarcerated women must pay for each medical visit. Although follow-up care and emergency treatment are theoretically exempt from the co-pay charge, prisoners often end up paying for these services as well. Five dollars may appear reasonable according to co-pay policies outside prison, but the extent to which this practice undermines access to health care is actually quite large. For women with no real financial income and a host of other expenses, this charge is a heavy monetary burden that functions as a fine for seeking treatment. Stakeholders indicate that in some cases, women are forced to make the decision between medical attention and other necessities such as hygiene products. Because inmates don't report health problems to avoid co-pay charges, their medical conditions worsen and require more expensive treatment. Ironically, rather than saving the CDCR money, the co-pay system actually ends up increasing expenditures (Stoller, 2001).

## **II. GAPS IN CURRENT SERVICE PROVISION**

### **Mental Health**

According to stakeholders interviewed, mental health treatment constitutes the largest gap in health care service provision for incarcerated women. While the Little Hoover Commission of 2004 cited almost a third of women in California's correctional system as having some kind of mental health problem, stakeholders estimated this figure was actually a great deal higher.

Mental health problems often land women in prison in the first place, and if left untreated, are likely pull them back behind bars. Prisons function in lieu of mental institutions for many low-income people. Incarcerated women are often imprisoned for symptomatic deviance, rather than placed in mental institutions or drug rehabilitation programs to address their underlying illness. Due to the relationship between mental illness, incarceration, and recidivism, mental health treatment is especially critical. Stakeholders cite mental health issues as a principle barrier to rehabilitation and cause of recidivism. Lack of treatment and exacerbation of mental illness within prison walls make women much more likely to become repeat offenders once they are released.

The most common mental health issues affecting women in prison are depression, anxiety, post-traumatic stress disorder (PTSD), and substance abuse. However, interview respondents have suggested that substance abuse is not a mental health problem in and of itself; rather it is a coping strategy for dealing with underlying issues of abuse and poverty.

Incarceration can exacerbate and even cause mental health problems. There is an inherent contradiction between mental health and the punitive nature of prison. Conditions undermining mental health include isolation, separation from family and children, loss of personal freedom, loss of sexual outlets, an atmosphere of punishment that decreases self-value, and psychological, physical, and sexual abuse. Separation from children, in particular, was cited by respondents as one of the greatest traumas to women prisoners, and a leading factor in their depression. Abusive conditions within prison walls are especially harmful for the countless women with PTSD, who have been previously victimized. Perhaps the single most damaging practice for mentally ill women, whose symptoms are often labeled as illicit behavior, is their inappropriate isolation in Security Housing Units (SHU). These cells employ mental torture as a means of punishment.

### ***Treatment***

Addressing mental health is also critical because of the ways in which mental health problems inform other physical health issues. Mental attitudes and emotional well being are often critical components of prevention and treatment for physical illnesses. Additionally, women experiencing mental illness are more likely to engage in unsafe practices that jeopardize their reproductive health.

Stakeholders believe that prison staff dismiss the significance and repercussions of mental health issues among prisoners. This disregard leads to grossly inadequate services. Counseling and intervention programs that address drug addiction are severely limited, such that only a small portion of the overwhelming population of substance abusers receives services. Preventative care is similarly scarce, illuminating a policy of reactive measures that address only acute symptoms without targeting underlying causes of poor mental health.

One of the most obvious ways in which the underpinnings of mental illness are ignored is the manner in which medication is prescribed as a substitute for mental health treatment. Some facilities do not have mental health counselors, only psychiatrists prescribing drugs. As a result, many prisoners receive only medications and no therapeutic interventions. Respondents also mentioned medical sedation as a method of controlling prison populations.

The lack of confidentiality and mandatory reporting policies governing mental health staff contribute to an atmosphere of mistrust among prisoners, and can seriously inhibit the efficacy of mental health treatment. Similarly, prisoners fearing punitive repercussions find it difficult to reveal their personal histories and speak truthfully to counselors with correctional affiliations.

### **Reproductive Health**

Incarcerated women are especially at risk for reproductive health problems due to histories of sexual abuse, high rates of sex work, and prior limited access to health care services and education. Unfortunately, reproductive health services within California's female prisons are severely deficient, and reveal significant gender bias generated by a male model of correctional health care.

There is no systematic or routine administration of mammograms, pap smears, or comprehensive STD screening. Chlamydia has become a significant problem among incarcerated females, particularly youth, who experience the highest rates of infection. Chlamydia is a particularly insidious disease that is often asymptomatic, but can lead to infertility when left untreated.

Despite the fact that routine pap smears assist early detection and treatment of cervical cancer, they are not routinely administered. When requested, the waiting period can exceed six months. Given the personal and invasive nature of this procedure, the behavior of staff is critical in establishing comfort levels for patients. Yet women in California's prisons are not afforded their legal right to request attention by female staff, and respondents report that treatment by a largely male staff is rough and abusive, with instances of using an over-sized speculum, and performing exams in abrupt, forceful manners. Further, upon completion, abnormal test results are often ignored, and women are denied both notification and necessary follow-up care.

Stakeholders also report horrible prenatal care. Some pregnant women, of whom many are considered high risk, do not see obstetricians nor do they receive sonograms. Concerns such as high blood pressure, lack of fetal heartbeat, and vaginal bleeding are often ignored, despite the relationship of these conditions to late-term miscarriage, premature delivery, still birth, and severe health problems for infants. Pregnant women are shackled for transport to outside hospitals; some remain shackled during delivery, violating international human rights standards. Adoption agencies then surface, offering women small financial gifts and other verbal manipulations in exchange for their babies. These women, who have just endured the trauma of childbirth and may be unable to make informed, coherent decisions, are coerced into giving up their children. The separation of a mother from her child can cause serious mental trauma to both the mother and infant, as well as serious physical repercussions for the child.

The lack of reproductive health care is indicative of a larger disregard for the reproductive status of incarcerated women, and translates into one of the cruelest forms of medical neglect. One stakeholder reported that invasive gynecological procedures are conducted without full consent or knowledge of the women, sometimes resulting in forced or coerced sterilization.

## **Physical Health**

### ***Chronic Illness***

Common chronic illnesses of incarcerated women include asthma, heart disease, high blood pressure, insulin-dependent diabetes, epilepsy, and various forms of cancer. Current health care services are inadequate and fail to address these and other serious illnesses.

### ***Infectious Disease***

Hepatitis C, HIV/AIDS, staphylococcus infections, and sexually transmitted diseases were cited by stakeholders as the most prevalent infectious diseases. Although tuberculosis is commonly understood as a problem in prison populations, as was mentioned by some stakeholders, the majority of stakeholders reported that tuberculosis is no longer a serious concern because outbreaks are rapid and place prison staff at risk, and are therefore prevented. Consequently, tuberculosis is the only infectious disease for which a solid testing protocol is in place.

### ***Treatment***

The discrepancy between treatment protocols for tuberculosis and the remaining infectious diseases is vast. Characteristics such as drug use, number of sex partners, condom use, and age of sexual onset, put incarcerated women at risk for many diseases before they even enter prison. Their risk amplifies significantly when compounded with the poor sanitation and overcrowding of correctional facilities.

Hepatitis C, in particular, has alarmingly high rates of incidence in prison. Nevertheless, there are no system-wide prevention, treatment, or counseling protocols in place. Respondents report numerous instances of women being tested, but not informed of their positive status. Even when notified, the lack of treatment mitigates the benefits of knowing about the status. Rather, women are ostracized by staff and inmates alike, as the lack of confidentiality of test results exposes them to this stigma. Prisoners affected with HIV and Hepatitis C are further disadvantaged because they cannot access newer, experimental treatments that are widely used in community settings, and are generally more effective.

Staphylococcus infections are easily transmitted through unsanitary conditions, and increase in frequency after surgery, due to poor follow-up care. Staphylococcus infections can be fatal.

### ***Medications***

A critical component of treatment is medication. Unfortunately, stakeholders cite one of the most frequent complaints among women prisoners is a delay in receiving their medication. In fact, women with medical problems that require daily medication, such as heart disease, high blood pressure, and asthma, often experience delays for days at a time. Women with Hepatitis C and HIV have precise medication regimens; disruptions are incredibly hazardous and can significantly shorten lives. In addition, pain medication is notoriously difficult to obtain, even for women recovering from surgery or suffering from a terminal illness. When a person in such extreme pain is granted palliative medication, they are required to endure the Hot meds process.

### ***Dental and Vision Services***

Gaps in health care include vision and dental services. Eye care is rare, as many incarcerated women cannot afford exams or eyewear. Dental health is a particular problem, especially for women who have experienced a lifetime of dental neglect and suffer from methamphetamine and other drug addictions that cause significant dental problems. Cleanings are rarely administered, and root canals and other basic dental procedures are not offered. Instead, tooth extraction is the main form of treatment. Waiting periods to receive dentures and other needed care are sometimes up to a year, forcing women to endure great pain.

## **III. CONTINUITY OF HEALTH CARE**

Chronic diseases, particularly cancer, have a profound effect on the physical health of incarcerated women. These negative effects are exacerbated due to the lack of continuity of care in California's facilities. Specifically, this lack refers to the inadequate and inefficient medical care provided to women at every stage of health care service.

## **Preventive Care**

Prevention efforts allocate resources most efficiently, and promote the highest levels of physical and mental well being. Women's prisons employ virtually no prevention services, despite their known benefit.

### ***Nutrition and Exercise***

Stakeholders report inadequate nutrition levels in prison food, as well as limited options for physical activity. Heart disease, high blood pressure, and diabetes—all diseases that affect imprisoned women at high rates—frequently develop as a result of poor nutrition and exercise. Given the increasing numbers of women serving longer sentences, the effects of poor nutrition and exercise are also rising.

### ***Routine Screening***

Because of physiological differences, women require far more routine screening processes than men to maintain good health. Yet preventive procedures within women's prisons are limited, only available upon an inmate's request, and generally involve waiting periods of at least several months. Stakeholders report waiting periods of almost a year for procedures, such as the pap smear, that are supposed to be administered every six months. Cancer, particularly reproductive cancer, often goes undiagnosed and untreated until the imprisoned woman is in a very serious condition beyond assistance. Respondents attribute a high proportion of health related-deaths among women prisoners to cervical cancer.

### ***Education***

Compounding the problem is the reality that incarcerated women do not request routine screening procedures because they lack the health education to know to do so. They have little chance of learning this information in prison.

## **Follow-up Care**

There are numerous gaps in the provision of follow-up care. Abnormal test results, including pap smears, are often either completely ignored or addressed after time delays that have already caused irreparable damage to the woman's health. It is not uncommon for test results to be misfiled, so that neither the inmate nor the doctor, know the results. Even in instances where women have self-referred with breast lumps or discharge and abnormal bleeding, they have waited months before receiving further testing and care.

Doctors also frequently ignore the recommendations of the previous doctor for follow-up tests and treatment, particularly if the first doctor is from an outside agency. The lack of individual accountability is also a problem, as no specific staff member assumes responsibility for ensuring the completion of the doctor's recommendations. An inmate might not receive a prescribed wheelchair, for example, because no specific staff member is accountable for ensuring that the wheelchair was ordered and delivered. The lack of responsibility is also evident in the careless post-operative attention female prisoners receive. Prisoners are often neglected after surgery, with bandages left unchanged and "call bells" unanswered.



## **Transitional Care**

The poor follow-up care received in correctional facilities parallels the lack of transitional care provided for women released from prison. The process of transition out of prison offers no continuity of care for incarcerated women. Once released, women are not directed to community resources that will allow them to access health care. Furthermore, these women are generally unequipped to navigate the bureaucracy of health care outside, and are flooded with a host of other life management concerns. They face the challenges of finding housing or jobs, and reunifying with their children. Additionally, few women receive substance abuse treatment upon release. Available substance abuse programs for released women can treat only a small portion of the women who actually need drug addiction treatment. Without adequate transitional services to address those needs, health care is of relatively low concern.

A woman released from prison is abruptly disconnected from even those meager services. Immediately upon release, women are taken off their medications, are no longer allowed access to their medical histories, and do not receive notification of abnormal test results that surface even a day after their release.

## **Communication between Staff and Institutions**

The lack of connection and communication between institutions and among staff causes fundamental barriers to proper continuity of care. According to stakeholders, medical records are often not transferred or are lost entirely when an incarcerated woman moves from one facility to another. Accordingly, prescriptions are also generally discontinued upon transfer between institutions. Women must also be re-diagnosed for diseases and receive new treatment plans, all processes that waste resources and lead to delays during which the woman's illness may worsen. Procedures that should have been completed during follow-up care must be completed once again during initial visits, forcing women to waste time and pay additional co-pay fees.

Generally, employees fail to communicate effectively. Nurses and doctors rarely make functional notes for one another in patient files, leading to poor documentation of patient histories, which can seriously impede quality of follow-up care.

## **IV. QUALITY OF STAFF**

Some medical employees within corrections facilities are altruistic and hard working. It is crucial that these employees be supported and provided incentives to maintain their services. However, interviews revealed that the majority of medical staff in women's correctional facilities are inadequate, unqualified, and underpaid. Since employees essentially work as gatekeepers of health care services, low-quality staff translates into low-quality health care provision.

### **Positions**

Although the number of staff and positions vary among facilities, the basic structure remains the same, with positions in administrative supervision occupied by the Chief Medical Officer (CMO) and Health Care Services Manager. Medical Technician Assistants (MTA), nurses, technicians, and doctors provide the actual medical care. The practices of MTAs were frequently reported as detrimental to quality care.

MTAs illustrate most clearly the incompatibility between correctional and medical duties. They are essentially custodial staff with less than twenty hours of medical training that they acquire to increase their salary as correctional officers. As members of the guard's union, they wear their custodial uniforms over their medical ones to assert their allegiance. Despite their lack of qualification, they perform triage, determining whether or not a prisoner requires medical care. Due to their overwhelmingly negative attitude towards prisoners, MTAs often assume women are malingering or complaining unnecessarily. Stakeholders have cited numerous occasions of critically ill women who have been refused treatment by MTAs, with several deaths resulting from these incidents.

### **Distribution of Resources**

Correctional facilities are often viewed as necessary components of society. As such, they are heavily funded. However, when it comes to adequate health care provision to incarcerated women, the ways in which correctional facilities distribute their resources is inherently ineffective. A striking example of an insensible practice involves salary: correctional officers without medical training are often paid more than prison doctors, as are guards with limited medical training.

### **Attitudes**

Many medical staff exhibit hostile behavior toward incarcerated women seeking health care. Hostility inhibits appropriate patient-doctor relationships and permeates all aspects of physical, reproductive, and mental health care. One striking example involves a sign hung in a clinic, which mandates that patients complain about no more than two symptoms. Creating such an abusive and suspicious environment further discourages utilization of health care services. All of these practices undermine the coherence and purpose of the medical program, and encourage an environment within which it is virtually impossible to either provide or receive effective health care. Moreover, respondents reported cases of sexual, physical, and psychological abuse of women who are likely to have been previously victimized.

### **Qualifications**

Respondents frequently indicated that the majority of medical employees in women's prisons are under-qualified or lack medical competence. According to a stakeholder, a University of California study found that 25% of prison doctors were incompetent. Another 50% required extensive re-education in order to attain competency. The fact that doctors with revoked licenses are only able to practice in prisons echoes the study's findings. Many medical employees servicing incarcerated women would be legally restricted in providing the same services within communities, precisely because those services would lack in quality.

### **Administrative Limitations**

Women's correctional facilities are large, crowded, and plagued with administrative barriers. The health care delivery systems within these facilities are no exception. Often, vital medical information is excluded from patients' files, even though documentation is required. One particular issue raised in interviews was the inconsistency in note-taking within files. This practice impairs the ability of doctors and nurses to track medical histories. Furthermore, lockdowns and other security measures are detrimental to staff's ability to provide comprehensive care.

## **V. CULTURAL COMPETENCY**

The majority of stakeholders agree that disproportionate minority confinement is a serious issue in women's prison facilities. They estimate that over 70% of incarcerated women are minorities. Therefore, cultural competency, which refers to respect for and understanding of cultures outside of one's own, is a serious concern in improving standards of health care for incarcerated women.

### **Language Barriers**

Cultural insensitivity inevitably worsens language and communication barriers. Many incarcerated women are not proficient in English, and inadequate translation services seriously undermines the quality of health care these women receive. For example, lack of translated co-pay and 602 appeals forms may discourage non-English speaking women from seeking medical assistance. It also eliminates recourse for non-English speakers who wish to protest improper or abusive treatment. Additionally, medical staff, including primary doctors, are often unable to communicate with women in their first languages. This situation jeopardizes the well being of these women who may not be able to effectively communicate their medical problems or understand feedback from staff. Furthermore, medical staff often use the "proper" form of English indicative of higher socio-economic status and higher levels of formal education. Many prisoners have never acquired proficiency in this form of English and may be unable or uncomfortable communicating effectively with medical staff. Different cultures exhibit different forms of literacy and communication, which place them at a disadvantage in the written and verbal expression of their illness.

### **Racial and Ethnic Breakdown of Staff**

The world views and beliefs of racial and ethnic groups impact the way in which they understand illness, express symptoms, view mainstream knowledge and respond to dominant health care modalities. Yet medical staff within correctional facilities are not representative of the ethnic distribution of the female prison population. This cultural gap between provider and receiver of health care services creates serious barriers to adequate health care. Many stakeholders reported the existence of racist attitudes and discriminatory practices among medical staff towards prisoners of different ethnic and racial backgrounds. Several interviews suggest that medical staff, who do not identify with women of color, view these women as dishonest, dirty, unintelligent, and generally undeserving of adequate health care. Furthermore, reports reveal preferential treatment of imprisoned white, middle-class women. In addition, given the historically abusive relationship racialized minorities have experienced with the medical community, stakeholders suggest a general distrust of health care providers by communities of color. All of these factors translate into the inability of incarcerated women of color to create an environment that fosters the trust, communication, and comfort critical to quality health care service.

## RECOMMENDATIONS AND DISCUSSION

Based on these preliminary findings, the stakeholders' strategies for improvement to health care to incarcerated women in California are outlined below. Respondents overwhelmingly reported that the first step toward effective health care provision is the state-wide decarceration of women who do not belong in correctional facilities. Respondents also suggested strategies to improve services within correctional facilities, increase continuity of care, and promote cultural competency.

### I. DECARCERATE AND PROMOTE ALTERNATIVES TO INCARCERATION

#### Special Populations

Women's prison facilities are currently unnecessarily crowded, making the provision of comprehensive health care difficult and costly. A large proportion of incarcerated women are low-level offenders, mothers, disabled, elderly, or chronically ill. In addition, many women undergoing sentencing and at risk for incarceration share these same circumstances. For these populations of women, decarceration and the promotion of alternatives to incarceration are the best endorsements of health and rehabilitation.

*Low-level offenders*—Low-level offenders include women who have been incarcerated due to non-violent drug and property offenses, a large proportion of whom have mental illnesses or substance abuse problems. These women do not pose threats to public safety, and would greatly benefit from interventions in community settings, including substance abuse treatment, counseling, and financial advising. Decriminalization of substance addicted and mentally ill women is a necessary step toward fair and adequate health care provision.

*Mothers*—It is estimated that over half of incarcerated or at-risk women are mothers to children under the age of eighteen (Little Hoover Commission, 2004). Moreover, they are often single parents and are solely responsible for providing parental guidance and care. While in prison limited contact with their children causes mothers extreme stress. Additionally, the children of incarcerated women suffer unimaginable anxiety as a result of prolonged separation from their mothers. They are also far more likely than other children to become involved in the juvenile justice system. It is imperative to consider incarceration alternatives for mothers, and place them back into the community where they will be able to receive quality interventions and simultaneously provide adequate parental supervision and support.

*Compassionate release candidates*— Hospice units within California's prisons exist in name only. In practice, they amount to dismal, solitary rooms where women behind bars wait to die. They do so without health care services that might prolong their lives and increase their comfort. Inmate eligibility for compassionate release- a legal procedure that allows a terminally ill prisoner to be released on parole for the remaining days of her life- needs to be evaluated and applied more liberally. Not only do many women denied compassionate release pose little risk to public safety, their release would save the state considerable expense by placing these women in locations appropriate to the level of care they require. Denying these women some comfort in their last moments of great suffering is inhumane and purposeless.

## Legislative Reform

Legislative reform is crucial to achieving viable, long-lasting systemic change regarding the unwarranted incarceration of women. Particularly discriminatory legislation includes the three strikes laws, mandatory minimums, truth-in-sentencing, and parole revocation policies. These legislative policies ostensibly diminish subjective practices, but in practice, their greatest consequence has been the imprisonment of low-level offending women struggling with drug addiction, abuse, and poverty.

## II. IMPROVE SERVICES INSIDE CORRECTIONAL FACILITIES

### Improve Standards in Health Care Services Quality

Women's correctional facilities do not provide adequate health care, as necessary services are lacking in both availability and quality. This failure compromises the physical, mental, and reproductive health of incarcerated women. The following improvements in the standards of health care provision is essential to the well-being of women in California's prisons.

*Improve Access to Care*—The state should eliminate unnecessary bureaucratic and financial barriers to care. Eliminating the co-pay fee will increase early utilization of medical services by sick women and save the correctional system money. The practices of sick call, co-pay forms, and emergency care must also be dismantled. Alternatives include a sick call system that visits women in their own housing units through same day appointments. Measures must also be taken to assist women who struggle with English literacy in requesting appointments. Emergency care as well should be accessible to all women who feel they require immediate medical attention. A system that assumes the women cannot be trusted cannot provide them adequate health care.

*Promote protocols and policies that protect incarcerated women*—Moreover, protocols and policies that protect incarcerated women should be created to increase standards of service. Such policies should be gender-specific and prioritized according to the specific needs of the women they are intended to serve.

*Increase prevention efforts*—Prevention efforts should likewise be increased to prevent unnecessary health complications and painful conditions. Specifically, exercise and nutritional needs must be addressed, routine screenings should be systematized, and voluntary testing for threatening or infectious disease must be made available and kept confidential.

*Provide quality education*—Another important component in the improvement of standards is the provision of quality health education. Effective education programs would inform women about prevention and coping strategies with which they may be unfamiliar. Health education is effective in maintaining health and addressing disease. Peer education in particular has demonstrated efficacy as well as rehabilitative benefits.

*Prioritize mental health*—There is no doubt that many incarcerated women have been victimized. The prioritization of mental health services is therefore crucial to these women's psychological and emotional well being. To achieve quality mental health services, the availability and quality of counseling and assessment must be increased. Specifically, it is crucial that these therapeutic interventions involve adequate one-on-one interactions with qualified therapists, and do not merely entail the distribution of medication without counseling. Furthermore, these interactions must

remain confidential so that incarcerated women are able to form trusting relationships with health care providers. In addition, the importance of mental health must be recognized and accepted by the correctional system and its employees.

*Prioritize reproductive status*—The promotion of reproductive health is essential to providing effective gender-specific health care. Prenatal care, fertility protection policies, regular feminine care, and access to feminine hygiene must be provided to all incarcerated women. Given that a large proportion of correctional staff are male, issues related to reproductive health may be deemed irrelevant in prisons, when in fact such issues are crucial to women's health.

### **Eliminate Administrative Barriers**

Administrative obstacles are inherent to large institutions, and reduce efficiency. Deliberate steps must be taken to correct for such administrative barriers, especially when repercussions jeopardize the lives of inmates.

*Transfer the provision of health care services to an agency outside of CDC jurisdiction*— A system structured around punishment is fundamentally unable to provide adequate health care to women in prison. Utilizing an agency outside of CDC jurisdiction such as the Public Health Department/Department of Health Services, the UC Medical School system, or other non-profit organizations was most frequently cited by stakeholders as the most important step in reforming health care service provision to incarcerated women. Such a move eliminates problems of dual loyalty and confidentiality for medical staff, ensuring that medical rather than correctional standards govern the provision of health care services. Having community providers result in community standards of care, and establish links with community agencies that facilitate smoother transitions for women upon release.

*Improve standards and responses*—Standards for record keeping should be increased to improve the reliability and validity of patient health care information. Responses to abnormal test results must be systematized in order to prevent serious health complications. Also, protocols should be created to eliminate time delays and facilitate the provision of health care services.

*Promote accountability*—The accountability of correctional facilities and staff must be enforced in order to assure that illegal practices are eliminated. Specifically, the roles and responsibilities of staff should be well defined, and individual staff should be monitored. Additionally, the transparency of correctional facilities with regards to health care should be increased and public awareness promoted. Also, the appeals and grievances process should be improved so that patients can help advocate for the quality of their health care.

### **Improve Quality of Staff**

Oftentimes who determines whether incarcerated women receive health care services are the staff these women come into contact with on a daily basis. Also, the competency and attitude of staff can affect the psychological and emotional states of the women they encounter. As such, it is crucial that staff quality be taken seriously. Specifically, standards of hiring must be improved, and recruitment and retention incentives provided in order to assure that competent and well-intentioned staff are employed. Furthermore, quality training must be provided to ensure that the correct services are administered and positive attitudes are exhibited. Importantly, support should be given to

competent staff already in place, so that they are retained and used as valuable resources in training of new staff. Finally, the use of MTAs—who have virtually no medical training—must be eliminated, as they are not in a position to make meaningful health care assessments for prisoners.

### **III. SUPPORT CONTINUITY OF CARE**

Few female offenders are incarcerated for life, and will inevitably face the challenge of transitioning back into their communities upon release from prison. Formerly incarcerated women face incredible difficulties upon release—trouble finding food and shelter, getting a job, paying the bills, and caring for their children. Health care, therefore, is often a last priority. However, it is incredibly important to provide adequate transitional health care to ensure the safety and health of formerly incarcerated women, their families, and the communities to which they return. In reality health problems can undermine success with all the rest of women’s goals.

Adequate transitional care includes linking incarcerated women with community-based health organizations prior to their actual release from prison. This practice will also facilitate an equally important aspect of effective transitional care: efficient transfer of medical records. These policies will help ensure that incarcerated women’s medical histories are preserved and communicated to health care providers outside of prison. Also, given that many incarcerated women receive medication inside of prison, correctional health care providers must ensure the provision of an adequate supply of medication to women who are released.

In addition, women should be provided education on a range of community resources, and taught how to make use of these resources. Such resources should not be limited strictly to health care organizations. Rather, resources should help formerly incarcerated women successfully make the transition into a healthy and productive life, and can include child care facilities, career and financial advising, social work organizations, and mental health facilities.

### **IV. PROMOTE CULTURAL COMPETENCY**

It is estimated that almost three quarters of incarcerated women in California identify as ethnic or racial minorities (Little Hoover Commission, 2004). Given these demographics, California’s correctional system cannot provide quality health care to imprisoned women without addressing cultural competency. Steps must be taken to prevent both intentional and indirect discrimination, which may result from culturally insensitive policies and practices.

*Provide translation services*—Cultural diversity often means differences in language and communication. It is imperative that both verbal and written translation services be available to women who struggle with English. To deny incarcerated women such access effectively reduces their ability to obtain adequate health care services.

*Representative staff and training*—Corrections staff must be trained on cultural sensitivity to avoid discriminatory practices. Furthermore, efforts should be made to hire staff representative of the ethnic and racial backgrounds of incarcerated women. In this way, an environment of trust and communication can be fostered. These practices would also reduce language barriers, as staff would have better communication with the women they supervise.

*Holistic approach to health care*—The current correctional system provides only allopathic, or “Western,” medical treatment. Some incarcerated women, the majority of whom are minorities, may be unfamiliar or uncomfortable with allopathic interventions; what seem to be normal practices from a mainstream perspective may appear harmful and intrusive to women of other cultures. Therefore, health care services would benefit from the introduction of alternative medical practices in correctional health care facilities.

## **CONCLUSION**

This paper presents findings based on information gathered from key stakeholders working in areas involving women, health care, and incarceration. The study characterizes the current system of health care service delivery to incarcerated women, and provides policy recommendations for improvement. Given that incarcerated women in California face numerous obstacles in accessing quality health care—services, continuity of care, and culturally competent practices are all inadequate—stakeholder recommendations should be implemented to provide a more humane system of health care.



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## APPENDIX: INTERVIEW INSTRUMENT

### WOMEN AND PRISON STAKEHOLDER INTERVIEWS

**[READ]** Through this survey, we would like to get your insights on a variety of healthcare-related issues faced by women in California prisons and jails. The interview is intended to take 30 minutes. Please feel free to voice any questions or concerns you may have about the content of this survey or about our project.

**[READ.]** We'll start with a few questions about your background and experience with issues faced by women in the justice system.

- Q1. First, a very general question: What kind of work related to female offenders do you do?
- Q2. For how long have you been working with issues related to women in the justice system?
- Q3. Do you do this work professionally, or as a volunteer?
- Q4. Briefly, what motivates you to engage in this work?

**[READ.]** Now, I'd like to ask you about **health issues** facing women in California's justice system.

- Q5. What are the three most important mental health issues for women in California jails and prisons?
- Q6. Thinking now of infectious diseases, in your opinion, what are the three most urgent threats to the physical health of women in California jails and prisons?
- Q7. In your opinion, should jails and prisons require testing for infectious diseases for all inmates?

[Interviewer note: Infectious diseases = communicable diseases; e.g. HIV/AIDS, Hepatitis in all forms but especially Hepatitis C (HCV), and Tuberculosis (TB). Also includes STDs and many food borne illnesses.]

- Q7a. (Ask if YES) If infectious disease testing were mandatory, what types of health and mental health services would then be needed?
- Q7b. (Ask if NO) What might be some long-term implications for women in the justice system if communicable disease testing remains voluntary?

Q8. What are the most important reproductive health issues facing women in prison?

Q9. What, if any, are other significant health issues facing women in the justice system?

[Read.] In this next section, I'd like to gather your insights about **healthcare service delivery** to incarcerated women.

Q10. Do you feel that women's jails and prisons have enough quality staff to handle the number and severity of health issues faced by incarcerated women?

Q10a. (Ask if Q10 = NO.) What recommendations would you make to improve the quality of medical staff at women's prisons and jails?

Q11. Do you feel that prisons and jails offer an appropriate selection of services to meet the healthcare needs of incarcerated women?

Q11a. (Ask if Q11 = NO) What services are missing?

Q12. What are the major barriers to healthcare service delivery to incarcerated women?

Q13. What recommendations would you make to promote culturally-competent health care to women in the justice system?

Q14. What would an ideal system of health care service delivery to incarcerated and paroled women look like?

Q14a. What barriers exist to implementing the system you've just described?

Q14b. At a minimum, what *should* a health care service delivery system for women in prison and on parole look like?

Q15. What are the gaps in the continuum of healthcare services for women in the justice system? In responding, please consider the healthcare system as a whole, in addition to the areas we have specifically talked about.

Q15a. What factors contribute to each of these gaps?

Q15b. What can be done to close each of these gaps?

- Q16. What are the most serious consequences of inadequate healthcare service delivery for the families and communities of incarcerated and paroled women?
- Q17. What are the most serious consequences of inadequate healthcare service delivery to female prisoners and parolees *for the corrections system*?
- Q19. In your opinion, what, if any, are the pros and cons of privatizing healthcare service delivery to women in prison?

In this last section of the interview, I would like to direct your attention to the **future of healthcare service delivery** for incarcerated, jailed and paroled women.

- Q20. In your opinion, what, if any, are the most important positive developments involving healthcare delivery to incarcerated women?
- Q21. In your opinion, which approaches and mechanisms, if any, are most effective in *enforcing* prisoners' rights to adequate health care?
- Q22. What are the three most important improvements *you* would make in healthcare service delivery to incarcerated and detained women in California?
- Q23. **[READ]** I have just one more question for you: As part of this project, we're looking for model programs that address the health care needs of women in the justice system. Do you know of good programs we should look into?

**[READ]** Thank you again for taking time to talk with me today. We appreciate your sharing your ideas and opinions with us, and we've learned a lot from this conversation. If a question or concern should come to mind regarding the survey or this study, please don't hesitate to call us; we'd be happy to talk with you again.

**[TERMINATE]**

END OF SURVEY