
An Honors Thesis

by

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Abstract
Over 100,000 prisoners are currently behind bars in the U.S. Researchers suggest that up to 25% of entering female convicts are pregnant or have given birth within the year leading up to incarceration. Three times as many female inmates suffer from mental health disorders than women in the general population. The percentage of HIV-positive female inmates has jumped approximately 2.1% since 1995. Despite these overwhelming statistics, women's healthcare in prison is primitive at best. This research paper takes a critical look at the prison medical system for women. Specifically, the primary concerns of those who want to see reform in women prisoners' healthcare facilities include the restrictive, traditional male-based medical models in women's prisons, HIV/AIDS rates, chronic disease such as HPV (human papilloma virus) and hepatitis, pregnancy, gynecological issues, and mental health.

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Author's Note
My original thesis plan was to conduct extensive interviews with the Indianapolis Women's Prison to add vivid, first-hand accounts of female inmates' and prison physicians' experiences within the prison healthcare system. My hope was that these interviews would put a face on the ambiguous female prisoner. In theory, it was a good plan; unfortunately, the reality was that I found myself blocked at every turn by the IWP Bureaucracy.

I can not express the frustration and anger I have felt these past few months in my attempts to visit the IWP. Every attempt I made to contact the IWP was thwarted or sidetracked. I began by directly calling the prison, using the "Contact Info" number listed on their web sight. I left over a dozen messages with various medical personnel and prison administration. Every single time I called a new person would answer the phone and direct me to yet another voice message system. I never once received a call back.

Not to be discouraged, I ventured forth with a new strategy: networking. A man I'd known from my childhood church had served on the Board of Correction in Indianapolis for many years. I called him and asked if he could assist me in getting my foot in the door. He informed me that he'd be more than happy to call the Superintendent of the IWP, Dana Blank, and put in a good word for me. True to his word, my insider called
Mrs. Blank and explained my thesis to her. Immediately after speaking with her, he called me and told me that now was the time to make my move. I was overjoyed! I spoke with Mrs. Blank for a few minutes and she informed me that my request would be simple enough. I only had to send her my request for interviews in writing with my personal information and—presto—I'd be in. That same day, I put a letter in the mail exactly as she had directed me. I waited. Finally, after two weeks, I called her personal secretary. I inquired after my letter and proposal. She sweetly informed me that Mrs. Blank was on vacation, but I would definitely hear something before the week was over.

I waited another week before calling Mrs. Blank’s secretary again. I was then informed that the Superintendent had forwarded my request to a department that more directly dealt with PR. When I asked what my next step should be, she told me to wait. So I did, for another week.

Luckily, by then, the Superintendent’s poor secretary was safe from my demanding phone calls. I received an e-mail from a Kathy Lisby, Director of the Planning/Research Department of the Indiana Department of Corrections. She forwarded me an application to fill out with my proposal, interview questions, etc. I was mildly frustrated that I hadn’t been directed to do so in the first place as applications took a while to be processed, but I was still naive and hopeful at this point. I dutifully filled out my application and sent it to the directed address. And then I waited. And then I waited some more....

A few weeks after having submitted my application, I received another e-mail from Mrs. Lisby. This one really got me excited. She wrote that the department had, indeed, received my application and I only needed to answer a few more questions before the board would make a decision. I e-mailed her back that SAME DAY with answers to her questions. And then I waited. You can guess what came next.

Finally, after a week and a half with no word from Mrs. Lisby, I e-mailed her to inquire after the status of my application. She e-mailed me back a few days later claiming that I had never answered her previous e-mail! I dug in my Microsoft Outlook Sent Items Box and, sure enough, there was the e-mail I had sent her more than a week ago. So I forwarded her the original copy and told her I was “extremely sorry that my e-mail had somehow managed to get displaced.” As if.

And this is where my sad story ends. I haven’t heard a thing back from Mrs. Lisby or any other member of the Indiana Dept. of Corrections or the IWP—even after additional e-mails and phone calls. To say that I’m disappointed is an understatement. I was really hoping that interviews would give some real breadth and depth to my paper as well as inspire me in the process.

Although I’m bitter, I’ve grudgingly learned from this experience. The powers of bureaucracy in the prison infrastructure are a force with which to be reckoned. It became obvious through my failed attempts that society must really have no idea what goes on behind bars, because almost no one can get in! Unless you have some major clout with the prison administration or have the stamina and time to withstand failed attempt after
failed attempt at permission, you’re not getting anywhere! The prison administration
doesn’t have me beat yet, however; if anything, this disappointing experience has
inspired me even more to discover the truth about life in prison and share it with others. I
hope my actual research paper, minus my desired interviews, can still be an informative
source that might inspire people to take a closer look at our prison system, especially in
regards to women prisoners’ healthcare. Perhaps I’ll send a copy to the IWP and see if I
get a response.

Prison healthcare is primitive at best. Prison medical facilities, if present at all, are in a frightful physical condition—but why should the average American care? After all, the Supreme Court has extended the Eighth Amendment with a statute especially designed for dealing with medical care in prison. The Supreme Court has ruled that “prisoners do not have a right to every potential beneficial medical procedure and that reasonable care is constitutionally sufficient” (Banks 89). So why delve further and advocate for this much neglected issue?

The first and perhaps most important argument for improving women's healthcare in prison is that most women behind bars will get out someday and will be absorbed back into mainstream society (Braithwaite and Treadwell 1680), and their health problems will become society's health problems. Incarcerated women have higher rates of mental disease, communicable disease, substance abuse, and chronic disease, outstripping those of incarcerated men and of women in the general population (1679); thus, if their health problems are not dealt with while they're locked up, they will eventually, through transmittance of illness or by increasing pressure in already understaffed medical facilities, weigh heavily on the state of general health and healthcare in free society when they are released. Secondly, due to harsher drug conviction penalties enacted in the 1980's, the female inmate population has grown at a rate much faster than the male prison population, jumping almost six-fold over the past twenty years (1679). Over 100,000 female offenders are now behind bars in the U.S.,
growing at a 4% rate from 2003 to 2004 ("Prison Statistics"). For every one of these inmates, an average of $21,000 is required a year to cover living requirements and healthcare (Enders 433). This cost is a substantial amount being funneled away from the American government's tax dollars and resources. Taxpayers should be able to expect that their money is being put into the hands of competent medical prison personnel and medical programs.

Another appeal in support of better women's healthcare in prison is based primarily on an incarcerated woman's role as mother. Women in the general population, and likewise in prison, are much more likely to be the head of the household. Two-thirds of women in prison, in fact, are the primary guardians of their children under the age of 18. Fifteen percent of these inmates are primary caregivers for infants less than six weeks old (Braithwaite and Treadwell 1680). Additionally, these women receive little to no help, financial or otherwise, from male relatives and partners (Browning and Church 22). What are the implications for these children if their mothers suffer from medical neglect while incarcerated? A female prisoner released with untreated hepatitis or an HIV infection is hardly in a position to effectively care for her children. Any improvements in the healthcare of these dependents' caregivers will be a benefit to those children and, ultimately, to the community at large.

Although the arguments for women's prison healthcare advocacy are strong, not much substantial documentation or research has been done in this area. The primary concerns of those who want to see reform in women prisoners' medical facilities are the restrictive, traditional male-based medical models in women's prisons, HIV/AIDS rates,
chronic disease such as HPV (human papilloma virus) and hepatitis, pregnancy, gynecological issues, and mental health. Many of the medical issues underlying these concerns are unique to women and are overlooked by the typical male-based standards in prison healthcare.

In the 1970's and 1980's, minimum sentencing laws were enacted to insure that female inmates received sentences equitable with those of men for the same crimes, the previous tendency being for prosecutors to hand down lighter sentences to females (Browning and Church 20). Equitable sentencing, however, does not equate to an equitable experience behind bars: “Once women are locked up...they swiftly find they are no longer equal.... Even now authorities argue that the number of females is so small, relative to males, that there are no 'economics of scale' in designing special programs for them” (20). And even if all programs were designed equitably between female and male offenders, the reality is that women have different medical needs than men. Prison administrators, however, have often sought to “treat women as if they had the same needs as men” (Banks 79). Normal staffing, in both men's and women's prisons nationally, has been set at three nurses for every three hundred offenders despite women's unique medical needs including gynecology, prenatal/natal care, and higher rates of chronic disease. This staffing ratio, when strictly applied to both sexes, is absurd when women's medical needs in prison are two and a half times the rate of men's (84). The result of this rationalized, traditional male-based model has been a prison healthcare system that often neglects the unique medical needs of women in a system already poorly funded and facilitated.

One major issue often neglected in women's healthcare in prison is the
escalating rate of HIV-positive female inmates. The rate of HIV/AIDS incidence behind bars often takes the spotlight in the media, with the discussion usually centering around the rate of occurrence within the male prison population and its frightening rate-and for good reason. More than 21,000 male inmates were infected with the immunodeficiency virus at the end of 2003 ("Prison Statistics"). What is little known, however, is the shockingly high rate of HIV infection among the female inmate population. In free society, the male HIV-positive incidence is much higher than the incidence for women in the general populace. In prison, however, this is not the case. Women offenders, according to the findings of one study conducted in ten correctional facilities, have a higher rate of HIV infection than male offenders (Vigilante 410).

Specifically, the Bureau of Justice Statistics stated that in 2000, 3.6% of female state prisoners were HIV-positive while 2.2% of male state prisoners were infected (Simon and Ahn-Redding 108). Additionally, the rate of HIV infection was increasing faster among women prisoners than among their male counterparts. Since 1995, the percentage of HIV-positive female inmates has jumped approximately 2.1%, from 2,402 infected female inmates to 2,472, while the percentage of HIV-positive male inmates only increased by 0.7% (108).
This deviation of gender-based HIV patterns in prison, as compared to the general free population, is easy to trace. Roughly 60% of all female inmates in federal prisons have been convicted on drug-related charges (Browning and Church 20). The most common sources of HIV infection for women come from the sharing of needles during intravenous drug use and from sexual activity (Vigilante 413). Many of these women have been convicted for prostitution (often considered a drug-related charge) or for other high-risk behaviors that directly put them at risk for HIV infection, such as illegal intravenous drug use. Another reason for the high rate of HIV occurrence in women's prisons is that the virus affects a disproportionate number of minority women who are already disproportionately represented in prison; HIV infection is sixteen times higher for black women than for white women in the general population (Vigilante 413). Hispanic women are seven times more likely to be infected with HIV than white women in the general populace (413).

It is easy to view these statistics in isolation and take the view that poor healthcare is simply part of a prison setting, without thought to the previous history of female inmates. This myopic vision must be pushed aside if any progress is to be made. The personal history of a female inmate has everything to do with her present state of health and her medical care needs. Joanna, an inmate who contributed a story from her life to Jane Atwood’s *Too Much Time: Women in Prison*, describes horrific past physical abuse by her husband ranging from rape to broken teeth to fractured ribs. This personal information, if provided to appropriate medical personnel, would be incredibly informative and improve effective treatment strategies for both the mental and physical
health of a female inmate like Joanna. Regrettably, past abuse is a common theme for female offenders. Fifty-seven percent of women in prison have a history of sexual abuse, physical abuse, or experienced both. One in four female offenders has suffered this abuse before the age of 18 (Enders 434). Not only do these past abuses prove corrosive to mental health, but they greatly increase an inmate's chance of suffering chronic disease and engaging in higher risk behaviors such as prostitution, unprotected sex, and drug use, which also contribute to long-term disease. Statistics reflect, for instance, a greater incidence rate of hepatitis, HPV (Human Papilloma Virus), STD's, and other problematic gynecological issues among females who have shown a history of physical and/or sexual abuse (Braithwaite and Treadwell 1679). It is logical, imperative even, that past experience be taken into account when considering both a female offender's risk for chronic disease and for her healthcare needs in general.

One of the most glaring discrepancies between the traditional male-based model in prison healthcare and a female prisoner's requirements in healthcare is an issue that is, strangely enough, rarely addressed by prison administrators. Five to ten percent of incoming female inmates are pregnant (Braithwaite and Treadwell 1680). Researchers
even suggest that up to 25% of entering female convicts are pregnant or have given birth within the last year before incarceration (Banks 83). Despite these overwhelming statistics, medical prison facilities are poorly equipped to handle pre-natal, natal, and post-natal care. A prime example is the federal prison system's sole hospital for women in Lexington, Kentucky, where no full-time OBGYN or gynecologist is consistently employed (Browning and Church 21). This discrepancy is not only distressing, but overwhelmingly illogical; female inmates not only have a disproportionately higher rate of poor health themselves, but their risk of serious complication during pregnancy and labor greatly outstrips that of the general female population (20). One pregnant inmate sued the state of California (Yeager v. Smith) for her horrific treatment during pregnancy and labor (Siefert and Pimlott 126). Incarcerated during her second trimester for writing bad checks, she received no prenatal care and was confined to an overcrowded cell for 24 hours a day where she slept on the floor; furthermore, she was exposed to tuberculosis, lice, and measles. After her water broke, she begged guards to alert the medical staff of her condition only to be informed that she would have to wait until the next day since no medical personnel were working. She gave birth on the floor outside the medical office with a guard in attendance. These dangerous inadequacies in staffing punish both the unborn and their incarcerated mothers and are unconscionable in a civilized country.
The abnormally high rate of miscarriage of pregnant women in prison has been documented throughout the country (Banks 86). One study carried out in California even goes so far as to suggest that these rates are a direct result of poor prenatal care, difficulties in transport to nearby hospitals (due to the absence of on-site labor facilities) and "low levels of competence among medical staff" (86). Add to this the low levels of exercise women in prison are allowed, and the result is a harsh environment for a pregnancy that often results in spontaneous abortion.

Another disturbing concern for pregnant offenders is their often inhumane treatment during labor. Offenders may have lost their full rights as citizens, but they do not deserve to be treated like animals. In 2001 Amnesty International conducted extensive research and surveys to explore the issue of restraint during labor in women's prisons ("States' Policies"). Shockingly, only two states in the U.S., California and Illinois, have implemented federal guidelines dealing with restraints during labor (including belly chains, handcuffs, and leg irons); neither state allows shackling of a
female prisoner during transport to a birthing facility nor during labor. As for the rest of
the country, guidelines for use of restraint during labor vary considerably. In Ohio,
inmates are restrained by at least one limb during labor. In Massachusetts, women
prisoners are handcuffed during transport to nearby hospitals but are restrained only if
they are deemed "disruptive." Prisoners in Michigan are restrained with belly chains
and handcuffs during transport and all the way through labor (Banks 87). These
inconsistencies grant a dangerous amount of power to the individual whim of a guard or
administrator who decides how to treat a woman in labor. Vanessa, a female inmate
imprisoned in Alaska, was handcuffed to a hospital bed during labor, not because the
hospital administration approved of restraining inmates, but because the two armed
guards accompanying her insisted upon it. Later, when her cesarean was underway, the
operating room doors were held wide open--one armed guard, garbed in scrubs and a
mask, peered in to prevent the most improbable of escapes (Atwood 91).

Fig. 4, Jane Atwood, Too Much Time: Women in Prison 2005.
A lack of concrete guidelines concerning restraints and the attendance of a guard
during labor provides an open window for abuse and degradation. But more than that,
what is the logical basis for shackling women during labor? Women are hardly in a
position to flee while in the throes of a contraction. Often, a guard is posted outside a
female inmate's hospital room to prevent just such an unlikely attempt at escape. The
policy of restraint is not only unfounded, but can also, obviously, prove dangerous to
the birthing process. Belly chains and handcuffs may result in hemorrhaging or
decreased fetal heart rate ("States' Policies"). Furthermore, if a caesarian section is
needed, the time wasted on fumbling with restraints could have serious consequences.
There simply is no real basis for this unduly harsh treatment.

Lack of proper gynecological examinations, although not as dramatic or as
potentially inflammatory as the issue of restraints during labor, is no less crucial to
women's healthcare in prison. Although annual gynecological exams and pap smears
are common practice for non-incarcerated women, the same can not be said for women
in prison. Somehow, these crucial examinations have slipped through the cracks of
constitutional "reasonable care." Although very little data exists on the subject, women
in prison cite a general lack of gynecological care and feel as though their medical
needs are often dismissed, off-handedly (Braithwaite and Treadwell 1679). Instead of
strictly exploring statistics, graduate students at San Francisco University conducted
individual interviews with female inmates and service providers in the California
Department of Corrections (CDoC), a state system that governs the two largest female
prison facilities in the world, to analyze the quality of healthcare the prisoners received
(Magee 1712-1713). Specifically, the interviews were focused on the qualitative
assessment of procedures for requesting a pap test, the experience of the actual test, and how follow-up and treatment proceeded. Overall, the interviews described a sometimes callous and ineffective state of healthcare existing in these California women's prisons. Not only was the infrastructure of the prison impeding the process to obtain a pap test through conflicting instructions, general disorganization, and lost results, but many of the inmates felt that the attending physicians were unprofessional or even rude. One anonymous participant offered her sentiments about being treated as an offender-client: “Even though I'm in prison, I'm a human being just like everybody else. I'm not different” (qtd. in Magee 1715). Service providers, too, attested to this antagonistic atmosphere in their interviews. Some who participated in the assessment stated that a considerable burden in the physician-patient relationship behind bars is that a general sentiment of antagonism is encouraged in prison healthcare administration; compassionate doctors can be cited by their supervisors for “fraternizing with inmates” (1715). Obviously, these circumstances do not encourage much trust between female inmates and their medical care providers, an element non-imprisoned women would consider crucial to the patient-physician relationship—especially with the physical vulnerability inherent in a woman's gynecological needs.

Another colossal impediment to proper gynecological care in prison is the financial barrier. The average wage for a female offender across the country is 7 to 13 cents an hour. In California and many other states the $5 co-payment for non-emergency medical care slices away a hefty percentage of her earnings (McNulty). This required fee becomes virtually an impossibility for women in maximum security prisons who are often not allowed to work. The US Justice Department has
demonstrated some concern over this financial difficulty, but so far no regulations have been implemented in the federal prison system ("States’ Policies"). Too often, women are more likely to put up with their symptoms with this financial deterrent and, as a result, wait until their symptoms grow unmanageable and even more expensive to treat.

A last medical issue that is a major concern for women behind bars is mental health. Statistics reflect that three times as many female inmates suffer from mental health disorders than women in the general population (Human Rights Watch). This is no surprise when we take into account women inmates’ personal histories, which demonstrate a wide range of abuses; additionally, the pressure of being the head of a household adds to the mental distress these women must feel. Specifically, a 1999 report from the Bureau of Justice Statistics states that 29% of white female inmates, 20% of black female inmates, and 22% of Hispanic female inmates in state prisons nationwide suffer from some form of mental disorder ranging from anxiety to extreme depression to schizophrenia (Human Rights Watch); however, the alarmingly high percentages of inmates suffering from mental disease are not the only cause for concern. Mentally ill female inmates can suffer limitations in regards to their freedom behind bars as a direct result of their health status. In New York State’s Bedford Hills Correctional Facility, women prisoners suffering from serious mental illnesses are kept in maximum security, even if their security level was originally minimum or medium, because Bedford is the only prison in the state with intensive mental health care services (Human Rights Watch). Serious mental disorders include schizophrenia, depressive disorders, bipolar disorders, and general psychosis. What kind of an advantage could maximum security possibly provide a female inmate suffering from one of these severe
mental disorders?

Unfortunately, most of the public and many correctional officials do not strongly support providing psychological therapy behind bars, which is most likely seen as going beyond the statutory guideline of “reasonable care.” Instead, female inmates with mild mental or emotional problems are often given drugs, not therapy; tranquilizers, antidepressants, and psychotropic drugs are often over prescribed to female inmates in order to calm them down and keep them pacified (Banks 81). One study conducted in 2000 included interviews with 42 female inmates who complained of such abuses. One woman even claimed that she had been sedated before her trial and as a result “did not testify convincingly and was told that she was perceived as cold and remorseless. She felt that the drugs made her inarticulate” (81). More detailed federal regulation concerning the prescription of tranquilizers and other drugs in prison would go a long way towards preventing such abuses.

The prison system was originally established in Pennsylvania and New York to encourage inmates to reflect and to “reform them into temperate, industrious, hard-working citizens, and to return them to their societies as new men. With the emphasis upon reformation of the criminal…” (“The Evolution of the NY Prison System”). Jane Atwood, a distinguished author and photographer, describes the strategy of today’s women’s prisons as one of punishment and “humiliation rather than rehabilitation” (12). But this retribution has simply been carried too far, to the point of being almost all-encompassing for a typical female inmate. She is punished with isolation from loved ones and lack of freedom, but even more than this, her body is punished by lack of proper medical attention and her children, both unborn and born, serve her term
simultaneously. Her statutory “reasonable care” provision is too ambiguous to provide clear, definite regulation of routine medical examination and treatment. The American prison system needs specific federal guidelines to govern how prisoners, both male and female, in state prisons and federal, request medical attention. Those guidelines should also specify, more clearly than “reasonable care,” just what medical attention prisoners should expect. Anything else will leave a perilous power gap between women in prison and the not always tender mercies of prison administrators or personnel.

A female inmate's lack of medical funding is another inexcusable inadequacy in the prison system. The rationalization of 'economy of scale' is cold and transparent. In a country that supposedly protects the rights of minorities, she is left behind because her numbers pale in comparison to her male counterparts. Will society wait until the actual percentage of women in prison is the same as males before taking action? It will be too late by then, and hindsight is not something America can afford on this count. Additionally, we must recognize that women in prison have distinct medical needs not covered by the traditional male-based model. Equitable medical attention between the sexes is not acceptable; women need medical care designed to meet their unique needs.

Recognition and implementation of federal regulations geared towards the distinct medical needs of women prisoners, however, is not enough. Personal histories must be taken into account by prison medical supervisors and personnel when deciding upon medical treatment for a female inmate. She has most likely experienced abuse and trauma in the past that may have a profound effect on her present medical and mental condition. Physicians and the prison administration need to take a closer look at a female prisoner's history if not for compassion and humanity, then for efficiency in
treating her illness. Finally, of course, for medical treatment to work best, a patient must trust her physician. One woman prisoner had a suggestion for her attending physician: “Can you just stop for a moment and look at me? Maybe if you look in my face you will hear me better” (qtd. in Enders 437). This inmate is simply asking for some basic, personal interaction from her physician. Altering the dynamic of the entire prisoner-physician relationship is a complicated task that would require further sensitivity training for both physicians and administrators in the prison system, but it is necessary for improving communication and, therefore, effective treatment strategies.

Society needs to begin to understand exactly how we are being negatively affected by the often neglected medical care our country's prisoners receive. We suffer financially when our tax resources are not efficiently utilized in competent medical programs. We suffer emotionally when women in prison, 2/3 of who are the heads of household for children under 18, are released with untreated chronic disease due to primitive prison healthcare. We need to see these prisoners as individuals with names, faces, and families, not just as lifeless numbers and statistics or as felons who deserve nothing but punishment. We need to remember that inmates all have their own stories and feelings: “I feel like, don't just look at my number, look at my face. I have a spirit. You have a spirit. I feel, you feel” (qtd. in Enders 437). Statistics and numbers have their place, but public health must include the voices of disenfranchised women in prison who are a part of this society and will most likely rejoin activities one day. Recognizing and truly comprehending the gravity of our prisoners’ medical care will propel us towards much needed action in regulating medical programs in federal and state prison systems. We need to decide what can be done to improve prisoners’ health,
both mental and physical, to enable them to become productive members of society after their release. This is not a selfless action, but a logical step if we are to improve the general health of the American population. Moreover, it is necessary if we are to consider ourselves an enlightened and civilized society.
Works Cited


