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ORIGINAL RESEARCH

Malign Neglect: Assessing Older Women's Health Care Experiences in Prison

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Abstract The problem of providing mandated medical care has become commonplace as correctional systems in the United States struggle to manage unprecedented increases in its aging prison population. This study explores older incarcerated women's perceptions of prison health care policies and their day-to-day survival experiences. Aggregate data obtained from a sample of 327 older women (mean age=56) residing in prison facilities in five Southern states were used to identify a baseline of health conditions and needs for this vulnerable group. With an average of 4.2 chronic health conditions, frequently histories of victimization, and high rates of mental health issues, the women's experiences of negotiating health care was particularly challenging. By incorporating the voices of older women, we expose the contradictions, dilemmas, and obstacles they experience in their attempts to obtain health care. It is clear from the personal accounts shared that, despite court mandates, penal harm practices such as delaying or denying medical treatment as well as occasional staff indifferences are common in women's prisons. With older women having the greatest need for health care, an age- and gender-sensitive approach is recommended.

Keywords Aging women · Prison health care · Penal harm · Health anxiety · Prisoner rights

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Introduction

The United States' prison population began to increase dramatically in the 1970s when incarceration became the foremost strategy for controlling crime (Haney 2010). With roughly 2.2 million adults incarcerated in federal and state prisons and county jails, the United States' incarceration rate of 756 inmates per 100,000 residents far exceeds the imprisonment rates of other Western democracies (Clear and Frost 2014). This rapid expansion of prison systems created mass overcrowding that adversely affected living conditions in many prisons (Haney 2010). Paralleling these dramatic increases in incarceration rates in the United States has been a vigorous "penal harm" movement in which a strategy emerged to make offenders suffer (Aday and Krabill 2011). Virtually every aspect of the punishment system ranging from mandatory minimum sentencing to penal policies shifted to a more punitive stance (Clear and Frost 2014). An intentionally harsher form of the "deprivation of liberty," retribution activities such as rationed or unappetizing food, small and overcrowded cells, hard bunks, insufficient protection against extreme weather conditions, sleep deprivation, strip searches, and denial

or harassment of family members during visits have been reported in many prisons (Haney 2006).

The penal harm movement, apart from introducing harsher conditions, also has been extended beyond the custody and control of inmates and into the inmates' health care treatment (Maeve and Vaughn 2001; Vaughn and Collins 2004). Research has found that health care providers in some correctional settings have adopted the attitude that punitive measures directed toward prisoners are well justified (Granse 2003). Based on research by Vaughn and Smith, it is the "collective demonization" of inmates that allows medical care workers to violate their ethical obligations (1999, 217). Penal harm also has been documented among correctional officers when they engage in tasks intended for qualified medical professionals (Vaughn and Collins 2004). Penal harm may take place due to specific correctional facility policies such as when security concerns override the suggestions of medical personnel (Ammar and Erez 2000). Some researchers have suggested that penal harm medicine has become so commonplace that such practices now pass for standard operating health care procedures (Maeve and Vaughn 2001). Regardless of whether penal harm actions are due to system-wide policies or simply staff indifference, the quality of services frequently deteriorates from what is considered an acceptable level of medically indicated care.

With the annual cost of detaining an elderly prisoner calculated in the range of $70,000 (Human Rights Watch [HRW] 2012), states have introduced a variety of cost-saving practices such as the denial or delay of treatment, restrictive prescription lists, and telemedicine (Maeve and Vaughn 2001; Vaughn 1999). In a further attempt to manage the soaring costs of caring for offenders, prisons have increasingly implemented co-payment policies to discourage inmate medical requests (Gibbons and Katzenbach 2006). The majority of the state correctional systems require inmates to pay between $2 and $15 for a sick-call request, a doctor's visit, and, in some states, a prescription (Aday 2003). These fees can be insurmountable for sick, aging inmates who are less likely than younger prisoners to have in-prison employment or a source of income outside of the institution (Shadmi et al. 2006). Such a practice could be viewed as discriminatory against women since they have more serious health problems than males (Morton 2004). Research based on data from 36 states shows that co-payments do, in fact, reduce sick calls anywhere between 16 percent and 50 percent (Stana 2000).

The Case of Older Women

One outcome of new sentencing policies is increasing incarceration rates and longer sentencing for women (Leigey and Hodge 2012; Leigey and Reed 2010). Today, more than 108,000 women are incarcerated in state and federal institutions in the United States (Carson and Golinelli 2013). While the growth of incarcerated women has leveled off in recent years, the number of female inmates has grown eightfold since 1,980, when only 13,000 were imprisoned (Aday and Krabill 2011). Of this group of incarcerated women, an increasing number are now among the rapidly growing population of aging prisoners. According to the most recent Bureau of Justice figures (Guerino, Harrison, and Sabol 2011), more than 11,000 women aged 50 and above are housed in U.S. prisons. In addition, almost 30,000 female prisoners currently in their 40s are set to join the ranks of aging inmates in the near future (Wahidin and Aday 2012).

Women in prison are considered a much-neglected population and more recently have been recognized as a significant subgroup with a variety of special needs (Aday and Krabill 2011; Human Rights Watch [HRW] 2012; Wahidin 2004). The historical neglect of women prisoners, coupled with massive increase in women's incarceration, makes this an increasingly salient health care problem. Yet despite the tremendous increase in the number of incarcerated women, little attention has been given to their unique health concerns (Braithwaite, Treadwell, and Arriola 2005). There is a growing body of literature that suggests that female inmates are more likely to have serious health problems than their male counterparts and as a result seek medical care in prison at two and a half times the rate of men (Fearn and Parker 2005; Morton 2004). From a historical perspective, correctional institutions have struggled to provide adequate health care and other sorts of health services to female offenders. Initially, health care for this population received little attention due to the small number of female inmates. Furthermore, prison health care has been largely based on what is needed and provided in men's correctional facilities (Ross and Lawrence 1998), frequently resulting in inadequate staffing and a lack of essential specialized women's health services (Morton 2004; Braithwaite, Treadwell, and Arriola 2005).

Older women in particular present unique health challenges to correctional health care providers, bringing with them any number of chronic mental and physical health conditions. Chronic illnesses most prevalent

among this subgroup include arthritis, hepatitis, hypertension, and heart conditions (Leigey and Hodge 2012). Among older female inmates cancer, diabetes, and kidney problems also present pressing health concerns (Caldwell, Jarvis, and Rosenfield 2001; Genders and Player 1990). Exposed to high rates of violence and victimization, women prior to imprisonment frequently have histories of poverty, unemployment, and drug abuse. As a consequence, women enter prison having suffered from personal stress, trauma, and fear in many stages of their lives (Aday and Krabill 2011; Fearn and Parker 2005). Socioeconomic hardships combined with extensive histories of violence and abuse negatively impact the short- and long-term health condition of older women and place them at greater risk for coping with imprisonment.

Understanding the incarcerated world as experienced by older female inmates requires a fundamental knowledge of Goffman (1961) notion of "total institutions" and the extent to which prisons, as total institutions, strip inmates of former identities while placing them in settings with "undesirable" populations. While Sykes (1958) chronicled the "pains of imprisonment" particularly for male prisoners, women inmates also experience a similar fate (Fisher and Hatton 2010; Pollock 2004). More specifically, the "pains of imprisonment" for female offenders include personal, social and familial, and environmental deprivations. With the emphasis on the punitive and stigmatizing aspects of incarceration, women often leave behind families facing financial hardships; moreover, the responsibility of caring for children can weigh heavily on the minds of incarcerated mothers. Relationship disconnections may lead inmates to experience emotional trauma, resulting in symptoms of depression, sadness, loneliness, and uncertainty (Christian 2005).

The physical condition and structure of the institution also can create significant problems for older female inmates, and few women aging in prison report being satisfied with their living conditions (Krabill and Aday 2007; Wahidin 2004). Older, frail offenders, in particular, often find the prison environment to be oppressive, with poor lighting and ventilation and cold, damp cells (Kratcoski and Babb 1990). Stale air from smokers, top bunking, overcrowded conditions, and being housed too far away from dining services and bathrooms have been viewed as significant environmental problems (Aday and Krabill 2011). Many states require geriatric women to participate in physically demanding work activities with little or no access to environmental modifications for functional impairments. For example, Williams et al. (2006) reported that 61 percent of the 120 female offenders aged 55 or older in their sample were assigned to jobs too difficult for them to perform. In addition, of those women with mobility issues, 50 percent reported having had a fall within the previous year. Well over half had great difficulty with Prison Activities of Daily Living (PADLs), such as dropping to the ground for alarms, getting on a top bunk, and standing in the pill line.

Despite the increasing numbers of older female prisoners, research has not kept pace with the growing concerns of this prison population (Aday and Krabill 2011; Leigey and Hodge 2012; Williams and Rikard 2004). With the lack of theoretical development to guide policies, research is needed that examines issues related to being both elderly and female within correctional facilities. When considered together, the lack of adequate attention to the aging female offender has been described as "malign neglect" (Williams and Rikard 2004). In addition to a comprehensive mental and physical health analysis to identify special health needs, inmate personal accounts will need to be utilized to capture the challenges of gaining access to medical services and how such barriers influence their social and psychological well-being. Vaughn and Smith, for example, explain that "[i]t is imperative to investigate prisoners' personal narratives before their stories are filtered and sanitized by the justice system" (1999, 219). Thus, we choose to employ such methods in our study and, while our results cannot be generalized beyond our sample, the individual voices and personal narratives of the women we interviewed contain a wealth of information for researchers and policymakers seeking the empirical reality of correctional health care systems.

Research Procedures

This research was conducted in seven women's prisons in the Southeastern United States. Permission for this study was obtained from the University's Institutional Review Board as well as each state's Prison Human Subjects Committee. Potential participants were informed at each facility about the research objectives of the study and were given the opportunity to review the survey and ask in advance any questions they might have regarding issues of confidentiality or

the instrument's purpose or content. All participation was voluntary. Respondents signed consent forms before participating and were reminded that they could withdraw from the study at any juncture. A 12-page, self-administered questionnaire emphasizing demographic information, prison activities and social networks, prison adjustment, and a variety of health-related indictors was used for all participants, except those with visual or literacy barriers. In those instances, researchers administered the questionnaire orally. Only demographic and health-related questions were used for this study.

The Study Sample

Participants included 327 women ranging in age from 50 to 77, with a mean age of 56.4 years. The majority of the sample (63 percent) were white and the remaining 37 percent black. Only 22 percent of participants reported being married, with 59 percent classified as either divorced or widowed, eight percent separated, and 10 percent never married. Most of the women (66 percent) reported having graduated from high school and 38.3 percent reported having some college education or a college degree. For 71 percent of the women, this was their first arrest leading to imprisonment. The mean age at incarceration was 44 years, with some of the women imprisoned as early as 17 years of age and others as late as their 70s. The average length of time served to date for the current offense was 8.8 years. The majority of the inmates in our sample were serving time for violent crimes of murder or manslaughter (41 percent), followed by drug-related offenses (25 percent).

Research Measures

Health Status

Participants were asked to rate their health as "excellent" (3), "good" (2), "fair" (1), or "poor" (0) and identify whether they believed their health was "better" (3), "about the same" (2), or "worse" (1) compared to two years ago. The questionnaire also asked participants whether they attended sick call "weekly" (1), "once or twice a month" (2), "once every few months" (3), or "hardly ever" (4). In order to measure chronic illness, the survey asked participants to select their illnesses from a checklist of 26 possible conditions, with the option of selecting "other" and reporting an additional illness. Additionally, the questionnaire asked respondents how many over-the-counter and prescription medications they were taking. Finally, functional health was measured by a series of seven (yes=1; no=0) statements about the inmate's capabilities such as "the ability to walk independently," "difficulty walking long distances," or "difficulty standing in line for long periods."

Hopkins Symptom Checklist

Anxiety, depression, somatization, and interpersonal sensitivity were measured using a modified version of the Hopkins Symptom Checklist (Derogatis et al. 1974). Participants were asked to rate the level at which they were bothered by certain symptoms as "never" (0), "rarely" (1), "sometimes" (2), or "pretty often" (3), so that a higher score indicated a greater manifestation of the Hopkins symptoms. Sample items from each subscale include: anxiety (trembling, feeling tense, heart pounding); somatization (soreness of muscles, chest pains, back pain); depression (hopelessness, worrying, loneliness); interpersonal sensitivity (feeling critical of others, feelings easily hurt, feeling that people dislike you).

Demographics

Respondents were asked about several demographic variables: age, race, marital status, and educational level. Respondents also were asked to identify their racial group. Due to the small sample size of several ethnic groups, a small number of Hispanic respondents were grouped into a non-black category for comparison purposes with black respondents. Marital status was coded into five categories: (1) married, (2) widowed, (3) divorced, (4) separated (not as a result of incarceration), and (5) never married. Respondents were asked about their educational level with the question: "Before your admission on (most recent admission date), what was the highest grade of school that you ever attended?"

Qualitative Data

In addition to assessing quantitative demographic and health data, the questionnaire asked general open-ended questions regarding participants' health and well-being. The first of these asked, "What changes, if any, would you like to suggest for improving health care services

here?" Another question asked, "What difficulties do you have in obtaining health care at this facility?" Responses to these open-ended queries added depth and meaning to information gathered through closed questions. Moreover, these questions allowed participants to voice their perceptions of health care provisions within the prison system and make recommendations for improvements.

The qualitative information was independently coded using a thematic analysis approach and typically was used to illustrate the quantitative measures. In order to protect the anonymity of the women, specific prisons were not identified in the analysis. While this may be considered a limitation in making distinctions between individual prisons and health care disparities, it was an important consideration for ensuring that those who were critical of prison health care policies and treatment would not be singled out or punished.

Results

Using a mixed-methods approach, the results presented here are based on descriptive aggregate data and personal narratives. Aggregate data are useful for documenting the multitude of health problems found among older incarcerated women and their future health care needs. Identified are the medical issues experienced by this group of older women, including the functional health impairments that limit their ability to negotiate the physically challenging prison environment. Numerous defects in the prison health care system, such as lack of awareness, limited resources, and correctional policies, are identified as common barriers to health care access.

Major Health Disparities

A descriptive analysis of this sample reveals that older female offenders suffer from a variety of mental, emotional, and physical health problems. For example, a substantial number of women in this study were suffering from either high or severe levels of depression (46 percent), anxiety (43 percent), and interpersonal sensitivity (42 percent), indicating extreme levels of hypervigilance, interpersonal distrust, and posttraumatic stress. Perhaps a contributing factor to the protracted mental health issues was the fact that half of the women reported a history of sexual or physical abuse, with many cases leading to serious trauma and physical injuries. More than half of those reporting abuse histories indicated they were hit with a fist (58 percent), pushed or shoved (73 percent), bullied (69 percent), forced to have unwanted sex (52 percent), threatened with their life (73 percent), or had a weapon used against them (55 percent). As a result, one out of four reported suffering from broken bones and an even larger number had been treated for internal injuries (40 percent), cuts (49 percent), and bruises (59 percent).

Table 1 provides a summary of self-reported health conditions by race. While whites reported significantly more chronic illnesses ($t=3.05$; < 0.01) and consumed more daily medications ($t=1.97$; < 0.05) than their black counterparts, only minor differences were observed when controlling for race. Overall, the majority of participants reported their physical health to be fair or poor (64 percent), while 29.6 percent described their health as good. Only 6.3 percent described their health as excellent. The most common chronic illnesses mentioned were arthritis (61percent), hypertension (53 percent), issues related to menopause (30 percent), digestive disorders/ulcers (29 percent), and heart conditions (26 percent). One 73-year-old serving life in prison described the multiple health problems she faces:

> My health problems include arthritis, emphysema, and sigmoid hypothyroidism. I have a hiatal hernia, ulcers, hypertension, and circulatory problems. … My mental health is also poor and I suffer from anxiety disorder and depression. I take approximately a dozen medications, including Prozac.

When asked about recent changes in health status, more than half (53 percent) of those classified as white stated their health had declined over the past two years compared to approximately a third (37 percent) of blacks. As a whole, only eight percent stated that their health had improved, and when asked how they saw their health in the near future, most of the women (68.5 percent) predicted that their health would remain the same or become worse. Declining health was expressed with sentiments of helplessness. Illustrating this, two inmates stated:

> Without decent care I will just get worse. I can tell, [and there is] nothing I can do about it. I've spent

Table 1 Self-reported health characteristics by race

Health characteristic	Total %	Black women *n*=121	Non-Black women *n*=206
Self-reported health			
Excellent	6.3	27.9	31.3
Good	29.6	43.4	41.8
Fair	42.6	20.5	22.4
Poor	21.4	8.2	4.5
Self-reported mental health			
Excellent	29.2	30.1	28.4
Good	32.5	30.2	34.8
Fair	29.5	30.2	28.8
Poor	8.7	9.5	8.0
Number of chronic illnesses	4.2	3.8	4.5
Leading chronic illnesses			
Arthritis	60.8	56.6	65.0
Hypertension	53.3	55.7	50.8
Menopause problems	30.0	33.5	26.6
Digestive disorders/ulcers	28.7	22.1	35.3
Heart condition	26.0	13.9	32.0
Emphysema/ulcers	24.7	7.3	42.1
Daily number of medications	4.7	4.5	39.0
Health compared to two years ago			
Better	10.9	14.3	39.0
About the same	43.3	47.7	39.0
Worse	45.2	37.0	53.5
Functional health problems			
Hearing problem	66.3	70.8	61.0
Vision problem	83.6	81.1	86.2
Problems walking independently	88.5	83.7	93.3
Problems with stairs	65.5	62.3	68.7
Need ground-level housing	49.4	53.3	45.5
Need a lower level bunk	85.8	86.9	84.7

> months trying to see a specialist on the outside and every day I'm getting sicker, frustrated, and one day closer to death, and when I wake up, there's no one here that gives a damn.

> My health has gone down since I arrived here. I used to walk six miles a day before I came in here. My health deteriorated while I was serving 16 months in jail before and during my trial. When I got to prison, I had to learn to walk again and now I've been having chest pains and I feel my health is failing.

Fears about one's personal health can be influenced by the fact that the majority of women's prisons are located in predominately rural areas and removed from easy access to health care services (Reviere and Young 2004). Of the seven prisons in this study group, all but one were located in very remote areas. As a result, many of the older women expressed anxiety regarding the difficulties of meeting their health care needs in such an isolated and confined environment. This point is illustrated with the following remark:

> We are out here in the boonies and miles from a hospital. I lie in my bed at night and think about what if I had a heart attack or something. How long would it take to get a guard to call for assistance? How long would it take for an ambulance to get me to a hospital? This thought really scares me.

In fact, more than three-quarters (78 percent) of the participants confessed they had a fear of getting sick and dying while in prison. Many participants indicated that fear of illness arose due to their perception of prison medical services as substandard and uncaring. In fact, in numerous cases, respondents described care that seemed to have been negligent. For instance, participants noted:

> The death anxiety is very high, due to the lack of medical care that we get. The majority of the time [inmates die] because they did not have the medicine that they needed, but more often, because they were left in a critical condition and couldn't get anyone to respond.

> I am fearful of the medical care offered here. I have witnessed people going to medical, getting Mylanta [an anti-acid], and then dying. I am really frightened about having a heart attack in here for fear the medical staff will be nonresponsive. At one point, I was given the wrong medication, but took it anyway or I'd have gotten written up.

> Before people came to prison they had decent health care. Now they're state property and now the state doesn't take care of them. Dogs get better care than we do in here. I go to sick call and see one doctor and the next time we see a different one. They constantly change my medications back and forth.

Concurring with the notion that the medical facilities in many prisons are simply unequipped to effectively provide the appropriate care, participants expressed feelings that prison health care is inadequate and can have potentially dangerous consequences (see also Deaton, Aday, and Wahidin 2009–2010).

Functional impairments also create adverse experiences for older female inmates and are important indicators of health care costs (see Williams et al. 2006). Health characteristics examined in this study included measures of difficulties with activities in the prison environment such as hearing, vision, and problems walking or standing. A majority of participants (62 percent) reported that their health prevented them from doing things they would like to do. As Table 1 indicates, functional health issues included persistent problems with negotiating stairs (67 percent), difficulty standing in line for up to 15 minutes (61 percent), problems walking long distances (59 percent), and, for some, the inability to walk independently (8 percent). In addition, a majority of the women reported that they sometimes or very often experience symptoms of lower back pain (78 percent), headaches (65 percent), heart or chest pains (60 percent), weakness in parts of the body (75 percent), muscle soreness (74 percent), numbness or tingling (69 percent), and hot or cold spells (63 percent). Although these physical problems were evident, penal policies often required inmates to walk extended distances, sometimes in bad weather, wait in long lines, and traverse stairs:

> We have to walk to meals during cold winter rain and security refuses letting us taking a shortcut between buildings. Picking up our daily meds, they make us stand in line until our turn to enter, sometimes 20 to 30 minutes in rain, sleet, and snow or in hot weather in the summer. They have no heart.

> It is very hard for the older women. We can't get around like the younger ones. I can't walk everywhere and stand on my legs for long. I have trouble with the stairs—especially when I am carrying laundry or supplies from the commissary.

As a result of functional impairments, 82 percent of participants stated that they desperately needed a lower bunk. Several women commented on this need not being met and the problems that resulted. One women suffering from deteriorating health and obesity voiced her frustration with a system that continues to ignore her plea for new bunking accommodation:

> I had a horrible injury to my leg. I tried to climb into the upper bunk. I'm a big girl—that didn't work, it almost fell over on me. I need a bottom bunk, but medical keeps refusing. I've written a grievance, but I am still waiting. We are too old to be climbing like children.

Moreover, some of the women did not feel that their need for a bottom bunk was taken seriously. For instance, one 52-year-old woman suffering from back problems relayed that she had been written up for disobeying a direct order when she was unable to climb into a top bunk. Other research has noted that the need for a lower bunk is not considered a real requirement for older female inmates. This is consistent with Ammar and Erez (2000) observation that requests for lower bunks were seen by prison medical staff as a form of attempted manipulation. In other words, it is taken as a request for a convenience, not the avoidance of pain related to age or chronic illness.

Barriers to Health Care

The majority of respondents (62 percent) reported visiting the health clinic between once a fortnight and once every two months. Only 6 percent reported going on a weekly basis, and 32 percent of the sample stated that they hardly ever go to sick call. Many women simply did not like the policy of being charged a co-payment when simply attending the clinic to make an appointment with an attending physician, at which time they would be required to pay an additional co-payment. The following narratives provide an example of the typical sentiment expressed by the majority of the inmates regarding prison co-payment policies:

> We do not have the money to go to medical all the times that we really need to. We need medical to care and stop charging three dollars on the seventeen cents we make an hour. It takes three days to work to pay for this.

> After you reach a certain age most of your family is gone and if you don't have children, there is no

> one to help you financially. Get rid of the co-pay so I can afford medical help.

This view supports previous research, which has noted that co-payment prison procedures prevent access to health care. This policy has prompted inmates with legitimate medical concerns to delay or forgo seeking necessary treatment. Strupp and Willmott (2005) note that these payments represent a significant expense for older prisoners who lack a steady income from friends and family outside the prison. Therefore, co-payment policies force many older female prisoners to choose between accessing medical care and purchasing necessary goods such as food and hygiene items.

Other inmates expressed a concern for the lack of preventive health care and many of the women called for healthier diets. Almost one in five noted concerns with abnormal weight gain and obesity. Participants also expressed feelings that prison health care is inadequate and difficult to access. One woman stated, "Most of the time they go against what the outside provider recommends for our needs which causes our conditions to worsen." The notion that those barriers to or denial of decent health services have become a significant issue in prison (Jacobi 2005) is further illustrated by the following statements:

> Occasionally, we will run into a nurse who will just tell us the truth. To be honest with you, they will look at you and just say, "Honey, they're not going to do that because it costs too much money." Of course, this is a nurse that cares, so she won't last long, guaranteed.

> Although I have several health conditions including TIAs [transient ischemic attacks], a prior broken hip, and bone cancer, seeing a prison doctor in here is still difficult. The nurses are fairly nice but rotate around and the doctor won't listen to my complaints and refuses to acknowledge my medical history.

Another potential barrier to seeking medical assistance included the perception of negative attitudes by health care staff toward older female inmates and views of prison health care as lacking empathy. Although older female inmates have a greater need for medical services than any other inmate group, many health providers question whether sick inmates should receive expensive medical procedures at the same level as law-abiding citizens (Caldwell, Jarvis, and Rosenfield 2001). Women in this study frequently mentioned uncaring attitudes of the medical staff toward aging female offenders:

> I feel the medical staff looks down on us. If they believe that one inmate is not sick, it applies to all, not taking our age and needs into consideration. They should be more patient with us instead of getting agitated because of our many medical complaints.

> The prison does not look at our age. Medical cares about us even less. They only want three dollars. Not mine—I will stay sick. Our warden said that it is cheaper to pay for a wrongful death than it is to provide us adequate medical care.

> I have seen a woman have a stroke and left to lie on the ground while medical personnel walked to the person and smoked and joked as they walked. The prison system has neglected [prisoners who died of illness] and should be held responsible. It angers and disgusts me.

These impediments to health care access coupled with an overwhelming fear of deterioration in their physical health are constant reminders of the vulnerabilities faced by older inmates, especially those in poor health. Such views of penal health care are supported by other researchers who have noted that lack of trust in prison health care providers creates a barrier to receiving health care among older female inmates (Caldwell, Jarvis, and Rosenfield 2001; Strupp and Willmott 2005). Enders and colleagues (2005) note that this results in feelings of hopelessness, helplessness, and vulnerability.

The women in this sample also frequently mentioned problems with appropriate medical treatment where medications are concerned. Such claims are consistent with recent research on medication prescribing practices for older prisoners in the Texas prison system, where researchers found inappropriate prescriptions were written in 32 percent of the cases (Williams et al. 2010). In addition to inadequate pain medication, the women in our study reported concerns about the adequate, accurate, and timely delivery of medications:

> The drug formulary is so limited that we sometimes have to take several medications rather than one that would be more effective. At least one woman has died from not being given the meds that she needed. You don't hear about it in the media.

> Many of the ladies that are insulin dependent have had many problems with receiving either too much or not enough medication. Women with gout often go for over a week without any medication. The doctors may prescribe a medication, but the prisoner never receives it because it is not on the approved formulary.

Some participants claimed that medications they once took are now no longer available. Others complained that pain medication was improperly administered or that doctors constantly changed dosages depending on who they saw when visiting the health clinic. The following serve as examples of frequently mentioned concerns:

> They won't give anything for pain but Motrin [ibuprofen], and lots of women experience much pain. Motrin is the drug for everything here and it doesn't work. Pain medications that I used to take to treat my condition are not prescribed. … We need something for severe body pain.

> Medical personnel need to be more attentive to our needs. No one knows our bodies and the pains that we go through from day to day (like we do). Often they fail to comply with the recommendations the outside providers have provided, and this causes our conditions to worsen. When we attend sick call, medical should show more patience with us instead of getting agitated because of our complaints.

Although inmates reported, on average, taking 4.9 over-the-counter or prescription medications on a daily basis to manage pain and other chronic illnesses, more than two-thirds of the women reported they sometimes or frequently have difficulty sleeping and pain was often noted as a major factor. As two women stated:

> The old suffer from back pains because of the lack of mattress and all the metal and concrete. Lying there is really so uncomfortable, you never really get to sleep. I wish we had thicker mattresses for those over age 50.

> The stroke affected my right side and I have difficulty getting comfortable enough to sleep. My health continues to deteriorate and each day is a struggle for me to get out of bed. Medical won't listen about my special needs even when my physical therapist quit and it took weeks to get a sub.

Ironically, the "pains of imprisonment" are not supposed to be physical. Yet, prisons are legally sanctioned to be uncomfortable, and the public's "threshold" of pain for the incarcerated is equally high (Haney 2006; Maeve and Vaughn 2001). Moreover, it has long been assumed that many inmates are malingerers who fain illnesses in an attempt to "get high" or gain medications to use as a commodity. As a result of these factors, it is likely that aging women behind bars experience physical pains that are discounted and go untreated.

Discussion

Using descriptive aggregate data and personal narratives, the findings indicate that co-morbidity is a common occurrence among older incarcerated women. This supports previous research that has estimated that as many as 85 percent of aging prisoners have multiple medical issues, often accompanied by mental health problems (Loeb, Steffensmeier, and Myco 2007). As a result, older women naturally experience health complications that require greater use of screenings, diagnostic examination, lab work, and follow-up services than other segments of the prison population (Aday 2003; Reviere and Young 2004). With high rates of depression, anxiety, and somatization, especially for women with an abusive past, a punitive environment can create additional fears of being further traumatized (Campbell 2002). For the majority of women, prison is the first time they have received systematic medical attention (Fearn and Parker 2005). While some inmates may initially view medical care in prison as a buffer against the hostile nature of prison, this view is quickly dispelled by the realities of scarce resources and constant attempts to create roadblocks for health care treatment.

While coping with multiple health problems, many older female inmates indicate they are not receiving adequate medical care, as many are denied access to medically indicated nutritional supplements, appropriate medications, regular vision screenings, and mammograms (Caldwell, Jarvis, and Rosenfield 2001). Others

are strongly discouraged from seeking needed medical treatment by being forced to climb stairs to reach prison medical facilities, being labeled "hypochondriacs" for requesting treatment, and being shackled upon entering non-prison hospitals (Wahidin 2002). Given that women generally have a variety of health problems requiring medical attention, the pay-as-you-go sick call system has a differential negative impact on incarcerated women (Morton 2004). By discouraging women from seeking health care or not providing preventive health services, the policy to save money may end up costing health agencies far more when they have to provide treatment to those with advanced illnesses.

As a result, prison life creates formidable challenges for aging women. Confronted with penal harm policies and a stark prison environment, the ability to receive adequate health care is virtually impossible (Fearn and Parker 2005). The ethical and efficient health care of prisoners becomes secondary to the precedence of security and discipline in such a controlling environment (Ammar and Erez 2000; Maeve and Vaughn 2001; Stoller 2003; Vaughn and Smith 1999; Watson, Stimpson, and Hostick 2004). Such an approach, designed to break the spirit of inmates, provides justification for the dehumanizing "ill treatment" of vulnerable prisoners (Vaughn and Smith 1999). Haney (2006) further notes that the specific nature of prison is to be a "place" that is structured for the purposes of punishment, custody, and discipline. Because of this, health care access is "continually thwarted by rules, custodial priorities, poor health care management, incompetence, and indifference (Stoller 2003, 2,263).

It has been stated that older female prisoners are a forgotten population who suffer from a lack of adequate medical care (Aday 2003; Cranford and Williams 1998; Reviere and Young 2004; Strupp and Willmott 2005; Wahidin 2004; Williams and Rikard 2004). The voices of women in this study echo this conclusion. Here, the "pains of imprisonment" are literal and physical and are exacerbated by aging, neglect, and negative attitudes. Issues such as custodial priorities, poor health care management, and incompetence are apparent obstacles to satisfactory health care. Most of these women reported that they are sometimes or always in some physical pain. Struggling with declining health and a health care system that often ignores their pleas for help, many women have simply retreated into a, sometimes dangerous, self-care mode. Without a better understanding of the symbiotic relationship between health factors and the adjustment of older female inmates, it is likely that the causes of these pains, whether physical or psychological, will more than likely never be determined or addressed.

Some caution must be used, however, when reporting outcomes that examine the perspectives of inmates regarding their perceived care (Ammar and Erez 2000). Conflicts continue to exist between the perceptions of inmates and their care providers, including differing views and expectations regarding health care delivery in a prison setting. It has been noted that often inmates have a misconception about the realistic level of care prison can provide given the level of staffing and scarce resources (Fearn and Parker 2005). Any delay in medical care may contribute to the notion of receiving inadequate care on the part of inmates. However, from the perspective of medical providers, lack of resources and the cumbersome task of transporting women to outside care providers are often recognized as reasons for treatment delays. Despite differing views among stakeholders, correctional administrators should consider how specific policies can affect the health care of inmates. Every attempt should be made to reduce the discrepancy between "the types of services corrections officials report exist, and what inmates actually receive" (Fearn and Parker 2005, 18).

Implications for Practice

The experiences that aging women encounter while confined to prison are particularly revealing for correctional policies. As a result, prisons are increasingly challenged to provide care to older inmates with a litany of chronic medical conditions, including diabetes, heart failure, cognitive impairment, and a number of other end-stage diseases. From a policy standpoint, there is a formal recognition that inmates are entitled to health services consistent with prevailing community norms. The U.S. Supreme Court's decision in *Estelle v. Gamble* in 1976 mandated that having custody of a prisoner's body and controlling his or her access to treatment imposes a requirement to provide needed care (Rold 2008). Any deliberate indifference to serious medical needs of prisoners may be judged as cruel and unusual punishment. Correctional facilities have a duty to hire competent medical employees and ensure they are capable of rendering proper health care services (Granse 2003). Administrators also have a duty to maintain

medications and equipment for the health and safety of inmates (Vaughn and Collins 2004). In keeping with the mandates of the Eighth Amendment of the U.S. Constitution, which prohibits inflicting "cruel and unusual punishment," correctional health care policy must continually monitor access, quality, and cost as part of a comprehensive plan to ensure quality care (Human Rights Watch [HRW] 2012). It should be noted that current prison health care policies in the United States do not recognize the principle of equivalence of care and, as a result, fall short of the human rights framework for prisoners recognized internationally. Thus, not only do current prison health care practices fall short of long-established World Health Organization guidelines, many prisons have been guilty of failing to meet existing lowered standards in the United States (Maschi and Aday 2014; World Health Organization 2007). This is particularly important for older prisoners because they tend to have more health problems and are more likely to be victimized than younger inmates.

While the American Correctional Association and the National Commission on Correctional Health Care standards require unimpeded access to medical care, in some institutions prison guards or other nonmedical personnel may be ultimately responsible for the initial decision of whether a woman can seek medical attention (Morton 2004; Robbins 1999). If the inmate is unable to convince a person in authority of her illness or if she is seen as a problem person or a chronic complainer, timely health care services may be denied. At the very least, correctional officers should receive training so they can identify the various physical, cognitive, social, and emotional changes that accompany the aging process (Cianciolo and Zupan 2004). Research has found that correctional officers frequently have very little knowledge of geriatric prisoners' disabilities, and significant improvement in disability assessment is needed (Williams et al. 2009). Despite training, some corrections officers, or medical personnel for that matter, will not have the personal qualities and aptitudes for working with older offenders.

It also has been acknowledged that medical facilities in many state and federal prisons are simply unequipped to effectively provide the appropriate care to treat advanced chronic diseases commonly found among older inmates (Gibbons and Katzenbach 2006). Some have suggested increasing the use of age-segregated units, not only as a cost-effective approach but also to provide older inmates with access to, and appropriate utilization of, quality health care services (Kerbs and Jolley 2014). Others have called for the establishment of annual comprehensive geriatric assessment for older prisoners to determine whether an older prisoner is housed appropriately (e.g., access to handrails, geriatric beds, and chairs; lower-bunk assignment; etc.) or placed in an appropriate therapy program or work assignment consistent with functional health status (Strupp and Willmott 2005). Finally, it should be recommended that policies and practices provide prisoners with a community standard of care, including provisions for the unique needs of older women.

With hundreds of millions of dollars being spent annually on health care alone, new approaches are being proposed not only to provide cost-savings but also to ensure a greater quality of care. The debate continues concerning the use of co-payments by managed care organizations and whether they may actually cost more to administer than any savings they may recoup (Gibbons and Katzenbach 2006). Some correctional systems are engaging in promotional health policies that encourage inmates to participate in chronic care clinics, physical activities, and nutritional diets (Aday 2003; Aday and Krabill 2011). Such proactive activities are no doubt providing older inmates with access to health care that the majority would not enjoy on the outside. Regardless of the negative perceptions of prison health care, many inmates acknowledge the benefits of the end-of-life care they receive.

Taking a healthy aging approach by reducing the risk for disease and advancing the health and well-being of incarcerated populations ultimately benefits the community at large when offenders reenter society (Braithwaite, Treadwell, and Arriola 2005. Given that approximately 80 percent of older offenders who are serving sentences other than life without parole will ultimately be released, providing a seamless bridge between prison and community is a key component for a smooth transition back to the community (Aday and Krabill 2011). Certainly, coping with physical health problems creates a significant challenge for successful reentry. The complex health issues of those being released can be a serious problem not only for the ex-offender but also for her community (Patterson 2013). Obtaining treatment for physical health problems is particularly challenging, as the majority of older offenders lack quality health insurance and must rely on Medicaid for support. Inmates who have turned 65 will be eligible for basic Medicare coverage but may not be

able to afford Medigap supplemental insurance that covers some of the costs (co-payments and deductibles) not originally covered. Since such health benefits are often suspended during incarceration, activating or reinstating benefits and restoring eligibility can take months (Gunnison and Helfgott 2013). The use of detailed assessments and case management strategies will be essential for ensuring a successful post-release transition and assuring that elders receive proper medical and mental health treatment.

Conclusions

Medical personnel in prison settings are sworn to adhere to the Hippocratic Oath, which calls for empathy, healing, and caring. However, they also frequently work in correctional facilities where the treatment component is subjugated to perceived security and cost management. While prisoners have a right to timely access to an appropriate level of care for serious medical needs, it is obvious from the findings here (and elsewhere) that criminal justice health care systems are under-prepared or unwilling to provide cost-effective quality care for older adults. The notion of "stack 'em deep" and "let 'em rot" is still a prevailing policy toward prisoners (Austin and Irwin 2012). Although not all prisons overtly create and advocate the misery and medical neglect of aging incarcerated women, it must be acknowledged that some prison systems do encourage medical delays and non-treatment. Vaughn (1999) reported in his assessment that medical personnel from 17 states and the District of Columbia were found by the courts to have practiced penal harm medicine by either denying or delaying health care to prisoners. With tremendous pressures to reduce penal health care costs, there is no reason to think that there has been a drastic decline in penal harm activities.

It is understood that correctional health care policymakers and administrators are often faced with limited resources and, in some cases, lack the power to deliver quality health care. They act—in theory, at least—in the best interests and care of incarcerated women (Morton 2004). Although Clear and Frost (2014) have recently called for a reduction in harsh conditions and mass incarceration, penal harm is still an invisible but ubiquitous presence in many prisons across America, including those occupied by women. While policy-makers must do more to address the negative consequences of penal harm in general, they also must introduce a gendered health care perspective into women's prisons (Aday and Krabill 2011; Britton 1997). It is apparent that current policies are often fraught with ageist and sexist attitudes, leading to a disregard for the human spirit, particularly among so many women who are nearing the end of their lives. Creating a welcoming medical environment within the confines of a harsh prison setting that fosters positive approaches to healthy aging can, in the long run, reduce prison health care costs while providing a more therapeutic milieu for women "aging in place."

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