Health Delivery Systems in Women's Prisons: The Case of Ohio

Nawal H. Ammar, Kent State University
Edna Erez, Kent State University

THE DRAMATIC GROWTH in the women's prison population has contributed to making the particular needs of incarcerated women a prominent issue among practitioners, academicians, and human rights advocates. The October 1998 Amnesty International findings of abuse of women prisoners and of inadequate medical care for them in Michigan, Illinois, California, and Maine evidences this mounting concern.

Introduction

To date, however, very little integrated empirical research has been conducted on systems and processes of health care delivery or on their perceptions by both prison medical staff members and patients. Most of the empirical work has focused on specific issues, such as inmates who are pregnant or are mothers (California Department of Justice 1988; Markovi 1990; Fogel et al. 1992; Woolridge and Masters 1993; Bloom, Lind and Owen 1994); inmates who are battered women (Lindsay 1978; Dobash, Dobash, and Gutteridge 1986; Sargent, Marcus-Mendoza and Yu 1993; Ohio Department of Human Services 1995); inmates who are infected with HIV (Kurshan 1989; Smith et al. 1991; Hankins et al. 1994; Durham 1994); female inmates who have mental health problems (Chonco 1991; Fogel 1992; Singer 1995); and inmates who use drugs (Kassebaum 1994; Maden 1994). Some studies focused on improving existing programs (Belknap 1996), and others have focused on successful programs (Flanagan 1995). None of these studies has approached the health delivery services in women's prisons as an integrated system or provided descriptions and evaluations of the provision of health care in prisons as a whole.

This article examines women's prisons in Ohio as an integrated system and thus fills the void in the current research on health delivery in prisons. Ohio's three women's prisons are used as a case study to enhance the understanding of the issues that confront the prison authorities and the medical staff providing services to prisoners. Specifically, the article focuses on two issues: 1) the structure of health care delivery system in women's prisons; and 2) the medical staff's perception of the structure, including the quality, processes, and ways to improve health care delivery services.

Methodology

The data were collected during visits to the three women's prisons in Ohio: Ohio Reformatory for Women (ORW) in Marysville; the Franklin Prerelease Center in Columbus (FPC); and the Northeast Prerelease Center in Cleveland. In each prison we employed several qualitative methods of data collection: focus groups with medical and paramedical staff members; unstructured interviews with physicians, wardens, and other medical staff members (e.g., nurses or nurse assistants) and observations of actual incidences. In all but one case, conversations were tape-recorded and later transcribed.

The Prisons and Their Populations

The Office of Correctional Health Care in the Department of Rehabilitation and Correction of the State of Ohio is responsible for health care delivery in the state prison system. The system has three major divisions: clinical office, recovery services, and medical care. Our research focuses primarily on the medical care division and on its staff.

The Ohio Reformatory for Women (ORW), which opened in 1916, housed (as of June 1998) 1,787 inmates. They include all security levels of female inmates.

The ORW employs 496 staff members, of whom 43 are corrections officers and 29 are part of the medical/paramedical staff. The prison at Marysville also serves as a reception center, and all female inmates sentenced to prison are sent to the reception center for initial processing and classification.[1] The Marguerite Reilly Hospital at ORW is at the center of the compound, and contains offices for all medical and paramedical staff members except the dentist, whose office is located in a separate building. The hospital also has seven infirmary rooms with single beds and two with showers, toilets, and sinks. The rooms are archaic, and their age is apparent. The hospital houses a pharmacy and also has a mammogram machine, a dental X-ray machine, and a telemedicine room.[2]

Franklin Prerelease Center in Columbus houses minimum and medium security female felons. It opened in 1988, and as of June 1998, it had 459 inmates. The Franklin

This study is part of a larger research project on health issues of women in prison, supported by a grant from the Open Society.

Prerelease Center, in sharp contrast to ORW, is a newer and more modern facility. This prison has 135 staff members, of whom 62 are correction officers and 12 are on the medical/paramedical staff; in addition an OB/GYN comes from the Ohio State University Hospital system on a rotating basis. The physicians at Franklin are all privately contracted through a company that oversees their operation. Unlike ORW, Franklin Prerelease Center is adjacent to the state's prison medical center, and hence does not have a pharmacy or any of the "isolation" infirmary units that are found in ORW. The medical facility itself is also very different from that of ORW. Housed in the cells building, it consists of three rooms and a space with a window for dispensing medicine.

Northeast Ohio Prerelease Center was opened in 1988. It is a minimum and medium security facility. As of June 1998, it housed 624 inmates. The prison employs 173 people, of whom 81 are correctional officers and 13 are on the medical staff (all nurses). The Center's three physicians—a podiatrist, optomologist, and a dentist—are all hired through a private contract, and their operations are organized by a secretary employed by the same corporation. The prison has no pharmacy; a registered nurse dispenses prescribed medicine that is purchased through the private corporation.

The demographics of the women incarcerated in these three prisons shows that 70 percent of the women who enter the prison system are incarcerated for periods ranging from 2 to 15 years and enter the system between the ages of 19-45 (ODRC, Bureau of Research, 1997). Although older offenders in Ohio's women's prisons are not an overwhelming majority, they nevertheless represent 55 percent of the inmate population. Most of these inmates (86 percent) are admitted to prison by or before the age of 50 (ODRC, Bureau of Research 1997). Over half (56.4 percent) of the women in Ohio's prisons are African-American, and Euro-American women form the second largest ethnic group (41.8 percent) (ODRC, Bureau of Research 1997).

The Structure of Service Delivery

Beaumont and de Tocqueville pointed out in the 19th century that "it is because they [female prisoners] occupy little space that they have been neglected" (1833/1964, p.72). This characterization still applies today to all women's prisons in the United States, including those in Ohio. Incarcerated women represent about 5 percent of the entire incarcerated population; the remaining 95 percent are men in male institutions, and a small percentage in coed ones. One of the medical directors said at the very beginning of our conversation with him:

> In the past two and half years the population of the prison increased from 1,400 to 1,800. There is not [an] equal amount of staffing in women prisons as in men prisons. People here are coming sicker than ever before. Staffing of the women prisons follows the male mode: 300 men to three nurses. But women in prison go to doctors two and a half times the rate of men. Women have problems that men do not have—depression, gynecological problems, etc. (Nurse Gregory).[3]

Another medical director at a different prison reiterated this idea that female inmates need many more resources than their male counterparts do in terms of health care:

> Female inmates are more demanding and have far more medical problems. You see an inmate on sick call and she has eight or ten complaints (Nurse Thomas).

Every health professional or group of professionals we interviewed mentioned the multiplicity of health complaints that incarcerated women bring with them to prison. One of the registered nurses noted:

> Most of the women are physically a mess: They have been shot, stabbed, hit in the head, and there are 20 or 30 of them in this institution that we know have HIV. They also have illnesses such as cancer of the breast, throat, brain, ovarian and thyroid, or terminal heart disease (Nurse Burns).

Another registered nurse at ORW stated:

> A third of the inmates are mentally ill, 20 percent are seriously mentally ill, and they go off and are prone to pseudo-seizures. Fewer men are mentally ill and [a] smaller proportion is on mental illness medications. Between 60 percent to 70 percent of the women here have problems with alcohol and drugs. They also have had erratic assessment of mental health and self medicate (Nurse Weller).

The general picture that emerges from the data is that the health care delivery in the three institutions for women in Ohio is managed as "crisis care" (Collins 1997). The system is highly overburdened and its population is very needy. The institutions are overcrowded, and they must overcome bureaucratic hurdles and follow procedures at every juncture, most notably because health care delivery in women's institutions is modeled after male prisons. The latter, however, require far fewer resources and less medical attention to the inmates. The health care professionals in the women's prisons, confronted with this reality, manage the problems they face as a perpetual crisis to which everyone has become accustomed. In the words of one health administrator,

> Health delivery here is like the emergency room. Every thing is noisy, done in a hurry and everyone is overworked. The women-inmates are also used to this environment of heath care (Nurse Wagner).

In one institution, the health workers hurried us into the dentist's office so we could witness the resource problems they face and see first-hand how the female inmates' lifestyle prior to incarceration affects their health care needs. During our visit, the dentist, who works six hours a week and serves more than 600 inmates, was treating four inmates. Two were waiting for the anesthesia to become effective, and one inmate who had a whole row of teeth pulled out was waiting for the next row to be pulled. The dentist showed us a 31-year-old patient with no teeth in the back of her mouth and with tips broken on all of her front teeth. We were told that the woman's teeth had been broken in domestic violence situations. The dentist said that the last time this inmate was in her chair, she had a seizure that frightened the dentist and caused alarm in the office and among the patients waiting to be treated. The dentist later learned that the head injuries that led to the seizure were caused by the battering the woman experienced in her marriage. The inmate was seeing the dentist because the infection in her gums affected her entire left cheek, including the sinus ducts. The dentist explained:

> Such an infection with a person who is prone to seizures of this kind can really hurt her. She had to wait for [a] few days for me to show up, and I

only have 6 hours a week. I need 6 hours to work on her alone. But I will stay here a little longer to finish my work.

This concerned and committed dentist is representative of the staff members we observed, and the ones who would survive in the institution and would not burn out quickly. They are keenly aware of the special needs of their patients, as well as the difficult and at times unpredictably dangerous surroundings in which they work. This description also fits the medical director at ORW, who complained about how difficult it is to hire competent people to work in the prison. In reply to our question concerning the way he manages inmate-patients this physician stated, "I make patients comfortable; I ask her why she is not taking her medicine. I manage female patients by treating them like everyone else" (Dr. Stanley).

Although there are a few commonalities among the institutions we studied — for instance, the crisis mode in which health care takes place and the caliber and dedication of many of the health care staff members— it is difficult to provide a clear-cut topology of the structure of these three institutions. Their differences and unique characteristics can be attributed to variation in size, function, and geographical location of the prisons.

Similarities in Health-Care Delivery

Delivery Routine

Routine health services are handled through sick call and chronic care clinics. Medical request forms, referred to as "kites," are available to inmates needing health services. Inmates fill in their name, identification number, date of birth, unit, the date of request, and the service they are requesting (dentist, podiatrist, gynecologist, optometrist, and medical).

For sick call, the nurses assess patients and then refer them to doctors. The assessment is made on a standardized form provided by the Ohio Department of Rehabilitation and Correction (ODRC). Women stand in line to take their medicine, including psycho-tropic drugs. Since physicals are not available every day, patients are scheduled to see the physicians on the day or days on which they are available. In an emergency, the physician is called/paged, and the nurse consults with her/him.

In all three institutions we visited, the immediate response to our question about "routine activities of medical and paramedical staff" was "There is no such day. There is no typical health problem and no typical day." After spending several days in some institutions, we realized that the medical staff is responsible not only for medical problems but also for evaluating the medical condition of inmates who are not ill. During an interview session in one of the prisons, the medical staff was called to a different building. One of the inmates was in segregation, and she had an emotional outbreak that led her to throw her food tray, an action that resulted in a broken fire sprinkler. After being restrained in the bed of the segregation unit, she was able to sit up in a posture that put an enormous amount of pressure on her wrists. The medical unit was asked to make an assessment of her wrists and to record their findings in a report.

The medical staff also conducts "chronic-care clinics" for diabetic, cardiac, pulmonary, asthma, HIV, TB, and seizure cases. These clinics, intended for inmates with chronic illnesses, were established because the Department of Rehabilitation and Corrections introduced a new system of co-pay in March 1997. This system requires that inmates pay $3 for each sick call they make. For chronic problems, the women are referred to these clinics on a weekly basis. Although we did not conduct a systematic study of the effect of the co-pay on the volume of sick call requests, the opinion of the staff was that it did not significantly reduce the number of women seeking medical help. One medical staff member said, "The volume of requests dropped the first two weeks after the co-pay system was introduced, but it has leveled off now"(Nurse Thomas). Another one commented, "The number of patients has not dropped. Actually, now the inmate wants to take care of all her problems in one visit"(Nurse Gregory). A third medical staff member noted that "the system of co-pay and the system of introducing off-the-counter medications in the commissary to buy has led women inmates to develop new manipulation techniques to reduce their expenditure of health care"(Nurse Weller).

All routine health care is delivered within these two structures. There is, however, other routine care such as prenatal care, dialysis, testing of blood, that is done on a case-by-case basis and is routinized through forms and scheduling.

Shortage in Human and Other Resources

A shortage of both financial and human resources was the major complaint that we heard from medical staff in all three institutions. Despite the differences in the type of inmates that they handle, all three prisons have a shortage of nurses. Ideally, three nurses should be on duty during each of the three shifts in the prisons. Generally, the best scenario that we saw was two nurses during the first two shifts and one nurse during the third. Some of the nurses in all three institutions mentioned this problem. The small pool of nurses, they explained, means that if one nurse becomes sick or cannot show up for work, the nurse on duty is "frozen" and cannot leave because the institution requires a nurse on staff at all times. This unpredictability in working hours was a serious concern, and nurses mentioned having to cancel family or personal plans in the past because they were "frozen." In addition to a shortage of nurses, the length of time that specialized doctors are available is also problematic. The dentist who is only available for six hours a week at one of the prisons noted that she could work at least work 30 six-hour days every month to finish treating all of her patients.

Space seemed to be a concern in terms of health care for the two smaller institutions we studied. Issues of privacy, transmutability, and room to maneuver are critical issues affected by the amount of space available. At ORW (the largest prison), the infirmary was a cause of concern because of its dilapidated condition, its lack of basic amenities in all of the rooms, and its proximity to the unit housing maximum security inmates.

At the time of our visits to ORW, there were seven vacant positions in the medical care unit alone. The problem shared by all three institutions has been the hiring of qualified personnel. According to the medical and nursing supervisors at ORW, qualified candidates for correctional health care need the following attributes:

> First, assessment skills, or the ability to be quick, figure out who is telling the truth and who is manipulating the situation so that they do not have to go to work; second, should be quick at dispensing medicine if they are nurses; third, care itself; and four, see inmates as humans (Nurse Gregory).

The medical administrator at the Franklin

Prerelease Center intimated:

> Correctional nursing is not for every one. There is a unique experience for correctional nursing. Manipulating is a constant issue. All nurses need to have the assessment skill to determine the difference between want and need (subjective and objective complaints). Correctional nursing is a specialty where you stay all rounded. You see problems of all kinds and unlike the outside world, you do not specialize (Nurse Thomas).

Yet, all of the doctors and nurses with whom we talked noted that the advantages of working in health care delivery within the prison far outweigh the problems they encounter. These problems included safety concerns; the perennial need to strike a balance between empathy and distance; the unappreciative inmates; and the lack of opportunities for professional advancement. Most of the staff members, however, found the working conditions satisfying due to the autonomy that the nurses have, flexible hours, and the rewards of seeing people who were "walking dead" improving and becoming healthy. Physicians noted that in view of escalating medical insurance costs and inefficient HMO conditions, prison health care delivery was a very good career opportunity.

In light of the inherent rewards testified to by the medical staff, we wondered about the reasons for the staff shortage in these institutions. In ORW the professionals we interviewed cited the bureaucracy of advertisement. It takes seven months from the day the Ohio Department of Rehabilitation and Correction offers someone a job before this person is actually working. Also, they said that they have had "some bad candidates, and some of the good ones bailed out the last minute."

Differences in Health Care Delivery

The major difference between the women's and the men's prisons in Ohio is that for the women, one parent institution, ORW, functions as a prison, reception center, and residential unit for the severely mentally ill.[4] The three women's prisons we studied differ from each other not only in the size and security levels of their populations, but also in the programs available to their inmates. The parent institution, ORW, has five of Ohio's Penal Industries, while the Franklin and Northeast Prerelease centers have none.[5] Furthermore, the parent institution is not accredited by the American Correctional Association, while the Franklin and Northeast Prerelease centers were accredited in 1995 and 1996, respectively. The institutions have different structures for their health delivery systems.

Level of Privatization

Although the nurses and the health administrators in all three women's prisons in Ohio are employees of the state, and all of the specialty physicians and the medical administrators are on a private contract, the actual "privatization" of the systems varies. At ORW, the medical administrator has a private contract with the state. This administrator is at the institution five days a week (Monday through Friday) and is on call during the weekend. He clearly works closely with the health administrator and the nurses and considers this closeness part of his job. He has no other private practice besides his state job.

In the Franklin Prerelease Center the medical administrator is also on a private contract with the state through a health care agency (ANACHE). He has a private practice in Cincinnati and works three days a week in Columbus for ten hours each day. The state nurses and the health administrator, however, conduct the screening and evaluation of patients in this institution. The physician is also available 24 hours a day by phone and by pager. At Franklin Prerelease, all other services are conducted by the neighboring institution, Correctional Medical Center; hence, Franklin has no pharmacist, podiatrist, dentist, optometrist, or laboratory technicians to test for blood on-site. The OB-GYN at Franklin, the institution where pregnant inmates are sent within the system, consists of Ohio State University Hospital doctors who work on a five-week rotation.

In the Northeast Prerelease Center, the medical administrator (an M.D), gynecologist, dentist, podiatrist, and optometrist are all contracted through a private company, Correctional Health Care Solutions. The company has an office inside the prison where a secretary helps the nurses screen the inmates' complaints. All the nurses are state employees. The medical administrator at the Northeast Prerelease is a retired neurologist who works three days a week. The physician who practices as a gynecologist works two days a week; the dentist works six hours a week; the podiatrist and optometrists work eight hours a month, and six hours every three months for diabetics. All of the medical and paramedical staff members meet bimonthly to coordinate the work and compare cases.

Such differences in the matrix and presence of private and public health care poses questions: Does the private health care company that coordinates health care delivery in the prisons provide the same quality of care as its public counterpart? Has private health care delivery solved some of the resource problems that the state faces? What are the tensions that exist between the state nurses and the private medical doctors? These are important questions that need to be addressed in future research.

Degree of Within-Institution Care

The three institutions also differ in the degree to which they provide care within the institution. The medical and paramedical staff members in the three institutions agree that female inmates prefer to be cared for inside the prisons. The health administrator at ORW said, "The women do not like to go out for clinics or treatment because they have to be shackled. It is demeaning to them"(Nurse Gregory). With the exception of emergency care, ORW provides the most in-house medical (and mental health) care.

ORW has a telemedicine facility in conjunction with the Corrections Medical Center and the Ohio State University Medical Center. This facility was initiated in 1995 as a pilot project by the Ohio Department of Rehabilitation and Corrections at the Southern Ohio Correctional Institution at Lucasville. The system has been expanded to include many prisons in Ohio, and it aims to provide improved access to specialty care. At ORW, the nurses use two-way video equipment as communication links, connecting medical devices to provide evaluation, diagnosis, and treatment.

The Franklin and Northeast Prerelease centers do not use telemedicine. The health administrator at Franklin pointed out that this kind of technology would eventually be used in the institution, but at Northeast Prerelease no one mentioned the technology or plans to use it. Moreover, due to the proximity of the Franklin Prerelease center to the Corrections Medical Center (they are adjacent), most specialty care and the more difficult cases are transferred from Franklin to the Corrections Medical Center. Hence, the Franklin Prerelease Center provides less in-house care than Northeast Prerelease Center.

Specialization in Case Management

The three institutions that house female inmates in Ohio differ in their management of health care delivery. In addition to ORW housing the Residential Treatment Unit (RTU) for the severely mentally ill, all debilitating, severe, and problematic health care cases are sent from the other two institutions to ORW. Terminal cases are often sent "on mercy" decrees to hospices or released to family members. In the Franklin Prerelease Center, we heard stories of the prison staff holding on to inmates with terminal cancers until they could be released. We learned of a case, however, in which an inmate with a terminal cancer and brain deterioration became violent and was sent to ORW.

In their specialization of case management, ORW carries the heaviest burden of severely ill inmates, including those with symptoms of AIDS, while the Northeast Prerelease Center retains only the inmates with average problems. We heard the statement, "We send them back to Marysville [ORW]" more often at the Northeast Prerelease Center than we did at Franklin.

Franklin, on the other hand, specializes in pregnant inmate care. The structure of the care is such that a regular number of inmates come to Franklin from ORW (every Tuesday); most of them are pregnant and some of them are sent after classification at the reception center. The health care administrator at ORW said, "The women who are found to be pregnant do not stay more than a week here, we send them immediately to Franklin Prerelease" (Nurse Gregory).

At ORW, the routine reception of pregnant women affects their staffing and procedures as well as the care they give women. One health administrator noted:

> We have between 20 and 46 pregnancies a month. For OBGYN, we book in priority of pregnancy, especially for the newcomers. OBGYN changes every five weeks, and there is an obstetrics nurse from Sunday to Thursday. On occasion, when the obstetrics nurse is not on-site, and the other nurses have to deliver, the other nurses do not like it because many have no experience in this field (Nurse Thomas).

Such specialization in case management and health care delivery requires specific planning and resource allocation for particular institutions even within the realm of the general category of women's prisons.

The Medical Care Staff's Perceptions

In addition to the adequacy of resources, four other themes emerged from probing into the medical staff concerning their perception of health care delivery. They include 1. the relationship between staff members and inmates; 2. the need for basic health education for the inmates; 3. the impact of security/custody demands on health care delivery; and 4. the pride in the quality of service.

The Relationship Between Staff Members and Inmates

The need to maintain boundaries and strike a balance in the relationship of the medical staff members to the inmates was repeated by all the medical staff with whom we spoke. The difficulty of maintaining such a balance has led to dismissal of a few nurses and doctors. This difficulty has in turn led to the shortage in staff members and overburdening of the overall structure. One health administrator observed:

> The advice is to keep your distance. The hardest thing to working in prison as a nurse is one can be sympathetic and empathetic, but to a degree. Unlike nursing on the outside, you have to protect yourself (Nurse Thomas).

One physician, in response to our question concerning the relationship between staff members and inmates, stated:

> In a prison situation, only the nurses and I are allowed to touch. The patients also have a need to vent personal information. The problem for a doctor in this situation is to balance between professionalism and the things that are beyond personal barriers. For example I want to know when someone has had sex with her friend so I can diagnose, without having them being afraid that I will turn them in. Lots of doctors have difficulty keeping this balance (Dr. Stanley).

In a focus group in which the health administrator and the nurses talked about their perception of health care structure and the relationship with inmates, one of the nurses stated:

> You have to watch out that you don't get involved with prisoners. You should make sure that the medical staff knows to draw the line between caring for someone and becoming over involved, yet not diminishing that person because they are just an inmate. These are unloved people, these are people from abusive relationships, and they do not know how to do relationships. It is something about unconditional respect. These women have never had this, and when they get it they don't seem to understand it and think you have some hidden agenda, that you want something from them. And that woman (referring to someone we met on the way to our focus group) as nice as she was and as nice as she is to me, when I said no to her, then she becomes abusive, and she will go out of her way to try to make the medical staff and the medical service here look terrible. So understand that is the kind of situation we get with this clientele. And I truly love these ladies. I want you to know that. I truly do, but you do have to remember that they are here for a reason. They're not just here because they are here. You have to remember that (Nurse Gregory).

Keeping a balance between professionalism and compassion in health delivery services within a prison was also perceived as an essential part of the administrator's job as well as something that affects the overall morale of the overall staff. One health administrator said:

> The effect of this need to balance your compassion with your professionalism is that you have to always watch out for your staff, keeping track, making sure they are OK and keeping their boundaries well, and they are staying safe and the inmates are not becoming overly involved with anyone or thinking that because so and so is nice to them, that means something else. This watching and telling staff affects their morale (Nurse Thomas).

The physician in one prison noted that this need to balance professionalism with compassion affects his job because:

> I get accused if I see someone too often for having something going with this inmate if I schedule a follow-up. I have not been able to see you for two months, but I see her twice in a week. But for example, in a case where

> the person has had a real emergency, she had a sore throat, then we discover she has throat cancer, then I have to prescribe radiation therapy and follow-up, then she loses her voice, and I have to follow up. In this case, I develop a close relationship with this inmate because of her sickness, but there is always talk about underlying relationships between me and an inmate (Dr. Stanley).

A related concern raised by the medical staff in all institutions was the continuous need to be on guard against being manipulated by the inmates who often use the staff or the delivery of health services for their own ulterior motives. For instance, inmates may ask the medical staff to provide medically based prerogatives (such as sleeping on a lower bunk bed in the room because one suffers from back problems and cannot climb to a higher bed), or receiving prescriptions for various medications (which in prison become valuable commodities that can be exchanged in the inmates' informal market system). Nurse Gregory noted how

> the women are nice to you today, they say good morning and ask you how you are doing. After a little while they tell you about how they can't climb on their bed and need an upper bunk. They fill a kite, and with the doctor the same complaint, not because they are in pain, but because they want a lower bunk.

This commodification of health-related services and products, and the exchange economy developing around them in prison, is closely related to the lack of basic health education among inmates, discussed in the next section.

The Need for Basic Health Education for Inmates

One issue that emerged from our focus group discussions and interviews with the medical staff was the need to educate the women inmates about basic health practices, and how to become better patients and prevent disease. Since most of the women in the three prisons have preexisting conditions, such as high blood pressure, seizures, diabetes, HIV, and gynecological problems, the staff repeated the notion that to improve health delivery services, education is essential. The health administrator of one of the prisons stated:

> You know half of our patients' level of education is like sixth grade, and they do not comprehend simple things, such as they need to wash their hands after they go to the bathroom. Simple things of how to prevent colds, how to treat colds, how to treat STDs [sexually transmitted diseases], what is immunization, and what should your child get. Just what you and I take for granted as givens, they do not know. They don't know what head lice are and how it spreads. They think they jumped into too many beds. They are a very poorly educated people when it relates to health issues. And that is the only way to deliver good health care, to educate them about their health. But at this point in time, we cannot provide this basic education because we do not have enough staff (Nurse Gregory).

A nurse at one of the prisons observed:

> We need to have smoking cessation classes for the women in here since more than 75 percent of them smoke. They need to know how to quit and what smoking does to them. But we do not have the staff. If some of these women quit smoking, we will reduce sick calls and "kite" writing (Nurse Graham).

The need for health care education was raised in all three prisons. In the Northeast Prerelease Center, they used to have nursing students teaching inmates health education. According to the secretary of the private health company, "We have not seen these people for a while"(Ms. Flora).

The Impact of Security/Custody Demands on Health Care Delivery

The way security needs affect health care delivery services was a primary concern to most medical and paramedical personnel with whom we conducted interviews and focus groups. This issue was of great concern, particularly for the professionals we interviewed at ORW. One person stated:

> It [security] does impact you, and we do have counts. And if they are here for sick call, and they're doing a count, they have to go back if they are here for their medications, and they may miss their medications (Nurse Burns).

Another person commented:

> I imagine if I were in a fire, I would approach it differently from a fireman. But imagine I was in a fire with a fireman, and I am ordering the fire marshall. That is how it feels when you deliver health care in prison (Dr. Stanley).

The same person expressed a frustration in managing the tension between health care dictates and custody concerns:

> There is also the problem of correctional officers (CO's). Working with this population, everything becomes right or wrong. An inmate is crying and runs to see the psychologist. The CO sees her out of place and gives her a ticket. The issue is not what can we do to help her, but that she is out of place. A lot of this is [being] uneducated. For COs, the medical needs are not as important as safety. Making sure an inmate takes her medication or not is not as important. I have someone who has recurrent chest pain. Soon, she will have a heart attack. I call, make an appointment with a cardiologist, make attempts to transport her, and in two days, she can see a specialist. Her appointment with the cardiologist is on Thursday. On Friday I ask her how was the visit. She says, "I did not go." I ask the CO, [who says] "There was fog, and we were understaffed. We will take her next week." There is a lack of education and appreciation of what is at stake here. The need for preventive care and critical thinking is lacking. We constantly fight with the limited vision of security. There are, for example, three or four people lined up, the warden wants X person right away to be seen. I interrupt my priority for the day because the warden is "God," and the warden has been approached by an inmate or (someone) and sees this as an immediate problem, and her priorities are more important (Dr. Stanley).

Pride in the Quality of Service

Pride in the quality of medical care delivery in women's prisons was a major theme among the people we interviewed and with whom we conducted focus groups. Medical care delivery, according to one prison nurse, is "excellent." This registered nurse continued, "I

would challenge you to find anyone from this group of women [that when on] the outside has the quality of care that they can get here on [a] daily basis." Our interviewee and focus group participants shared a general perception that the health care that women inmates receive inside the prisons is immediate and lifesaving. From the focus group at ORW, for instance, participants made such statements as: "Where would you find anywhere else a person complaining of chest pain being attended to within 5 minutes, except in a residential or nursing home?" "We are really able to do some good work with these women who were self-mutilating and using drugs" and "it is really good to see these women come back from the walking dead."

The staff reiterated that the inmates enter prisons without having seen a physician in years, emphasizing that the women suffer from prolonged neglect and abuse of their bodies and minds. Health care delivery at this point is assessed against a background of societal problems and economic hardships and not simply in terms of the delivery of services to heal physical ailments. One of the doctors described a woman who was diagnosed with uterine cancer for three years before her incarceration. However, she had eluded the authorities since her diagnosis, and as soon as she entered prison, she announced her sickness.

One nurse told the following story about a woman who grew up in Appalachia:

> She was sold to her husband when she was 13 and lived in a very violent domestic situation for many years, and ended up in prison. I think she assaulted her husband or maybe shot him and ended up in here. And she said to me once that this was the best place she had ever lived in her whole life. It was the first time that she started to learn to take care of herself, to be free from people abusing her, to be able to go to school, to be able to be cared for and not to be abused. So there are some success stories. It is sad to think that a reformatory is the best place that she ever lived, and there are more than a few who think that way, because it is the best place for many of them (Nurse Green).

In addition to a relatively higher job satisfaction level, the professionals also expressed their pleasure with the higher degree of job autonomy and quality of medical care they can offer patients in prison. One of the nurses commented, "We have a little bit of leeway. You know, there are no HMOs saying we can't do a blood test or whatever" (Nurse Mullin).

Working with female inmates also makes medical care service delivery more rewarding than it is in some other environments because women can be better rehabilitated. As one of the nurses observed:

> I am the quality assurance nurse, so I go down to central office and meet with many of the other quality assurance nurses in male facilities. There is the idea that a woman can be more rehabilitated than a man can. If a woman has a family on the outside, children, this gives them a goal to do their time and get out and be a mother again. This is not the case in male prisons. Men do not have the bond usually that the women have with their children. Yes, women do become repeaters, but not like men. I guess there [are] quite a few repeaters in men's prison. I've only seen a handful return in the two years I have been here (Nurse Peters).

Another nurse commented:

> Like I said, I've worked in a male facility. What is unique about a female prison is you get them here, you dry them out, you get them off the drugs, the alcohol, get them on their mental health meds. When you walk out there, it's like a college campus. These people say "hi" and "bye." A lot of the time they won't make eye contact because they are told not to, but these people are very respectful by and large. You'd be surprised how nice they are (Nurse Gregory).

Health care delivery in women's prisons is also easier, according to the medical professionals, because women are usually less violent than men. As one nurse stated, "Male inmates flare up. They hit each other and cause chaos, whereas here, it is just constant bickering, maybe some battering. But that is all" (Nurse Green). Another nurse commented, "Men lash out, while women lash in. They abuse themselves; they cut themselves" (Nurse Peters).

Working in women's prisons, however, is not always easier in terms of health service delivery. Women's problems are often of an emotional rather than physical nature. As one nurse observed:

> We have women that come here who just delivered a baby, and they just had it for a week or two. At least 80 percent of our population [has] been molested, so we have a lot of people with emotional baggage. A woman will come once, twice, and three times complaining about something hurting when really, it is an emotional issue she needs to deal with (Nurse Green).

Summary and Conclusions

The qualitative data collected through interviews and focus groups of medical health personnel in the three women's prisons suggest that Ohio women's prisons exhibit both similarities and differences in their health care delivery structures and processes. The prisons used similar routine health care delivery and all institutions experienced shortages of human and other resources. They differed in the level of privatization of the health care services—some included private medical companies in the decision-making process as well as in rendering services, while others kept privatization at the level of specialty care. They also differed in the degree to which they offered full care within the institutions, ranging from offering almost all services on-site (except for emergency care), to offering most services, except delivery of routine care, outside the institution. Proximity to the Correctional Medical Center and the use of telemedicine contributed to the variance in on-site service delivery. Lastly, specialization in service delivery also differed among the three health care delivery systems. The Ohio Reformatory for Women (ORW) specializes in the more difficult medical cases—the terminally ill, and the severely mentally ill—while Franklin Prerelease Center provides care for all pregnant inmates in the state. It is probably correct to assume that the differences between the institutions, and the division of specialization among them in terms of services rendered to specific populations or for certain medical problems, is related to the shortage in resources that is characteristic of the correctional field. Conserving resources and avoiding duplication of expensive services to a relatively small population of offenders has probably contributed to this division of labor. The attempt to privatize services is also related to strategies for keeping costs at a minimum while providing optimal services.

The similarities in the perceptions of the

health care staff of these institutions, however, are much more important and deserve attention. The health professionals in these institutions experienced common challenges and were presented with the same dilemmas in providing services to the inmates. Of major concern were the paradoxical demands imposed on the prison medical staff, including striking a balance between professionalism and compassionate care, and reconciling custodial and medical needs in an environment in which safety is a paramount consideration in setting daily routines and priorities. Overcoming problems that arise from the lack of basic health education among the inmates and the unique aspects of working with female populations also seemed to affect health care delivery of services to a considerable degree. These issues, together with other factors that preceded the inmates' entry into the system, were major concerns beyond "pure" medical issues which weighed heavily in the staff's delivery of services. This study confirms that, particularly with regard to this population of inmates, the social ills that affect women's lives spill over to the prisons that house them, and shape the kind of problems they present and the services they need. Women's social histories and experiences prior to prison strongly affect their health needs, which in turn affect the manner in which the medical staff delivers its services.

In designing effective policy for delivering health care in women's prisons, those responsible need to address the tensions inherent in the provision of health care services in custodial settings. Similarly, attention should be given to the social history or background of the populations women's prisons serve, and the intricate interaction of these characteristics with professional aspects of health care delivery. Addressing these concerns may be a worthwhile endeavor because, as the current study suggests, the value of professional health care in prison extends above and beyond attending to women's specific health problems or illnesses while they serve their time.

Bibliography

Amnesty International (1998). *News Release Issued by the Secretariat of Amnesty International*, AI INDEX: AMR51/72/98.

Beaumont, G. and Alexis de Tocqueville (1964). *On the Penitentiary System in the United States and its Application in France.* Carbondale: Southern Illinois University Press. Originally published in 1833.

Belknap, J. (1996). Access to Programs and Health Care for Incarcerated Women. *Federal Probation 40, No. 4*, 34-39.

Bloom, B.; M. C. Lind; B. Owen (1994). Women in California Prisons: Hidden Victims of the War On Drugs. *Center on Juvenile and Criminal Justice.*

California Department of Justice (1988). Women in Crime: The Sentencing of Female Defendants. Sacramento, CA, *Bureau of Criminal Statistics.*

Chonco, N. R. (1991). the Mentally Ill Female Inmate: Do Labels Matter Behind Bars? Ph.D. Dissertation, *Michigan State University*, 287 pages.

Collins, C. F. (1997). *The Imprisonment of African American Women: Causes, Conditions and Future Implications.* N. Carolina: McFarland and Company, Inc.

Dobash, R. P., R.E. Dobash and S. Gutteridge (1986). *The Imprisonment of Women.* Oxford: Basil Blackwell.

Durham, A. (1994). *Crisis and Reform.* Boston: Little Brown.

Flanagan, L. W. (1995). Meeting the Special Needs of Females in Custody Today: Maryland's Unique Approach. *Federal Probation*, 59, 49-53.

Fogel, C., et al. (1992). The Mental Health of Incarcerated Women. *Western Journal of Nursing Research.* 14 (1), 30-47.

Ingram-Fogel, C. (1991). Health Problems and Needs of Incarcerated Women. *Journal of Prison and Jail Health,* vol. 10, no. 1, Summer, 43-57.

Hankins et al (1994). HIV Infection Among Women in Prison: An Assessment of Risk Factors Using Nominal Methodology. *American Journal of Public Health.* Vol 84, no 10, 1637-640.

Harris, M. (1980). *Cultural Materialism.* New York: Praeger.

Kassebaum, G. (1994). Polydrug Use and Self Control among Men and Women in Prisons. *Journal of Drug Education.* 24 (4), 333-350.

Kurshan, N. (1989). Women and Imprisonment in The U.S., *New York Times* (October 8).

Lindsay, K. (1978). When Battered Women Strike Back: Murder or Self Defense? *Viva* (September), 58-59 and 66- 76.

Maden, T. (1994). Psychiatric Disorder in Women Serving a Prison Sentence. *British Journal of Psychiatry.* 164: 44-54.

Markovi, V. (1990). *Pregnant Women in Prison.* Chicago: The University of Illinois.

Ohio Department of Human Services, Office of Child Care and Family Services (1995). *Report: Placement Requests Regarding Pregnant Incarcerated Women 1987-1994.*

Ohio Department of Rehabilitation and Corrections (1997). *Older Offenders: The Ohio Initiative.* August, 1-54.

Rafter, N. (1998). Prisons for Women 1790-1980. (1997) In Flanagan, T.; J. Marquart; and K. Adams (eds.) *Incarcerating Criminals: Prisons and Jails in Social and Organizational Context.* New York: Oxford University Press, 30-45.

Sargent, E., Marcus-Mendoza, and C. H. Yu (1993). Abuse and the Woman Prisoner. In B.R. Fletcher, L. D. Shaver and D. B. Moon (eds.) *Women Prisoners: A Forgotten Population.* Westport, Ct: Praeger, 55-64.

Singer, M. (1995). The Psychosocial Issues of Women Serving Time in Jail. *Social Work*, 40 (1), 103-113.

Smith, P. F. et al. (1991). HIV Infection among Women Entering The New York Correctional System. *American Journal of Public Health.* 81 (supplement), 35-40.

Woolridge, J. and M. Kimberlym (1993). Confronting Problems Faced by Pregnant Inmates in State Prisons. *Crime and Delinquency.* (8): 195-215.

Endnotes

[1] The men's prison system in Ohio has two reception centers from which inmates are later transported to their receiving prison.

[2]The telemedicine room connects patients to the Ohio State University medical care facilities via television screens.

[3] Pseudonymous is cited in the text.

[4] Ohio has one reception center for men separate from the other 30 institutions that handle men and two male Prerelease centers that house prisoners six months prior to their release. The rest of the male prisons are specialized in terms of security levels.

[5] ORW has the following OPI's: (a)sign shop making directional signs, name tags, all signs and plaques; (b) optical shop making eyeglasses for all the prisons in the state; (c) flag shop making U.S. and Ohio flags; (d) tent shop making tent floors; and (e) telemarketing