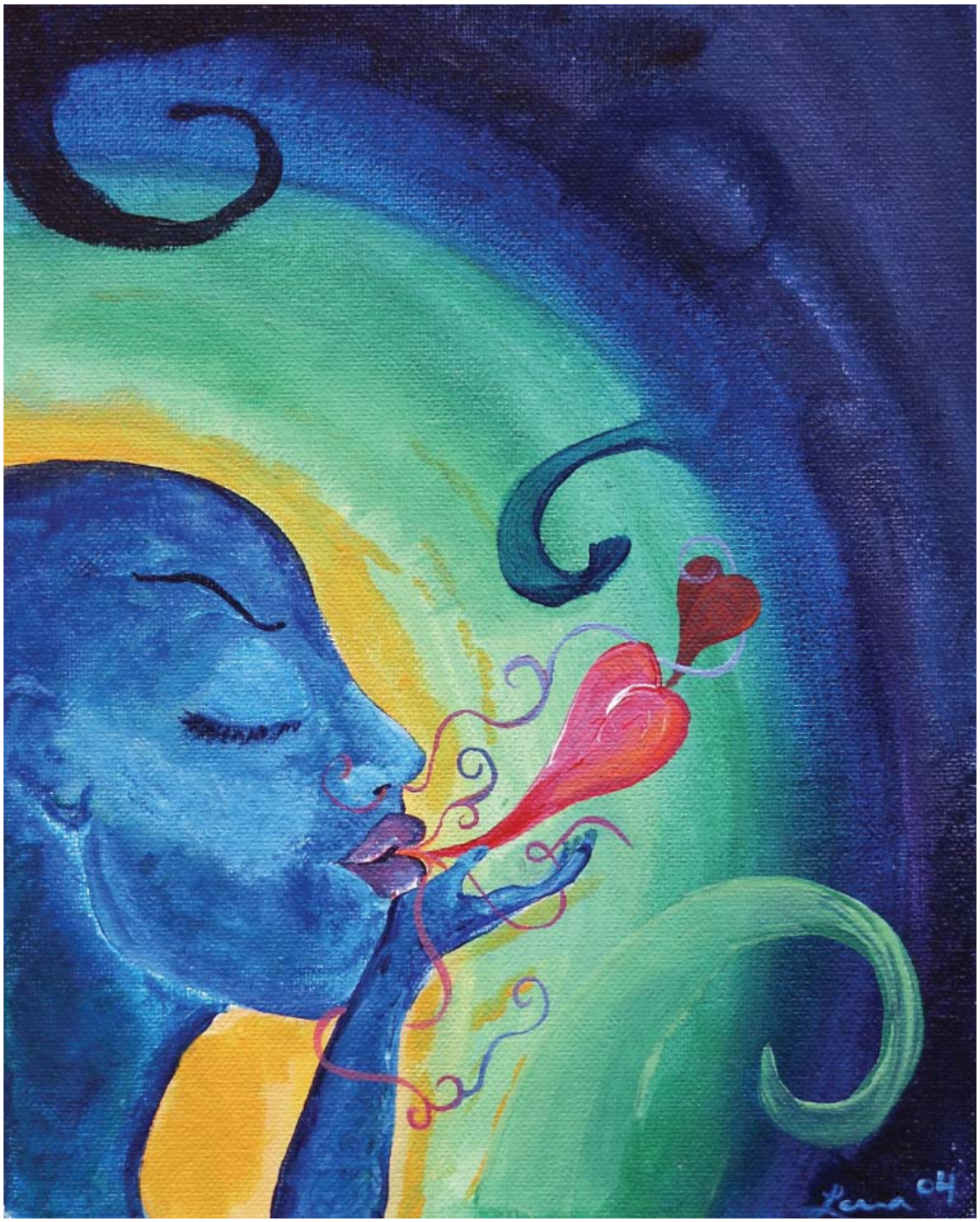
D.C.
Prisoners' Legal Services Project

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

From the Inside Out:
Talking to Incarcerated Women About Health Care

A SURVEY OF INCARCERATED WOMEN IN D.C. JAIL FACILITIES



"Breathe" by Laura Crescio,, currently incarcerated at the Federal Prison Camp, in Greenville, Illinois.

November 2005

D.C. Prisoners' Legal Services Project

The mission of D.C. Prisoners' Legal Services Project is to advocate for the humane treatment and dignity of all persons convicted or charged—or formerly convicted—with a criminal offense under District of Columbia law, to assist their family members with prison-related issues, and to encourage progressive criminal justice reform. It is a private, non-profit corporation.

DC Prisoners' Legal Services Project is the only legal organization with a mission of advocating for the interests of individuals incarcerated under D.C. law, regardless of where they are held. Our three-member staff, with the support of dozens of volunteers and student interns, provides non-litigation advocacy on conditions of confinement issues to more than one thousand clients a year. The Project is also involved in litigation in local and federal court on behalf of clients who have been denied medical care or suffered injury from breaches of patient confidentiality, who have been raped by corrections staff, and even murdered in overcrowded, understaffed correctional facilities. **Deborah Golden, Staff Attorney,** initiated and provided overall management for the project, with direction and support from **Philip Fornaci, Executive Director.**

Johns Hopkins Bloomberg School of Public Health

Johns Hopkins Bloomberg School of Public Health (Johns Hopkins University) has been named the nation's premier public health program for the last two decades, according to U.S. News and World Reports. It is the largest school of public health in the world, and widely regarded as the home of public health expertise.

The Johns Hopkins Center for Public Health and Human Rights was established in April 2004 to examine the impact of human rights violations on the general health of populations. Funded by a grant from the Development Fund of the Open Society Institute, the Center applies epidemiological practices and public health tools as a new approach to understanding and measuring the scope of human rights violations.

Chris Beyrer, MD, MPH, was appointed to direct the Center. Dr. Beyrer, who also serves as the director of the Fogarty AIDS International Training and Research Program (AITRP), asserts that social injustice is a primary cause of many health problems in the world. "The Center for Public Health and Human Rights uses critical evidence-based assessments of the role that repressive laws and social discord play in the health of populations. With this knowledge, we can develop public health interventions that take the harms and realities of rights violations into account."

Additionally, working on this project was **Julie Samia Mair, JD, MPH**, Assistant Scientist at Johns Hopkins, and faculty member of the Center for Public Health and Human Rights and the Center for Law and the Public's Health. Ms. Mair is a former prosecutor and now specializes in developing strategies to prevent violence, to improve the health outcomes of those injured in violent events, and to improve the health of vulnerable populations.

John Zambrano, **MHS**, was the principal student researcher on this project and is now with the Rand Corporation working on prison health projects data analysis.

Survey Project Volunteers

This survey was made possible through the outstanding efforts of a cadre of volunteer interviewers, who visited our clients in the D.C. Jail and the CTF. They include: Natanya Alon, Andrews, Malalai Amini, Jolie Apicella, Atiaf Alwazir, Rachel Augustin, , Nikita B Barai,. Jessica Beaman, Laura Bennett, Chandni Challa, Sonia Cheruvillil, Rockie Cluise, Kate DeGovia, Jessica Dos Santos, Fatimah Dozier, Kimberly Fahrenholz, Lisa Fineberg, Jill Finkelstein, Christy Fisher, Liza Fuentes, Linda Galib, Samantha Grayson, Kristin Harris, Emily Hodge, Christina Jenkins, Nyawira Karuri, Brandy Kelly, Sarah Kimberly, Adrienne Kohart, Christina Koury, Virginia R. Lamb, Amy Leader, Mariama Liverpool, Leericka Lucas, Catherine Lukach, Karen Mann, Rhya Marohn, K. Mauprivez, Aditi Mehta, Adacze Okongwu, Candice R.Owens, Jessica Parker, Dina Passman, Christine Plummer, Jeanette Quick, Natalie Rainer, Stacy Rapacon, Rashaunna Redd, Sandra Roach, Jessica Robidoux, Nisha A.Sachdev, Veena Sankar, Sara Shoener, Jennifer Sunshine, Adrienne Taylor, Amelia Terhune, Alaina Vaisey, Jhamillia Weekes, Alterik Wilburn, Aldrenna Williams, Sharon Williams, Kristin Younger

The cover illustration "Breathe" *(acrylic on canvas board, 2004) by Laura Crescio,, currently incarcerated at the Federal Prison Camp, in Greenville, Illinois, reproduced courtesy of the artist. Ms. Criscio, 26, has been in prison since she was 19. She describes herself as "a natural artist, meaning I never went to school for it." She's interested in drawing, painting, and architecture, "a way for me to release my mind from prison and the world and put myself into my work." Currently a college student, she hopes to get a degree in art.* Breathe *depicts "a blue soul blowing out love," shows "calmness and peace." Some of her art illustrates the way "we were created...to change. Hopefully we develop into something more beautiful as time goes on."* Breathe *was provided for this report by The Prisons Foundation, (*www.prisonsfoundation.org*), a nonprofit organization promoting the arts and education in prison and alternatives to incarceration*

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Recommendations Based on Survey Results

This report presents the results of a study based on a series of interviews with 117 women incarcerated at the D.C. Jail and the adjacent Correctional Treatment Facility (CTF), the two jail facilities in D.C., from October 2004 to April 2005. This effort was the product of a unique collaboration between D.C. Prisoners' Legal Services Project and the Johns Hopkins Bloomberg School of Public Health. The recommendations included below are drawn both from our interviews with incarcerated women and from our collective expertise and experience advocating on health care issues.

Recognizing that correctional authorities alone cannot solve the problems associated with disease in incarcerated populations, due to fiscal constraints and structural limitations, there are nonetheless significant contributions that jails and other places of incarceration can make. Below we make several recommendations specific to the D.C. Jail and the CTF.

1. **Review of CCHPS[1].** Using the services of the contract monitor for the CCHPS contract, the Department of Corrections should undertake a thorough review of medical services in light of the findings of this survey. The lags in access to care for chronically ill women, interruptions in medication delivery, and the failures of the sick call system generally point to a need to review current procedures. In addition to greater efficiencies and more effective health care delivery, such a review would likely result in cost-savings. More appropriate management of chronic conditions could dramatically reduce the use of the sick call system to manage these conditions and could be life-saving and resource-efficient.

   It is our understanding that CCHPS has adopted a chronic care management system, recognizing the inappropriateness of utilizing the sick call for people with chronic conditions. Nonetheless, as our results indicate, there are very serious delays and complete gaps in services for many chronically ill women. With more than half of the women entering the Jail and CTF reporting at least one medical condition at entry, further review of the medical delivery system is clearly warranted.

2. **Treat the Mentally Ill**. Jails and other places of incarceration are no place to treat the seriously mentally ill. To the extent that the D.C. jails are being used to "house" psychiatric patients, this practice must immediately be addressed and the D.C. Department of Corrections should investigate alternative placements. Our findings suggest that the current system of mental health care in the D.C. jails is failing to provide basic psychiatric services.

   In recent months, the D.C. Department of Mental Health has initiated a small ($1.5 million) jail diversion program, which may help to stem the tide of people with mental illness entering the jails, or to prevent those already incarcerated from returning to jail. If such efforts are to be successful, however, they need to be far more generously funded and fully embraced by and coordinated with the Department of Corrections and CCHPS. Ultimately, such efforts would be cost-effective, placing fewer people in expensive and inappropriate correctional settings in favor of community-based treatment programs.

3. **Ensure Delivery of HIV/AIDS Medications.** The delay and denial of HIV/AIDS medications is particularly problematic, as even relatively short delays have been shown to generate drug resistance. Once a patient has developed resistant forms of HIV, the medications they were taking are often no longer effective. Hence, the current situation is a very real threat to the lives and health of incarcerated persons with HIV/AIDS, and of their contacts both inside the facilities and upon release. CCHPS should take immediate action to ensure that both women and men housed in their facilities are receiving the appropriate HIV/AIDS medication in a timely fashion.

   The overcrowding at the D.C. Jail, and the chaotic practice of transferring people between the CTF and the Jail in response to overcrowding, contributes to interruptions in medication delivery. Because transfers between facilities are beyond the control of CCHPS, the D.C. Department of Corrections and CCA (which runs the CTF) must prioritize the medical needs of people in their custody by ensuring that transfers of individuals between the facilities are immediately reported to CCHPS.

[1] The Center for Correctional Health and Policy Studies, Inc., or "CHPPS," provides medical and mental health services under contract to the D.C. Department of Corrections, which manages the D.C. Jail, and the Corrections Corporation of America, which manages the CTF.

4. **Ensure Continuity of Care.** Upon release or transfer to another institution, no woman's treatment regimen should be interrupted. Continuity of care is essential for controlling disease. Currently, release practices are chaotic, with women often released at night without referrals to medical services and without a supply of medications. Although the Department of Corrections is taking some steps to remedy this situation, our survey reveals that a significant proportion of the women being released have serious medical needs, and minimal financial resources. It is incumbent upon the Department to drastically overhaul their release practices.

   There is a great deal of literature on this subject and several successful models, such as Rhode Island's Prison Release Program and Project Bridge and the Hampden County Correctional and Community Health Program in Massachusetts. The Department of Corrections should investigate the various continuity-of-care and reentry programs presently implemented and develop its own community-based partnership for this population of women. Until a fully-developed program can be implemented, at the very least, appointments with physicians in the community or at the new facility should be made well before release or transfer date, permission to transfer medical records to the providers should be obtained from the women, and a sufficient supply of medication provided to the women which will last until their next appointment(s). Costs of such efforts should not be borne solely by the Department of Corrections.

5. **Address Overcrowding.** The mental health and infectious disease health problems in the D.C. Jail and CTF are worsened by the severe overcrowding of the D.C. Jail, and its spillover into the CTF. The severe overcrowding results in delays in the intake screening process, interruptions and delays in delivering medications, delayed responses to sick call requests, and the chaotic release conditions noted here. With the D.C. Jail operating at its highest population levels in more than 20 years, the CTF is becoming similarly squeezed to accommodate a larger population. Every effort should be made to reduce this chronic overcrowding and to lessen the public health threats posed by overcrowding.

   In the short term, the DCDC may need to acquire additional bed space to house some of those currently held at the Jail, but over the longer term, options such as jail diversion programs for the mentally ill and vastly expanded drug treatment options could have a significant impact on reducing the Jail's population. The costs of alternatives to incarceration are dwarfed by the impact that overcrowding has had on the delivery of medical services in the Jail and CTF, and its impact on the public health more generally.

Background

In 2003, the U.S. District Court ended 30 years of litigation centered around conditions at the D.C. Jail, dismissing the long-standing *Campbell v. McGruder* class action. With the end of *Campbell v. McGruder* also came the exit of a court-appointed Special Officer to provide on-site monitoring of compliance with court orders and the removal of a long-standing cap on the Jail's population. It marked the beginning of an even more difficult period for people held at the Jail, and for those who work there.

In the two years since the case's dismissal, D.C. Prisoners' Legal Services Project has received hundreds of complaints from men and women at the D.C. Jail and the Correctional Treatment Facility (CTF)[2] on diverse issues, but most frequently focusing on problems around access to medical services. Their concerns range from the general unresponsiveness of correctional and medical staff to prisoners' medical needs to alarming accounts of failures to provide even basic medical and mental health treatment to people with chronic conditions.

Without access to the Jail as had been available under *Campbell v. McGruder*, our organization and other advocates have had difficulty detailing the scope of these problems, and institutional oversight, particularly of medical services, has been seriously deficient. A June 2004 report on medical services at the D.C. Jail performed by the U.S. General Accounting Office confirmed that the D.C. Department of Corrections (DCDC) has failed to provide sufficient oversight of those services.[3] Further, the DCDC has resisted efforts by the D.C. Council to assert oversight over the Jail and CTF, while actively barring advocates' access to the facilities.[4]

In response, the D.C. Prisoners' Legal Services Project sought an effective mechanism to shed light on conditions inside the Jail and the CTF, and to determine the most serious health care issues facing people held in these facilities. Because they often face greater challenges than men in securing health care in male-centered institutions, the Project wanted to focus its initial survey efforts on women in the D.C. Jail and CTF. We approached the Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health for assistance. The result was a comprehensive effort to survey the women themselves about their ability to secure health care while incarcerated. This unique collaboration yielded not only an enormous amount of information about medical services inside these facilities but also a rare snapshot of the women who end up there. Setting out to interview as many women as possible, from October 2004 through April 2005, we ultimately interviewed one-third of the women held at the Jail and CTF during this period, or 111 women.

As detailed in the following pages, the women incarcerated in the Jail and CTF, as a group, have extremely low incomes; a significant number suffer from chronic physical and mental illnesses, which generally worsened during their incarceration; and slightly more than a third lived in their own homes prior to incarceration. Although the report focuses on access to medical care, it is our hope that it can also be a catalyst for exploring alternatives outside the criminal justice system to address the very real unmet health care and social needs of these women.

[2] The Correctional Treatment Facility, or CTF, is adjacent to the older and larger D.C. Jail. Built in 1992 to provide drug and mental health treatment to individuals in the criminal justice system, the CTF is now considered merely an annex to the D.C. Jail. It is run by the private, for-profit Corrections Corporation of America (CCA), but medical services are provided by the same entity that provides services to the Jail, the Center for Correctional Health and Policy Studies (CCHPS)..

[3] *District of Columbia Jail: Medical Services Generally Met Requirements and Costs Decreased, but Oversight is Incomplete*, Report to the Chairman, Committee on Government Reform, House of Representatives prepared by U.S. General Accounting Office, June 2004.

[4] The D.C. Jail Improvement Act of 2003 required the Mayor to set a population limit at the D.C. Jail and DCDC to provide detailed information about environmental conditions, the grievance process, and other issues. The Mayor has failed to set a population limit at the Jail and the DCDC has provided only limited documentary information required under the Act.

History

D.C. Jail Facilities

The D.C. Jail, or the Central Detention Facility, opened in March 1976 as a replacement for the former District of Columbia Jail. In 1995, the D.C. government opened the Correctional Treatment Facility (CTF), adjacent to the D.C. Jail and connected by an enclosed walkway. Originally conceived as an intensive medical, mental health, and drug treatment center, the CTF now serves primarily as an annex to the D.C. Jail, with medical and other services merged between the facilities. Combined, the D.C. Jail and the CTF hold over 3,500 men and women.

The D.C. Department of Corrections (DCDC) manages the D.C. Jail, but not the CTF. In 1997, the District signed a twenty-year contact with Corrections Corporation of America (CCA), a Tennessee-based private, for-profit corporation, to administer the day-to-day functions of the CTF. However, medical services are provided by the same non-profit medical contractor in both facilities.

The D.C. Jail and the CTF are jail facilities. D.C. has not had a prison since 2001. In 1997, Congress passed the National Capital Revitalization and Self-Government Improvement Act, which mandated that the District close its prison complex in Lorton, Virginia. All people convicted of felonies in the District are now sent to the Federal Bureau of Prisons (BOP), where they serve out their sentences.

Unlike prisons, most people in the Jail and CTF are held there for short periods of time, with about one-third held for a week or less, and more than half held for a month or less. Most people held at these facilities are either awaiting trial or are being held for alleged violations of the conditions of their parole, with the remainder serving short sentences for misdemeanors. There are also approximately 200-300 people being held at these facilities at any given time who are awaiting transfer to BOP facilities.

Medical Services at the Jail and CTF

Medical services at the Jail and the CTF have a complex history. In 1995, the U.S. District Court placed medical services at the Jail under the temporary supervision of a court-appointed Receiver. This action was the result of the District's failure to address problems identified in *Campbell v. McGruder*, in particular failing to provide minimally adequate medical care for people held at the Jail. In 2000, the Receiver contracted with the Center for Correctional Health and Policy Studies, Inc. (CCHPS) to provide medical and mental health services.

CCHPS began providing care at the Jail in March 2000 and at the CTF in April 2003,[5] and remains the health care provider for both facilities. It is the only non-profit contractor for jail or prison medical services in the country. At the time of the survey, services provided for under the CCHPS contract at the Jail and CTF included:

- Intake services, including initial medical, mental health, and dental screening.
- Primary medical care, including chronic care services.
- Mental health services, including "outpatient" (group and one-on-one therapy, medication management) and "inpatient" (in specialized mental health units) services.
- Specialty care, including basic dental care, cardiology, dermatology, gynecology, neurology, ophthalmology, orthopedics, general surgery, podiatry, and pulmonary.
- Infirmary services.
- Pharmacy and laboratory services.
- Discharge services, including provision of a 14-day supply of medications upon release.

The question of whether women at the D.C. Jail and the CTF have access to these services is the question we have attempted to answer with this survey and analysis. The results are based entirely upon responses from the women affected. We did not review medical files, nor did we interview medical staff at the facilities. It was not our goal to assess the quality of services provided to women in the Jail and the CTF, nor the performance of CCHPS in accordance with its contractual obligations. Our goal was more basic: to ask women if they are getting the medical and mental health services they need. The following pages reveal their responses.

[5] Medical services provided at the Jail are accredited by the National Commission on Correctional Health Care while the CTF is accredited by the American Correctional Association, which accredits all aspects of the correctional facility, including medical services.

How the Study Was Conducted

A collaborative research team of the D. C. Prisoners Legal Services Project and the Johns Hopkins Bloomberg School of Public Health completed an assessment in May 2005 of health care access and health needs, including mental health needs and services, among women jailed at the two facilities in the District of Columbia.

Highlights

- Semi-structured, cross-sectional health survey
- Attorney-client privileged
- Strict ethical review

Methodology

The study was a semi-structured cross-sectional health survey. The health survey was developed through reviewing similar jail and prison studies, and through field testing of questions with former inmates for clarity, coherence, and level of complexity. The D.C. Prisoners' Legal Services Project requested Johns Hopkins to evaluate women's perceptions on access to health care in the D.C. Jail and CTF in order to address what they believed was an immediate and significant on-going issue, namely the women's lack of access to appropriate health care. To minimize any potential risks to inmates, we conducted the study interviews under the shield of attorney-client privilege, and we did not seek access to inmate medical records nor did we seek the permission of the facility.

Questions included demographic variables (age, race, marital status, employment status, income, family structure, etc.); health status prior to arrest, including any known diagnoses and medications; access to care in the jail, medical services, and prescription drug provision; sick call services; and finally new health conditions which occurred during incarceration, and how they were managed. Trained volunteers conducted the surveys. Eligibility criteria included: incarcerated women 18 years of age and older, currently in the D.C. Jail or CTF, and able to understand the survey and to provide verbal informed consent. The sampling was peer and key-informant driven.

Participant Sampling

Recruitment for study participants was carried out using peer-driven sampling and key informant sampling. With these methods, the first persons contacted are the "key informants" and they are recruited and then asked to participate and to discuss the project with their friends and members of their social networks in the jail. This peer-based approach was developed to recruit and enroll difficult to access populations in other settings. A key component of these methods is that the researchers keep in close touch with key informants to assess any potential harm a study may be causing as it progresses.

The study received all required ethics committee approval including that of the Committee on Human Research of the Johns Hopkins Bloomberg School of Public Health, which complies with all federal human subjects requirements and standards. The Johns Hopkins committee agreed to our request to undertake this study without the knowledge or approval of the DC Women's jail authorities, based on acceptance of the argument that the jail authorities could have had a conflict of interest in dis-allowing the investigation to be conducted.

Study Population

Women held at the D.C. Jail and CTF were interviewed from October 2004 to April 2005. Eligible participants were held at the District's correctional facilities during the time of interview, older than eighteen years of age, and able to provide informed consent. A total of 250 women held either at the Jail or CTF were approached by our legal staff and given information about the general background and survey objectives. Two women were not mentally competent to provide consent at the time of interview, two other women were not issued consent forms and 135 women declined to participate. Thus data was compiled for a final study population of 111 women, all of whom provided verbal informed consent to participate. The size of this study sample represents roughly one-third of the women at the two correctional facilities.

Study Population Characteristics

The profile of the women surveyed at the D.C. Jail and CTF is in accord with reports put out by the U.S. Department of Justice, and contributes information critical towards understanding the women under the District's supervision. As shown in Table 1, the average age of the participants was 37, with a range between 18 and 54 years. The racial/ethnic distribution of the study population was predominantly African-American (86 percent) and White (5 percent). Fifty-percent of the study population reported an annual income for the year preceding incarceration of $6,000 or less, while only 17 percent reported earning more than $24,000. Only 16 percent of surveyed women reported being employed at the time of their arrest. When asked about their place of residence at the time of arrest, over a third said they lived at their own residence and one third reported living "at someone else's residence." Twelve percent of respondents reported living on the street at the time of their arrest.

Highlights

- Average (mean) age: 37
- 86 percent African-American
- 5 percent White
- 49 percent made less than $6,000/year
- 12 percent lived on street at time of arrest

Table 1. Descriptive Statistics of Study Population (n=111)

	n, (%)
Site	
Jail	34 (31%)
CTF/CAA	52 (47%)
Unknown	25 (22%)
Age	37
Mean	(18, 54)
Range	
Race	95 (86%)
African-American*	4 (4%)
White*	6 (5%)
Hispanic	2 (2%)
Native American	3 (3%)
Biracial/Multiracial	
Income	55 (49%)
<$6000	13 (11%)
$6001–12,000	4 (4%)
$12,001–18,000	4 (4%)
$18,001–24,000	17 (17%)
>$24,001	
Place of residence at time of arrest	
Own residence	
Parent's house	39 (35%)
Someone else's residence	7 (6%)
Rooming/boarding house	37 (33%)
Halfway house	5 (4%)
Shelter	0
Street	6 (6%)
Residential drug/alcohol treatment facility	12 (12%)
other place	2 (2%)
	2 (2%)
Employed	18 (16%),

* Non-hispanic

Health and Incarceration

Of the 111 women interviewed, 37 percent reported having a medical condition prior to the current incarceration period and 17 percent reported having more than one condition. To understand the relationship of access to care to categories of illness, we grouped health conditions into three broad categories: chronic conditions, including diagnoses such as hypertension, asthma, and diabetes; infectious conditions, including HIV/AIDS and sexually transmitted infections; and mental health conditions, including major depression and schizophrenia. As shown in Table 2, a high percentage of women described a chronic condition (28 percent) and a comparable proportion of women reported infectious diseases (20 percent) and mental health conditions (21 percent). Disease prevalence was remarkably high for Asthma, HIV, Diabetes, and schizophrenia. In the general population, as an example, HIV infection rates among reproductive adults in the United States are well under 1 percent, and schizophrenia is diagnosed in less than 2 percent of Americans.

Highlights

- 54 percent of respondents reported at least one medical condition at entry
- Self-reported medical history:
  - 12 percent HIV
  - 14 percent asthma
  - 5 percent schizophrenia
- 38 percent of women with a reported medical condition at the time of arrest developed a new self-reported medical condition while jailed.

Table 2. Percent of Participants with Medical Diagnoses and Types of Medical Conditions

Medically diagnosed condition just prior to incarceration?					
Yes	41 (37%)				
More than one	19 (17%)				
No	50 (45%)				
Chronic condition	31 (28%)	**Infectious condition**	22 (20%)	**Mental Health condition**	23 (21%)
Asthma	16 (14%)	HIV	13 (12%)	Clinical Depression	16 (14%)
Hepatitis C	7 (6%)	STI	4 (5%)	Schizophrenia	6 (5%)
Blood pressure	11 (10%)	Hepatitis C	7 (6%)	Drug Dependence	6 (5%)
Diabetes	7 (6%)				
Other medical condition 31 (32%)					

As shown in Table 3, of the 60 women reporting a medical condition *before* entering the current incarceration period, 44 (73 percent) said their medical condition required either treatment or medication. At the time of interview over 93 percent (56/60) of these women continued to self-report a medically diagnosed condition. Within this group of 60 women, 52 percent reported problems with health care access as a result of being incarcerated while 45 percent did not. When asked about the development of new medical conditions or serious injuries, 16 (38 percent) participants reported the development of new medical conditions.

Table 3. Among Incarcerated Women Reporting A Medical Condition (N=60)

Are you receiving treatment or medications for (this/any of these) condition(s)?	
Yes	44 (73%)
No	16 (27%)
Do you still have a medically diagnosed condition?	
Yes	46 (77%)
More than one	10 (16%)
No	1 (2%)
Has jail affected access to medications?	
Yes	31 (52%)
No	27 (45%)
Have you developed a new medical condition or serious injury?	
Yes	23 (38%)
No	48 (80%)

Repeated Incarceration

We collected basic information regarding incarceration history from all study participants, included as Table 4. Comparing the number of days incarcerated among women at the two facilities who did not report a medical condition to those who did report medical problems, we found that women reporting medical conditions tended to have a substantially shorter average stay, 109.4 days compared to 158.3 days.

Highlights

- Participants reporting medical conditions:
  - Experienced higher levels of recidivism
  - Shorter average incarceration periods

On the other hand, women reporting medical conditions were more likely to have multiple incarcerations. Participants reporting a medical condition at entry to the facilities included a higher proportion who had been re-incarcerated, compared to the reportedly healthy group of respondents (95 percent vs. 66 percent), and this finding was statistically significant. Women with medical conditions had been incarcerated on average 6.5 times compared to 4.0 times for women not reporting a medical condition (Table 4).

Table 4. Health and Re-incarceration.
Women reporting medical condition at entry to DC correctional facility

	Yes (n=60)	**No** (n=50)	**p-value**
Re-incarceration (at least second time in jail)	95% (57/60)	66% (33/50)	<0.0001
Number of times in jail*			
mean	6.5	4.0	0.28
range	(2,80)	(2,15)	
Average number of days incarcerated**	109.4 days	158.3 days	0.15

*not restricted to DC correctional facilities
** t-test for homogeneity, p=0.08

Healthcare Access

We asked women reporting a medical condition about treatment provided by the correctional healthcare system. At the time of interview, 16 of the 60 women with a self-reported medical condition (27 percent) had not yet received any medical treatment for their condition. Figure 1 shows how many days study participants were incarcerated without receiving any medical treatment, stratified according to chronic, infectious, or mental health conditions. The delays described in Figure 1 commonly go beyond 15 weeks of incarceration with only five of these treatment lapses under seven weeks.

The implications of treatment lapses on disease progression will vary with disease, stage and age, but drug resistance for infectious disease treatments and irreversible damage due to a lack of chronic care will be common results for at least some women with serious illnesses. For example:

- Women with untreated hypertension may suffer ongoing organ damage including to the cardiovascular system and the kidneys.
- Untreated depression is a well known and common risk for suicidal ideation and suicidal acts.
- Untreated HIV/AIDS can lead to worse outcomes after treatment is started if the immune system is further compromised.
- Untreated sexually transmitted diseases can lead to pelvic inflammatory disease in women, infertility, and sharply increased risks for ectopic or tubal pregnancy.

Figure 1. Number of Days Incarcerated without Medical Treatment (each line is an individual woman)

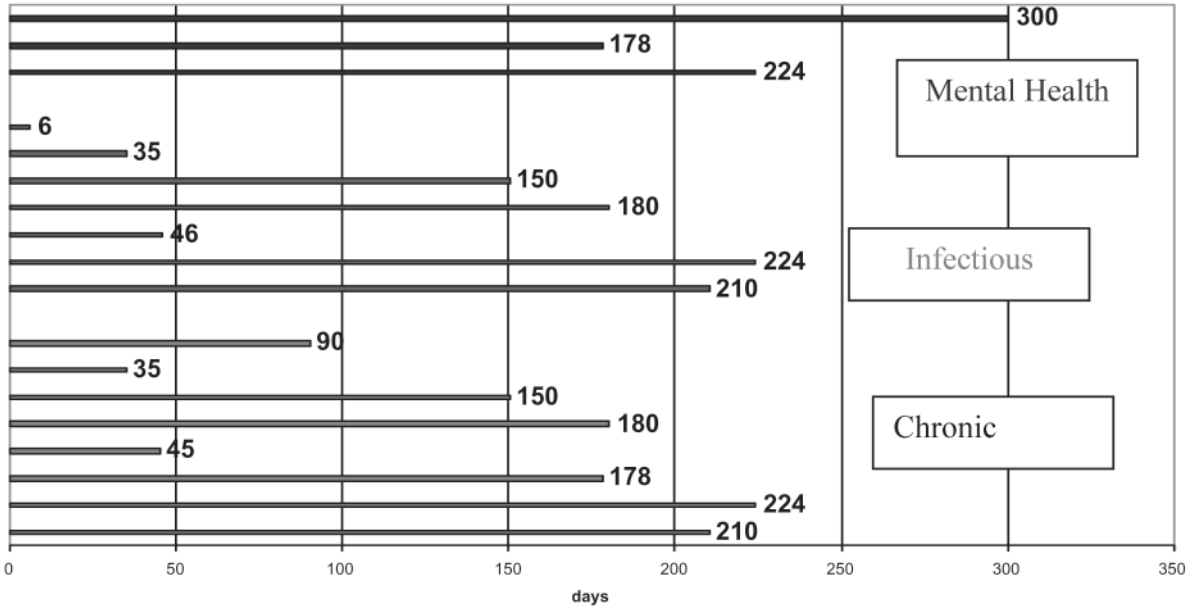


Figure 1 also shows that delays in treatment were common across all three principal disease categories. Looking specifically at those women with a known medical diagnosis who had access to medicine issues, we found problems for women with all three classes of illness, and across a range of time delays. Among women with chronic conditions, time without access to needed medication included women held for 35, 45, 90, 150, 178, 180, 210, and 224 days. For infectious diseases, time delays for needed medications were for 6, 35, 46, 150, 180, 210, and 224 days. For women needing psychiatric medications, the delays were longer: 178, 224, and 300 days. These findings point out that:

- Access to medication does not appear to improve over time in jail for women with any kind of condition, and delays are consistently long enough to lead to serious adverse events.

- While delays were common for all kinds of conditions, they were worst for women with chronic illnesses, where 62 percent of women reported delay*s*. Delays for women with infectious and mental health diagnoses were comparable, where 41 percent and 37 percent of women, respectively, reported medication delays.

In the context of HIV/AIDS, delays in receiving treatment for women who were on treatment before being jailed are actually treatment interruptions. Treatment interruptions with anti-viral therapy for HIV/AIDS can lead to drug resistance, complicate therapy for the individual, and dramatically increase the costs of later treatments. The generation of multi-drug resistant strains of HIV is a further concern, and one that may be facilitated by the high rates of re-arrest and re-incarceration we have found among women with serious illnesses.

These concerns are also relevant for tuberculosis (TB). Treatment interruptions are well-known to lead to multi-drug resistant TB (MDR-TB), a disease with enormous human, social, and financial costs. The MDR-TB epidemic in the New York State prisons in the 1990s cost an estimated $1.5 billion to contain, and led to the deaths of several prison staff from essentially untreatable forms of TB.

Clearly, the gravity of these threats, and the relatively high rates of reporting of treatment delays and treatment interruptions we have found, calls for a rapid and unbiased review of medical records and treatment records to further investigate what women have told us is happening in the jails. The urgency of these individual and community level threats to health suggest that this should be an urgent priority for the District.

Knowledge of Available Health Care Services

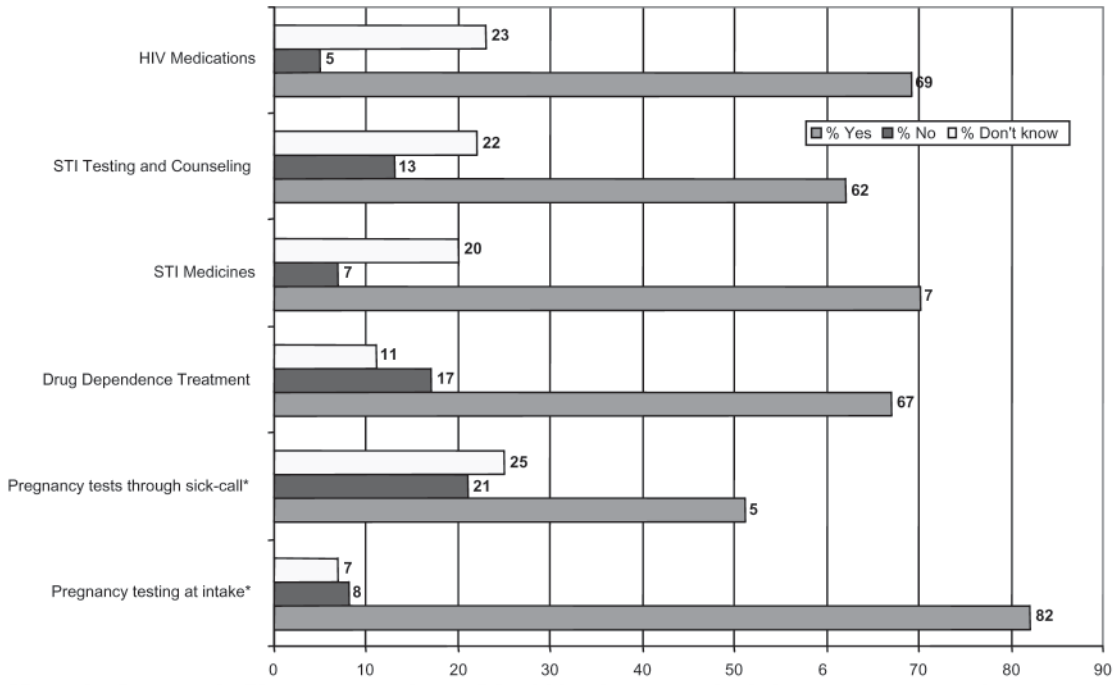
An important part of this study measured perceived access of correctional healthcare services. Their perceptions are extremely valuable in evaluating the delivery of health care. For example, it makes little difference to a woman who believes that treatment for sexually-transmitted infections (STIs) is not available at the D.C. Jail if in fact it is available. Given her lack of knowledge, she likely will not ask for care and will remain untreated.

Highlights

- 1 in 5 women did not know that they could get HIV treatment in jail
- 1 in 2 knew how to get pregnancy testing
- At most 2 out of 5 women received information about diabetes care, blood pressure care, HIV medications, hepatitis care, or pregnancy care

We asked all respondents if they knew of the availability of the services described in Figure 2. In general, about half of all study participants were aware of and perceived the specified medical services to be accessible to them while incarcerated. Roughly 70 percent of participants believed that HIV medications, medicines and testing/counseling for sexually transmitted infections, and drug dependence treatment were accessible to them.

Figure 2. Survey Results: Perceived Access



Note: *refers to only 73 women, a subset of the 111, who were asked about pregnancy testing.

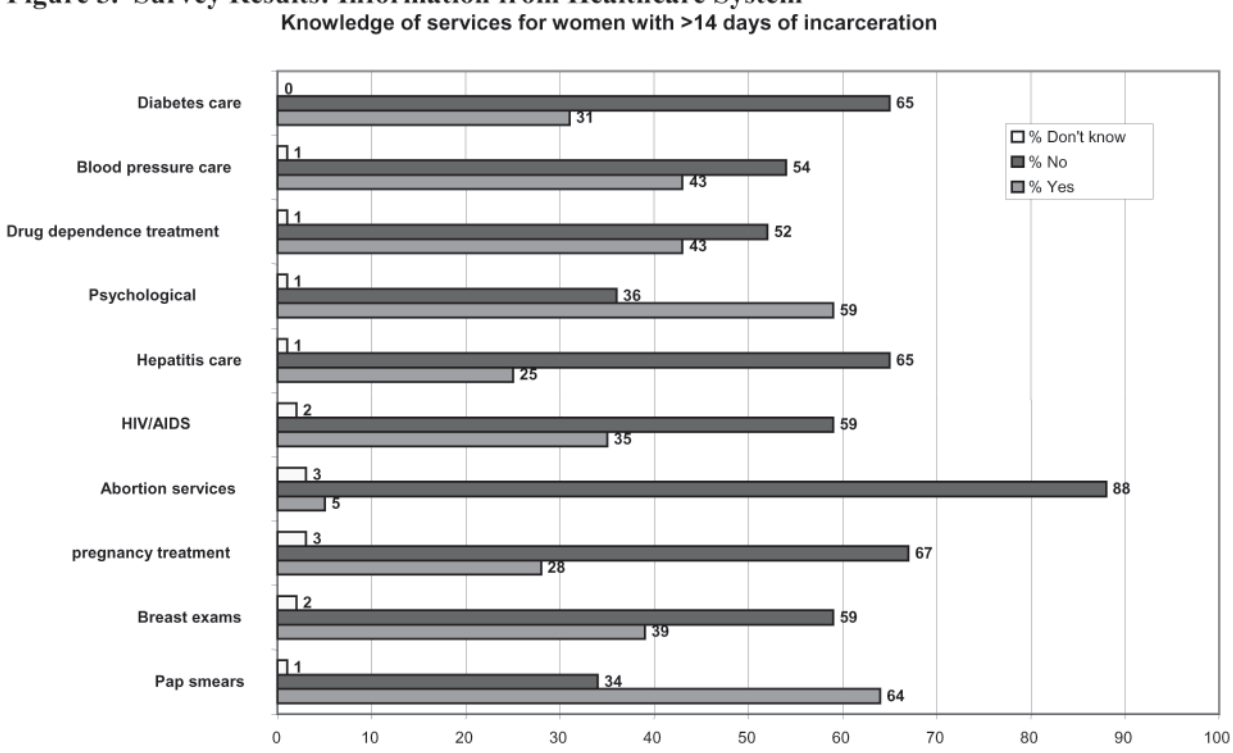
Questions regarding pregnancy testing at intake and via sick-call were subsequently added, and this information was collected for 73 participants. Proportionately, the highest level of perceived access was for pregnancy testing at intake (83 percent), while only 1 out of 2 women reported pregnancy testing through sick-call to be available. This finding is important because, despite rules against sexual contact among inmates and laws against correctional staff-inmate sexual conduct, sex occurs and some women conceive while incarcerated in these facilities. Early pregnancy identification enables the woman to make proactive choices about her pregnancy, including the decision to receive prenatal care, which is vital to the health of mother and baby.

A large proportion of the women (20 percent) *did not know* if HIV care, treatment/counseling for sexually transmitted infections or substance abuse treatment would be accessible to them while incarcerated. This is troubling given the prevalence of HIV and substance abuse in incarcerated populations.

Women who had been incarcerated at the D.C. facilities longer than 14 days were asked if they had received information about various preventative and regulatory medical services. Respondents had the highest level of knowledge around psychological services (59 percent) and pap smears (64 percent) from the presented list (Figure 3). The remaining items were characterized by very low levels of awareness with, at most, two out of five women reporting that they received information about diabetes care, blood pressure care, substance abuse treatment, hepatitis care, HIV medicines, pregnancy care and breast exams.

Survey question:
Have you received information from the healthcare system at this facility on any of the following?

Figure 3. Survey Results: Information from Healthcare System



Medical Screening at Intake

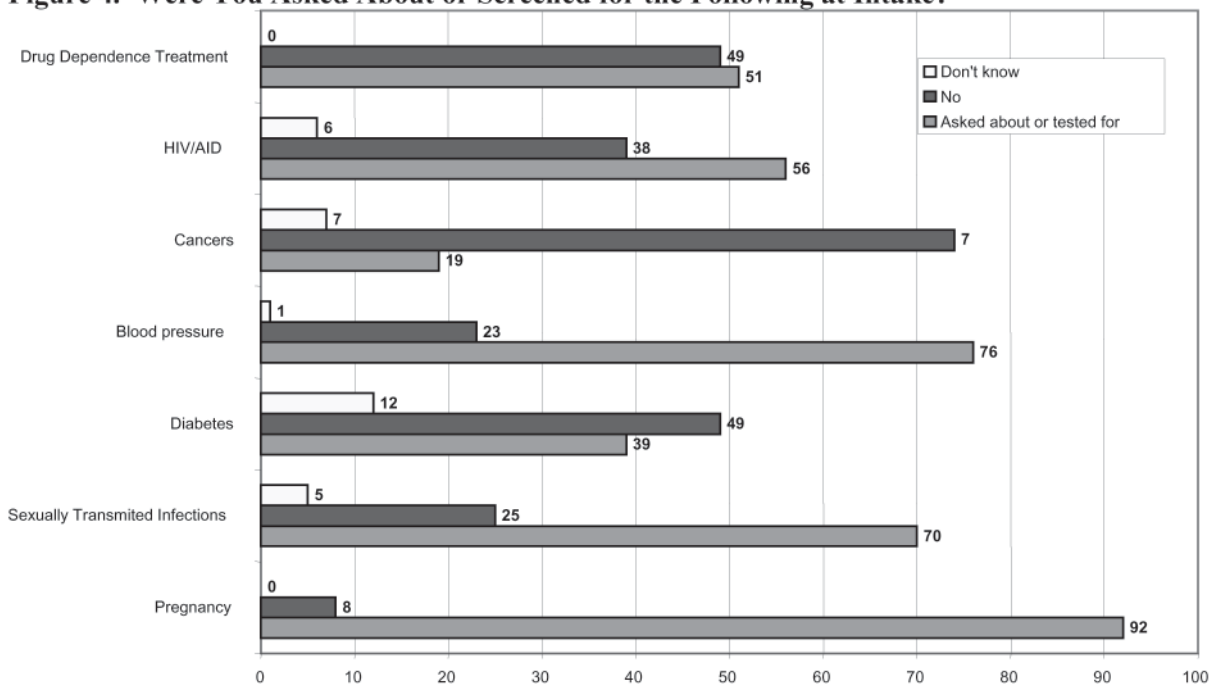
Medical assessment of all incoming inmates is a required component of U.S. correctional healthcare systems and at the two D.C. correctional facilities. Screening for infectious diseases as well as mental illness are considered important safety measures for both inmates and correctional staff. Chronic diseases are also assessed in order to determine the level of care an inmate will require while incarcerated. We surveyed study participants if they had been asked about or tested for any of the following at intake into the current incarceration period: pregnancy, HIV/AIDS, cancers, blood pressure, diabetes, sexually transmitted infections, and drug dependence treatment.

As show in Figure 4, a high percentage of participants reported either being tested for or asked about pregnancy (90 percent), sexually transmitted infections (70 percent) and blood pressure (76 percent). Lower proportions of women recalled being tested or asked about substance abuse treatment (51 percent), HIV (56 percent) and diabetes (39 percent). The lowest level of recalled testing was for cancers at 19 percent.

Of strong relevance to this study population are the high levels of negative responses to the recall of sexually transmitted infections testing (25 percent), diabetes testing (49 percent) and substance abuse testing (49 percent).

Survey question:
*We would like to get an idea of what the initial health screening was like at intake into the jail. From the list below do you remember being **asked about** or **tested for** any of the following?*

Figure 4. Were You Asked About or Screened for the Following at Intake?



HIV/AIDS

Because HIV/AIDS medication is particularly important both for individuals with this lethal infection, and for the larger community, and delays or interruptions in HIV drug treatment generates drug resistance and over time can create multi-drug resistant HIV strains, we conducted a separate analysis of AIDS drug treatment in the facilities. As revealed in Figure 5:

Highlights

- Women with HIV experience significant disruptions in medical care
- HIV+ women have an average of 6.9 incarcerations

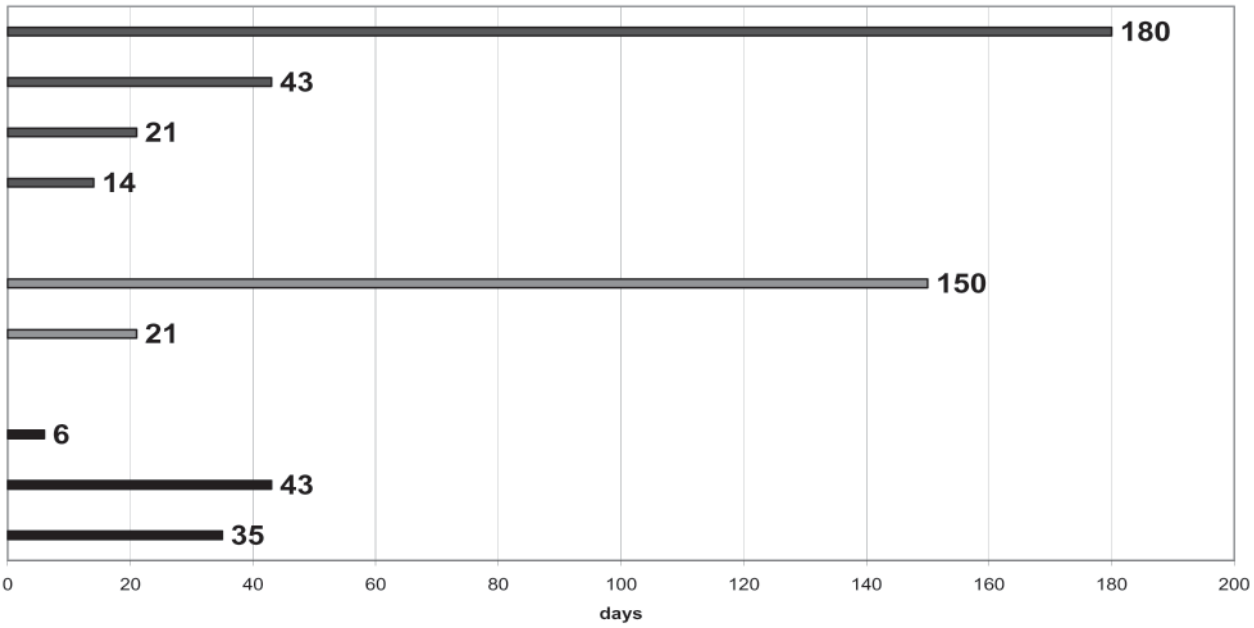
- Among the 13 women who reported having HIV/AIDS, 9 reported problems with their medication in jail:
- 4 women had significant delays (14, 21, 43, and 180 days without drug access);
- 2 women reported interrupted treatment.
- 3 women (jailed for 6, 35, and 43 days) reported having had their medications discontinued, and were still awaiting resumption of treatment.

Delays, interruptions, and discontinuation of HIV/AIDS drugs are all serious threats to health at individual and population levels as discussed above. It should be noted that while the HIV prevalence obtained in this study (12 percent) is much higher than the national average (3.6 percent), it remains an underestimate of the officially reported measure of 41 percent.[6]

Perceived Access to HIV Care

HIV positive participants were largely aware of availability of HIV medications, as show in Table 5. However, two women reported that they did not expect HIV medications to be available to them while incarcerated, and one woman did not know if medication was available.

Figure 5. Number of Days Incarcerated Among HIV+ Women



Note: The figure above describes the number of days of incarceration among HIV positive women who reported having various healthcare access problems as a result of incarceration (8/13 HIV positive participants, 1 participants reported missing doses as well as delays).

[6] "HIV in Prisons, 2000," U.S. Dept. of Justice, Office of Justice Programs, *Bureau of Justice Statistics Bulletin*, October 2002, NCJ196023, p.3.

Incarceration History

Only two HIV positive participants reported the current sentence as their first time in jail. As a group, these women had been in jail an average of 6.9 times, while HIV status is only known for the current incarceration period and was not ascertained for every time the inmate was sentenced, this information highlights the importance of adequate HIV care in the correctional setting among females in the district.

Table 5. Survey Data for HIV Positive Participants Only (n=13)

Does this facility provide access to HIV medications?	**n (%)**
Yes	10 (77)
No	2 (15)
Don't know	1 (8)
Number of times in jail.	
mean	6.9
median	4
range	(1,22)

The Sick Call System

The women in the D.C. facilities appear to utilize the "sick call" system for many of their health care needs, including chronic care. The sick call system requires the women to notify staff of medical needs at sick call, generally on a daily basis. They do not receive receipts after submitting a sick call slip. The staff collecting so-called sick call slips may have limited or no ability to read sick call slips or requests not in English, presenting a barrier to Hispanic and other non-English speaking inmates.

The sick call system is a situation somewhat analogous to an emergency room, geared to acute and symptomatic illness. Chronic conditions like hypertension and diabetes, while life-threatening, are often asymptomatic, and may be very poorly managed either in emergency rooms or through sick calls. Consequently, we investigated the extent to which women with chronic (30 women), infectious (20), and mental health (19) conditions used the sick call system.

Overall, 100 percent of the women who reported having one of these conditions had used the sick call system at least once in an attempt to get medical care. For women with chronic conditions, who our findings suggest have the most problems getting treatment, the number of sick calls was greatest.

- Most of these women reported 10 to 30 sick calls, but several reported submitting more than 50 slips in an effort to get care.
- For women with infectious problems, the range was 2 to 20 sick call slips, with an average of about 15 slips submitted to access care.
- For women with mental health conditions, most reported 10 to 15 such slips.

Women who were too mentally ill to answer questions and agree to participate in this study were likely to be too ill to use the sick call system, and so these numbers are difficult to interpret for the severely mentally ill.

As in emergency room settings, sick call slips are designed to identify acutely sick inmates in need of treatment at the time of sick call submission. Clearly, the sick call system is a poor fit for a substantial proportion of inmates needing care in the jails—many of whom have serious, but generally not acute conditions like hypertension or diabetes. While there apparently is a chronic care management system in place, the findings suggest that it is not meeting the needs of this population of women. Of course, untreated chronic and mental health conditions can and usually do lead to emergent and acute illness if left untreated, but waiting for this to happen is an inhumane and much less cost-effective approach than better matching of services to the needs of incarcerated women.

Discussion of Survey Results

Incarceration provides a unique public health opportunity to screen, treat, educate, and prevent disease in populations who otherwise may not have access to adequate medical care and accurate health information. At the same time, many people who enter corrections have already been diagnosed with disease and are receiving appropriate treatment. In this study, for example, 37 percent of the sample had a medically diagnosed condition before incarceration and 17 percent had more than one condition.

Seventy percent of those who reported a medical condition prior to incarceration were still receiving treatment or medication for their condition(s). If their treatment regime is discontinued or inappropriately modified, serious health consequences can occur to the individual. For example, as discussed more fully above, even a short interruption of antiviral therapy for HIV infection can cause increased viral loads, raising the possibility that that the virus will mutate and become resistant to current therapy, and ultimately lead to drug failure. Similarly, interruptions in medications to address hypertension can increase the risk of stroke, and missed medication for diabetes can result in a life-threatening emergency. Likewise, denial of psychiatric medications to mentally ill inmates is a clear threat to themselves, other detainees, and to prison staff.

Overcrowding and Health Care

The threats arising from treatment delays are compounded by overcrowding, particularly to the levels of overcrowding currently reported for these facilities. Whether it is a missed opportunity to provide health care to those who otherwise would not receive it, or the non- or suboptimal treatment of someone with a prior diagnosis, the negative consequences of treatment delays go far beyond the individual-at-risk. Medical and policy decisions made inside of jails and other places of correction also impact communities and society-at-large. Because the benefits of adequate treatment reach far beyond the D.C. correctional facilities, these facilities should not have to bear the sole financial burden. If necessary and appropriate, additional funds should be allocated to the facilities for adequate treatment of the women they incarcerate.

All of the women incarcerated in these facilities will eventually be released or transferred to another facility. With respect to communicable diseases such as HIV, sexually transmitted infections, and/or Hepatitis infections, the risk to the community or to inmates and staff in other institutions is obvious if their disease is allowed to progress without treatment and their high-risk behaviors continue. In the case of HIV infection, for example, if viral loads increase and/or antiviral resistance occurs, the risk of transmission is even greater. Overcrowding adds to the frequency and severity of some of these infectious threats, particularly those marked by person-to-person spread, such as TB and staphylococcus infections. And, given the very high rate (69 percent) of HIV/AIDS patients reporting problems gaining consistent access to medications in these facilities, some generation of drug-resistant HIV may already have occurred. The Department of Corrections and the Department of Health, working in collaboration with CCHPS, need to urgently address this issue to prevent the jails from serving as as incubators of drug resistant HIV for the broader DC community. Sexually-transmitted infections (STIs) are a significant problem for women who sell sex and could have negative consequences to their health, future fertility, and the health of their sexual partners. Ensuring that the women with communicable diseases get the appropriate treatment while incarcerated will reduce the risk of disease transmission in the larger community upon release, and in the D.C. jail or CTF if re-incarcerated.

Economic and Social Implications of Inconsistent Health Care Delivery

Beyond stopping the spread of communicable diseases, there are economic advantages to providing adequate and consistent treatment to the women incarcerated in these facilities. In general, it is far more cost-effective to adequately treat disease than to deal with the consequences of not doing so. Studies have shown the cost-effectiveness of many forms of treatment, including antiviral therapies for HIV infection; medications for chronic diseases such as diabetes, hypertension, hypercholesterolemia, and congestive heart failure; and antidepressants and other medicines for mental health diagnoses. Among other advantages, appropriate treatment can result in less frequent hospitalizations and emergency room use. Sick people often cannot work, decreasing the potential tax base and increasing disability benefits.

The social implications of not adequately treating disease are far-reaching. Successful reentry may be virtually impossible if the released individual is too sick to work, to get additional education or training, or to care for her family. Many of the women incarcerated have multiple diagnoses, including substance abuse, HIV, STDs, hepatitis, and mental illness. A single diagnosis might be a barrier to successful reentry if left unaddressed; a combination of conditions left untreated may be an insurmountable barrier. HIV-positive women with antiviral resistance or women who suffer a stroke that could have been prevented by medication may die leaving many children motherless, further disrupting family structures.

Lessons of the Women's Health Survey

The D.C. jail population is disproportionately poor, African-American, and has very high rates of chronic, infectious, and mental health conditions. While these data cannot suggest the cause for any one person's incarceration, they do tell us that the unemployed, homeless, and mentally ill are being jailed in very high proportions. Women with medical conditions appear to have higher rates of recidivism.

This study has identified clear and systematic delays in access to health care and prescription medications across a wide range of serious illnesses. These delays and access issues do not appear to improve over time and cannot be ascribed simply to high turn-over rates or short-term delays. Women cannot get the medication they need—not for hours or days, but for weeks and months at a time. These delays and denials of needed care are found across all categories of illness—chronic, infectious, and mental health—but they appear to most prevalent among women with chronic diseases, and especially grievous for women needing treatment for HIV/AIDS.

The sick call system is clearly a highly inappropriate way to provide needed care and treatment to patients with chronic and mental health conditions. These women *do* want treatment for their medical conditions, and are trying to access it repeatedly, but are not being managed through the sick call system as what they are: patients who need chronic disease management and mental health services, not emergency and sick call-based approaches. Chronic diseases need to be managed in a rational, non-emergent way, which could sharply reduce the demands on the sick call system. Most strikingly, mentally ill patients should almost certainly not be incarcerated in general prison populations, denied medications, and expected to be competent enough to use the sick call system to access needed care for conditions as serious as major depression and schizophrenia.

The ongoing denial and delay in provision of necessary medications and clinical care in the D.C. correctional facilities is a clear threat to inmate health, but has much wider implications as discussed above. Taken together, these findings suggest that many women in the D.C. correctional facilities are being denied the basic human right to a minimum standard of access to health care.

For additional copies of this report, or if you have any comments, please contact:

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