

## AVOIDING THE RUNAROUND: THE LINK BETWEEN CULTURAL HEALTH CAPITAL AND HEALTH MANAGEMENT AMONG OLDER PRISONERS\*

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*The link between incarceration and health is of emerging empirical interest to criminological scholars. Yet, we still know little about the needs of the rising population of older prisoners and the health issues they face. By drawing on qualitative data gathered from 193 interviews with older men incarcerated across three U.S. prisons, I examine the specific health promotion strategies available to, and used by, these men through a cultural health capital framework. Findings show that older prisoners make deliberate choices to protect their health from the constraints and deprivations inherent in their carceral lives. In the hopes of better managing chronic and acute disease, the strategies prisoners reference include acquiring medical information, making food and diet modifications, and health advocacy. Notably, the mobilization of cultural health capital is situated within a context of privilege, leaving important implications for both incarcerated individuals and correctional administrators.*

The United States currently houses more than 1.5 million men and women in state and federal prisons (Carson and Anderson, 2016). Reflective of an era of mass incarceration, the prison population has multiplied five times over since 1978 (National Prisoner Statistics Bulletin [NPSB], 1980), a trend that gained momentum despite decades of declining crime rates (see Truman and Morgan, 2016). Taxpayers spend on average \$33,274 per prisoner annually to keep correctional budgets afloat (Mai and Subramanian, 2017), overcrowding rates are extensive (see Carson, 2015), and only one other country in the world has a higher prison population rate (Walmsley, 2016).

The expansion of the prison population has caught the attention of social scientists partially because of a growing need to understand the collateral consequences of mass incarceration. Beyond the disparate impact of incarceration on people of color (Alexander, 2010), scholars have identified incarceration as a powerful stratifying force on both micro- and macro-levels (see Wakefield and Uggen, 2010, for a review). As a result of the stigma of incarceration (Decker et al., 2015; Pager, 2003, 2007), and because work and educational opportunities are disrupted, lifetime employment prospects and

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wages are diminished (Jung, 2015; Western, 2002). Incarceration also elevates risks for divorce and relationship dissolution (Lopoo and Western, 2005; Massoglia, Remster, and King, 2011; Siennick, Stewart, and Staff, 2014; Turney, 2015), diminishes childhood well-being (Geller et al., 2012; Hagan and Foster, 2012; Murray, Loeber, and Pardini, 2012; Turney, 2014, 2017; Wildeman, 2010), and weakens communities (Clear, 2007; Morenoff and Harding, 2014; Warner, 2015).

Research findings also link incarceration to many deleterious outcomes involving health and well-being (see Massoglia and Pridemore, 2015, for a review). Imprisonment worsens indicators of population health (Schnittker et al., 2015; Wildeman, 2016) and heightens risks for both infectious (Massoglia, 2008) and foodborne illnesses (Marlow et al., 2017). Furthermore, incarceration is tied to chronic disease (Binswanger, Krueger, and Steiner, 2009; Schnittker and John, 2007), obesity (Houle, 2014), diminished mental health (Porter and Novisky, 2017; Schnittker, 2014; Schnittker, Massoglia, and Uggen, 2012), trauma exposure (Anderson, Geier, and Cahill, 2016), and hastened mortality (Binswanger et al., 2007; Patterson, 2013; Pridemore, 2014; Spaulding et al., 2011).

These links between incarceration and health are now being compounded by an aging prisoner population. In their report on the aging state prisoner population, Carson and Sabol (2016) reported state prisoners 55 years of age and older increased 400 percent between 1993 and 2013 alone. My goal for this study is to provide an understanding of how older prisoners understand and respond to chronic and acute health needs during incarceration. I use data from in-depth interviews with 193 older incarcerated men and assess their accounts of strategies they use in attempts to protect their health from the depriving environments they are forced to live within. My examination contributes to the literature by offering important insights into not only how the health issues plaguing many older prisoners are experienced but also by contextualizing some of the realities of prison health care that prisoners must learn to navigate for survival.

## PRISONER AGING AND DISEASE

The U.S. prisoner population has not just experienced extensive growth over the last few decades; demographically, the population is getting older (Porter et al., 2016). Eleven percent of today's male prisoner population is at least 55 years of age (Carson and Anderson, 2016), compared with 3 percent in 2000 (Beck and Harrison, 2001). Although this is not a new empirical issue, these demographic changes have elevated the urgency of scholars' examinations of the needs and vulnerabilities of this growing population. Termed the "aging crisis in U.S. criminal justice health care" (Williams et al., 2012), multiple reports have been released as a call to action on this critical issue (American Civil Liberties Union [ACLU], 2012; Anno et al., 2004; Carson and Sabol, 2016; Center for Justice at Columbia University, 2015; Chiu, 2010; Human Rights Watch, 2012; Kim and Peterson, 2014).

One reason it is concerning to have such a rapidly growing older prisoner population is because it is financially burdensome, as older prisoners cost 2 to 3 times more to imprison compared with their younger peers (Anno et al., 2004; Luallen and Kling, 2014; Pew Charitable Trusts, 2014; Williams et al., 2012). The U.S. Department of Justice (DOJ, 2016) recently reported faring even worse, with federal institutions spending 5 times more on medical care and 14 times more on medications per inmate in institutions containing higher percentages of older inmates than those with smaller percentages of older inmates.

Cost differences stem primarily from the greater need for health-related services among older prisoners given their higher disease burdens.

Older adults are significantly more likely than younger adults are to have chronic health conditions such as diabetes and heart disease (Centers for Disease Control and Prevention [CDC], 2013). Research findings also reveal that as a population, prisoners experience accelerated physiological aging, making them vulnerable to chronic health conditions at earlier points in the life course than would be expected if they were living in the community (see Aday, 2003; Chodos et al., 2014; Loeb, Steffensmeier, and Lawrence, 2008; Williams et al., 2012). The age-related risks for chronic disease, coupled with risks for accelerated physiological aging, help explain why, when compared with younger prisoners, older prisoners are uniquely disadvantaged in regard to morbidity and mortality risk.

In particular, older state prisoners are significantly more likely to have chronic health conditions and infectious diseases than are younger state prisoners (Maruschak and Berzofsky, 2015). Multimorbidity is also normative among older inmates. Unlike their peers in younger age groups, older prisoners suffer from an average of two to three chronic health conditions at any given time (Aday, 2003; Chiu, 2010; Harzke et al., 2010; Loeb and Steffensmeier, 2006; Nowotny et al., 2016). Furthermore, mortality rates are highest among older prisoners. In 2014, only 18 percent of state prisoners who died in custody were younger than 45 years of age (Noonan, 2016).

Older prisoners are further disadvantaged in that prisons were never designed to accommodate the needs of an older population. Crawley (2005) used the term “institutional thoughtlessness” to underscore the difficulties older prisoners face when forced to walk far distances to medical units, shower on slippery tile without anti-slip mats or grab rails, and exercise without access to toilets—despite the mobility and morbidity issues that accompany older age. Often characterized by long corridors that require much walking, uncomfortable furniture for sitting and sleeping, and small-capacity medical units, prisons are egregiously inauspicious spaces for the old. Other challenges for older prisoners include no ability to modify extreme air temperatures and poor ventilation (Trotter and Baidawi, 2015).

Medical care is often inconsistent for older prisoners as well. Older inmates experience delays and changes in their medications (Sullivan et al., 2016) and report unmet dietary needs (O’Hara et al., 2016). Citing staffing shortages, the U.S. DOJ (2016) disclosed that aging inmates in federal prisons wait an average of 114 days to see needed medical specialists in cardiology and pulmonology. Many states are now requiring prisoners to provide co-payments in order to be seen by medical staff as well (Sawyer, 2017), a practice that raises serious ethical concerns regarding health-care accessibility.

Although lack of medical care is one of the most commonly cited prisoner grievances (Calavita and Jenness, 2015), we know little about the health-related behaviors of prisoners and how they attempt to maintain their health in an environment that prioritizes punishment and security above all else. This is particularly the case for older prisoners, who are especially vulnerable to morbidity and mortality, cost more to incarcerate, and often lack basic accommodations afforded by other institutions that care for older adults (Aday, 2003). Given the lack of research on the health management strategies of older prisoners, qualitative data are well suited to capture their experiences. Next, I introduce Shim’s (2010) cultural health capital framework as a valuable foundation for unpacking this pressing problem.

## DISEASE MANAGEMENT AND CULTURAL HEALTH CAPITAL

Pierre Bourdieu (1977) viewed social location as a critical determinant of individual life chances and theorized that inequalities are established and perpetuated based on social location and corresponding exposure to various resources. Resources, or “capital,” may take several forms (Bourdieu, 1986). Economic capital consists of income, property, and other material items, whereas social capital includes access to relationships that enhance networking and access to opportunities. Another form of capital, cultural capital, involves skills or knowledge a person develops over time such as the ability to speak multiple languages, understand art, or discuss wine competently (Bourdieu, 1986). In general, the more access someone has to these forms of capital, the more power that person will have in establishing and maintaining enhanced life chances in comparison with those who do not.

Because the three forms of capital drive one another, having access to any of them provides a cumulative effect (Bourdieu, 1986). For example, if someone has more cultural capital, that person will also have more social capital. Social and cultural capital in particular are important when looking at social location because they often translate into increased economic capital, meaning that having more social and cultural capital is often associated with having more economic capital (Bourdieu, 1986). Bourdieu also coined the term “symbolic capital,” again highlighting the cumulative effect of the three forms of capital. Symbolic capital is accomplished when economic, social, or cultural capital is converted into prestige or honor (Bourdieu, 1984). For example, a millionaire business person has economic capital because of the income he or she has made, but that may also translate into symbolic capital if that person is perceived as a worthy investment partner by others as a result of his or her successes.

Bourdieu’s (1986) perspective about capital provides a useful context for understanding inequalities and has been applied to understand a variety of them. Only in recent years, however, has the theory been expanded to include health disparities. Most commonly, Bourdieu’s (1986) theory of capital has been used to consider how health inequalities are perpetuated via social capital, including access to safe drinking water and sanitation (Bisung and Elliott, 2014), neighborhood environment and health (Browne-Yung, Ziersch, and Baum, 2013; Carpiano, 2007), food and health choices (Collyer et al., 2015; Kamphuis et al., 2015), and perceptions of mental and physical health (Pinxten and Lievens, 2014; Veenstra, 2007).

A more underdeveloped extension as it relates to health is the idea of cultural health capital, which involves skills and behaviors that can be used by patients in health settings to improve outcomes (Shim, 2010). An example of cultural health capital is a patient’s understanding of his or her medications and their expected side effects. This knowledge acts as a resource because ultimately, communication between the patient and his or her provider will be enhanced due to having that knowledge (Shim, 2010). Thus, scholars have started to apply cultural health capital to better understand health inequalities. Dubbin, Chang, and Shim (2013), for example, found that patients who were able to communicate their medical problems from a biomedical framework, such as being able to identify irregularities in one’s blood pressure, were held in higher regard by providers and received more satisfying patient-centered care.

Possession of cultural health capital is important, as patients are expected to transcend as merely consumers of health care to actively advocate for their needs, be well informed

about their conditions, follow prescribed treatments, and make important choices such as selecting appropriate insurance plans (Shim, 2010). Thus, without cultural health capital as a resource, patients are at a disadvantage. For example, patients who do not understand that they still have options when a medical claim is denied by their insurance provider are likely to pay more for their medical treatment or accrue unpaid medical claims that can damage their credit. Conversely, patients who understand they have the option to call their insurance provider and inquire as to why a claim was denied and then call their doctor and discuss recoding the treatment, have a distinct advantage protecting themselves from exorbitant medical bills.

Thus far, cultural health capital has not been applied to prison settings, so we lack an understanding of how cultural health capital translates from community to prison-based patients. Social capital has been used, however, to help explain key differences in visitation frequency among prisoners (Pleggenkuhle, Huebner, and Summers, 2017). Additionally, Calavita and Jenness (2015) conducted a multimethods study of the prisoner grievance system in California. Although the researchers did not use the term “legal capital,” prisoners who were able to articulate their complaints using the same legal language as Department of Corrections and Rehabilitation staff were less likely to have their grievances quickly dismissed than were those prisoners who were not able to do so.

By extension, cultural health capital provides a promising framework to explain how inmates’ choices (or lack thereof) regarding the management of their illnesses are influenced by the prison environment and the resources at their disposal. Prisons provide a theoretically distinct environment for studying disease management because in many ways choices about health in prisons are different than choices about health in the community. Explained by Fluery-Steiner (2008), “the prison’s ‘natural environment’ of aggressive discipline and custody deeply inhibits adequate access to health care” (p. 32). Meals are planned for prisoners, and they do not have a say in what the meals will be or what time they will be eating. Available time and space for physical activity are also limited so sedentary periods are extensive, especially for those in solitary confinement (Resnik et al., 2016).

Doctors are also selected by prison administration rather than by the patients, and second opinions are rarely options. Furthermore, by its nature, the prison experience is incredibly depriving (Sykes, 1958), status stripping, and isolating (Goffman, 1961, 1963). As captives, the overarching status of their existence is, in fact, “prisoner first, patient second” (Fluery-Steiner and Longazel, 2014: 12). These factors, combined with normative exposure to antagonistic relationships between guards and inmates, threats of victimization, and lack of privacy, make incarceration an acute and chronic stressor (Massoglia and Pridemore, 2015). The negative impact of stress on health (Pearlin, 1989) again highlights prisons as unique health-care settings. Yet, as a form of punishment, the prison experience is also subjective, with the layers of punishment within the prison system being perceived and experienced with variation (Sexton, 2015). Indeed, despite much evidence of its power to harm, some studies have pointed to incarceration as potentially protective of health among certain groups, most notably for Black men (Mumola, 2007; Patterson, 2010; Wildeman, 2012).

Although the rise of the older prisoner population, as well as the vulnerabilities to and extent of disease faced by this group, has been documented, there remains a lack of attention to the subjective nature of the disease experience for older prisoners and how this experience is structured by inequalities. In this study, I examine older prisoners’

accounts of living with disease and detail how privileged statuses are meaningfully linked to cultural health capital, ultimately shaping abilities to manage health effectively. The results enrich the literature not only by demonstrating the subjective nature of sickness within prisons and the lengths older prisoners must go to navigate health-related barriers but also by identifying another avenue in which incarceration exacerbates inequalities.

## DATA AND METHOD

### DATA COLLECTION

Data come from a broader multimethods study of the health and health-care experiences of older prisoners and were gathered from interviews with 279 incarcerated men over 13 months starting in 2013. Qualitative data were derived from supplemental explanations respondents added to contextualize survey responses as well as anecdotal accounts they shared to help explain concerns about their health-care experiences within the prison system. Of the 279 total participants who completed interviews, 193 (69 percent) chose to offer supplemental and anecdotal accounts. The qualitative data provided by these 193 men are the focus of this study.

Participants were recruited from three state prisons within one state in the eastern region of the United States. The prisons were selected to stratify the sample based on institutional security level. This offered the methodological advantage of including respondents who were housed across a range of security levels, and therefore diverse environmental settings, rather than focusing on one security level alone. The research sites included one minimum, one medium, and one super-maximum security state correctional institution (SCI).

The characteristics of the research sites can be found in table 1. The largest institution was SCI 2 (medium security), with an operational bed capacity for 2,152 prisoners, whereas the smallest was SCI 3 (super-max security), with an operational bed capacity for 1,478 prisoners. Notably, only one prison, SCI 1 (minimum security), was operating below its operational capacity (96.6 percent). Thus, similar to the majority of U.S. states at the time (see Carson, 2015), overcrowding was problematic at these male facilities, particularly at SCI 3, which was operating at a capacity rate of 119.1 percent. SCI 3 is also unique because it serves as the designated prison in the state for housing the death row population and has a large restricted housing unit (RHU). Totalling 384 RHU cells, 25.9 percent of the facility's capacity was designated for extreme isolation.

Because the study was designed to capture the health-related experiences of older prisoners, participants were required to be at least 50 years of age. This threshold was selected to be consistent with most studies that have been focused on the well-being of older prisoners (see Loeb and AbuDagga, 2006, for a review; see also Baidawi and Trotter, 2016; Iftene, 2017; Kerbs and Jolley, 2007; Trotter and Baidawi, 2015; Wangmo et al., 2015). Most researchers operationalize older inmates with a lower threshold than would be used in community settings because research findings suggest that prisoners experience hastened physiological aging, meaning that their aging is accelerated in comparison with their community-dwelling counterparts by approximately 10 to 15 years (see Aday, 2003; Chodos et al., 2014; Loeb, Steffensmeier, and Lawrence, 2008; Williams et al., 2012). At the time of the study, between 20 and 24 percent of the prisoner population at each research site was at least 50 years of age. By comparison, approximately 19 percent

**Table 1. Select Characteristics of Research Sites**

Characteristics	SCI 1	SCI 2	SCI 3
<b>Institution Characteristics</b>			
Security classification	Minimum	Medium	Super-Max
Year established	1978	1993	1993
Total acres	239	357	128
Inside perimeter	37	67	44
Outside perimeter	202	290	84
Number of housing units	13	10	11
Operational bed capacity	1,494	2,152	1,478
Current population	1,443	2,301	1,760
% of operational bed capacity	96.6	106.9	119.1
Number of beds on medical unit	12	18	19
RHU capacity	56	68	384
% of population housed in RHU	2.3	2.9	14.3
Death row capacity	0	0	128
<b>Prisoner Characteristics</b>			
% of population 50+ years of age	22.5	24.1	20.4
Mean age	39.1	40.5	38.1
<b>Staff Characteristics</b>			
Total number of FT employees	440	530	693
% of staff who are female	22.1	23.8	5.8
Number of COs	206	320	465
Number of medical staff	27	43	35
<i>n</i> of respondents*	37	77	79

*ABBREVIATIONS:* CO = correctional officer; FT = full time; RHU = restricted housing unit; SCI = state correctional institution.

\**N* = 193.

of the state male prisoner population was at least 50 years of age nationally (Carson, 2015).

Additional inclusion criteria required English-speaking capabilities as funding was not available for a translator and resources were not available within the prisons to accommodate language barriers. Participants were also excluded if they had a death sentence, an IQ score 2 standard deviations or more below the mean, or a severe state Department of Corrections (DOC) mental health classification.<sup>1</sup> The IQ and mental health parameters were established and required by the university institutional review board (IRB) and DOC research review committee (RRC) to ensure exclusion of anyone who had cognitive or mental health impairments possibly severe enough to compromise their abilities to provide informed consent.

With the assistance of the DOC RRC chairperson, a computer-generated list of all eligible respondents was prepared for recruitment. Of the 5,504 men housed across the three prisons at the time, 1,270 (23 percent) were at least 50 years old and 1,158 of those (91 percent) met the selection criteria. Once recruitment lists were created, data collection began and consisted of three phases—phases 1, 2, and 3 were carried out at the medium, minimum, and super-max security SCIs, respectively. All data collection efforts

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1. Requisite criteria for this DOC classification included the following: 1) The respondent had a mental health history and required significant monitoring by the psychiatric review team (PRT) AND 2) the respondent was currently receiving treatment for a substantial disturbance of thought or mood that significantly impaired judgement, behavior, capacity to recognize reality, or cope with the ordinary demands of life.

were scrutinized and approved by two layers of ethical review, including the appropriate university IRB and the DOC RRC.<sup>2</sup>

At each SCI, data collection began with a prerecruitment site visit. Given the deprived nature of the prison environment, especially regarding the restrictions placed on inmate movement (Fluery-Steiner and Longazel, 2014; Sykes, 1958), there are few options for researchers to approach gathered groups of inmates without compromising security in the minds of prison administrators. This is compounded by the political nature of prison research (Calavita and Jenness, 2015; Umamaheswar, 2014). During initial negotiations with DOC staff regarding the research design, religious services attendance was offered as the only possibility for meeting my request to make contact with groups of prisoners and to begin establishing rapport in advance of mailing out recruitment letters. I was told I would not be permitted to enter housing blocks or the yard per DOC policy and that my presence needed to be as minimally disruptive as possible—attendance at religious services met these criteria. During prerecruitment visits, I shadowed a religious staff member for the day as he coordinated worship services. To reach as many interested prisoners as possible, I attended as many denominational worship services as scheduling allowed.<sup>3</sup>

Prior to each service, I was provided several minutes to introduce the research to attendees, explain that they may receive a letter in the coming weeks inviting them to participate, and encourage them to inform others not in attendance about the study. Attending prisoners were also permitted to ask questions, and it was clear based on the questions asked that many had concerns about the prison health-care system that they wished to voice.<sup>4</sup> In total, I had contact with 215 prisoners across the three SCIs during prerecruitment. Given that not all prisoners avail themselves to religious services, my presence at these events was not relied on as the sole prerecruitment strategy. A Microsoft® PowerPoint™ slide was also placed on rotation to help explain the study through the prisoner-run television channel to open up prerecruitment beyond religious services and to minimize any potential selection biases.

After prerecruitment, recruitment letters were created using the computer-generated list that the RRC chairperson provided. These letters were personally addressed to each eligible prisoner and placed in each prisoner's mail drawer. Within the letter, recruits were informed of the study's purpose, told that participation was voluntary, and instructed that choosing (or not choosing) to participate would have no impact on parole status or SCI privileges. If after reading the letter prisoners wished to participate, they were required to write a note to the point of contact I identified at the SCI (the superintendent's acting assistant) stating that they wished to participate and would like to be scheduled for a research interview.

Prisoners were asked to send a note to the superintendent's assistant to appease not only the IRB but also the RRC. Given that prisoners are classified as an especially vulnerable class of research subjects (Schlosser, 2008; Umamaheswar, 2014), these

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2. Approximately 13 months were spent securing approval from the IRB and RRC. Note that working on drafts and securing buy-in from the RRC prior to submitting to the university IRB helped to minimize delays with the IRB.
  3. Denominations attended included Protestant, Catholic, Islam, Native American, and Jehovah's Witness.
  4. Examples of questions raised included "how can we sign up," "what will you do with the findings," and "why do we have to be at least 50 years old to participate?"



stakeholders wanted additional precautions embedded within the research design to lessen the likelihood that men would feel coerced to participate. Although other researchers have had success with approaches that require less direct contact between prison staff and respondents during recruitment (see Calavita and Jenness, 2015; Loeb, Steffensmeier, and Myco, 2007), such approaches still require participants to inform staff, albeit only verbally, if they would like to meet with the research team. Requiring prisoners to send a note in advance offered the methodological advantage of giving recruits plenty of time to decide whether they wanted to participate and make an informed, deliberate choice to move forward with participation rather than having to tell a staff member who has regular control over their carceral lives “yes” or “no” on the spot. The risks for coercion were thereby likely reduced, and the message that the study was entirely voluntary was enhanced.<sup>5</sup>

The superintendent’s assistant then compiled the list of prisoners who submitted letters and scheduled call-out lists for each day I was assigned to visit the prison to conduct interviews. I visited each SCI between 2 and 4 days per week, depending on institutional allowances at each prison, until the list of men who expressed a desire to participate had been exhausted. Prior to participating in the interview, each potential respondent was given an informed consent document that outlined the study’s purpose, its voluntary nature, and what the respondent would be asked to do. I explained all components of the document with each individual and made sure he understood the content and had opportunities to ask questions. After signing the document, the interview would commence. Given the ethical concerns and institutional rules and regulations, incentives could not be offered to respondents for their participation, which is normative for prison research (see Schlosser, 2008).

In total, 1,158 prisoners were asked to participate across the three SCIs, 374 submitted notes expressing interest in participating, and 279 completed interviews. Those who submitted notes but ultimately did not participate ( $n = 95$ ) were either paroled, scheduled to work on the day of the interview and did not want to miss their shift, were too ill to attend, or changed their mind. To reduce any problems with reading and writing barriers, as well as to enhance trust and rapport between respondents and myself, I read each question aloud to respondents and logged their responses. Respondents were instructed that they could share any additional concerns or details they felt were important as we moved through the interview. This resulted in rich, detailed accounts from many of the men who participated about how they were grappling with various health issues. All interviews were conducted one on one between myself and each respondent in either the no-contact visiting area or at a table inside the general population visitation room, depending on the needs of the institution each day.

Of the 279 who completed interviews, 193 (69 percent) offered qualitative accounts to supplement the survey questions. These interviews, which are the source of this project, averaged 54 minutes, with a range of 40 to 100 minutes, depending on each respondent’s experiences with the prison health-care system, his health-related concerns, the extent of witnessed medical issues of other prisoners, and desire to share those experiences with

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5. Even though this likely contributed to the production of a below-average overall response rate, which is a limitation of the data, this was considered a reasonable sacrifice to offer additional protections to this vulnerable class of human subjects.

me. So as not to threaten institutional security, I was banned from bringing a recording device into any of the prisons. To overcome this common prison research barrier (Schlosser, 2008), I hand-recorded detailed notes on each survey as respondents elaborated on an answer or expressed a concern that a multiple-choice answer could not sufficiently address. I used a coding system to accomplish this that included clearly distinguishing direct quotes from notes.

Although originally a barrier, hand recording notes ultimately seemed to enhance the trust respondents had in me, as many commented that they appreciated me taking their concerns seriously by recording such detailed notes. Frequently during interviews, respondents would explicitly tell me, “be sure to write that down.” As word about the structure of the interviews spread throughout the prisons, respondents began to bring documents and data they wanted me to record, including case numbers, names, dates, lawsuits involving medical neglect, and lists of medications. It became apparent that I was viewed by many as having power through my position as an outsider (see Sexton, 2015) and that I was trusted to take the information they shared with me beyond prison walls to the outside world. After each day of interviews, I transcribed all notes and added necessary detail to increase the quality and richness of the data and to minimize error (see Smith, 2015). In total, 212 single-spaced pages of data were compiled across the three prisons. These data, in addition to the extensive field notes I took over the 13 months I spent at the prisons while interacting with prisoners, guards, and visitors, are the sources for this project.

## ANALYSIS STRATEGY

Typed qualitative data were analyzed using NVivo, v.10 (NVivo, 2012). Because no specific hypotheses were tested, yet the data were collected with the intention of exploring broadly the experiences of older prisoners in regard to health and health care, a modified grounded theory was used as the analytical technique (Charmaz, 2009; Cutcliffe, 2004). Open coding was used first to widely open the inquiry and establish a list of exhaustive themes that emerged from the interviews by assigning excerpts of the transcript’s descriptive words (Glaser and Strauss, 1967; Strauss, 1987). Examples of open codes that were initially established included advocacy, food, medication issues, and family visits. After identifying initial categories, data were reviewed again using a process of secondary coding. This process of refined coding was used to eliminate any overlapping codes and expand the initial list of codes into more meaningful categories. For example, the initial code “advocacy” developed into “self-advocacy” and “external advocacy.”

After this layer of refined coding, all codes that were connected by sharing focus on respondent concerns toward health management were then selectively coded (see Lofland et al., 2006). For example, “self-advocacy” was selectively coded to separate instances of verbal assertions from formal grievance procedures and was termed “primary advocacy.” “External advocacy” was then selectively coded to separate instances of family involvement from legal/attorney involvement and other organizational involvement and was termed “secondary advocacy.” All coding not directly tied to health management (i.e., “family visits”) was removed from this final layer of analysis. This process of data analysis resulted in several themes that captured the specific health promotion strategies available to and used by older prisoners and how these strategies help them manage health issues within a very constrained environment.

**Table 2. Select Sample Characteristics of Prisoners\***

Variable	<i>n</i>
Age (Mean; range)	58.4; 50–78
Race	
White	118
Black	75
Education	
11th grade or less	37
12th grade or GED	92
Some college	35
College degree	29
Employment	
Employed	110
Unemployed	83
Number of Chronic Health Conditions (Mean; range)	3.6; 0–11
Number of Medications (Mean; range)	3.9; 0–23
Security Level of Institution	
Minimum	37
Medium	77
Super-maximum	79
Prior Prison Term Served	
Yes	106
No	87
Life Sentence	
Yes	56
No	137

\**N* = 193.

**SAMPLE CHARACTERISTICS**

Sample characteristics can be found in table 2. The men ranged in age from 50 to 78 years, with a mean age of 58.4. Fifty-five percent had been incarcerated in a prison at least once before (*n* = 106), and although 29 percent (*n* = 56) were serving sentences of life, most were serving sentences ranging between 36 months and several decades. Eighty-one percent of respondents were incarcerated at either the super-maximum (*n* = 79) or the medium security (*n* = 77) institutions, whereas 19 percent were incarcerated at the minimum security institution (*n* = 37). Thirty-nine percent were Black (*n* = 75) and 61 percent were White (*n* = 118). Compared with national estimates (see Carson, 2015) and state DOC data at the time of data collection, Black respondents were slightly overrepresented, non-Hispanic White respondents were highly overrepresented, and Hispanics were not represented at all.

Respondents reported suffering from an average of 3.6 chronic health conditions, with a range of 0 to 11 reported per respondent and all but 3 percent reporting at least one. This is consistent with the existing literature. Most scholars report high frequencies of multimorbidity among older male prisoners, with the majority reporting means between two and three chronic health conditions at any given time (Aday, 2003; Harzke et al., 2010; Loeb and Steffensmeier, 2006; Nowotny et al., 2016; Wangmo et al., 2015; Williams et al., 2010, 2012).

The most common chronic health conditions reported included high blood pressure, high cholesterol, arthritis, diabetes, other heart problems, and infectious diseases.

Although these were the most common conditions reported, rarer conditions were also disclosed, including various forms of cancer, autoimmune conditions, and epilepsy. Thus, men in this sample were living not only with an average of 3.6 chronic health conditions: some were living with conditions that required substantial monitoring and treatment to maintain positive prognoses. Respondents reported taking an average of 3.9 medications, with a range of 0 to 23 reported per respondent and varying levels of difficulty consistently adhering to medication regimens.<sup>6</sup>

It is worth noting the immense and sustained strain faced by these men. Many discussed losing loved ones while incarcerated and not being able to attend funerals. Most disclosed exposure to extreme acts of physical violence, either personally or from witnessing the victimization of others. One respondent described being thrown from his wheelchair by another prisoner, for example. Another discussed a time he ended up with a broken collar bone and a shattered pelvis after being assaulted by a guard. Others described suffering from burns, stabbings, and broken wrists, jaws, and ribs. Sexual assaults were also disclosed. Seventy-two percent ( $n = 139$ ) reported witnessing the death of another inmate as a result of an illness. Respondents also described witnessing suicides of cellmates or other inmates on their housing units. Given the clear links between stress and health (Pearlin, 1989), these and other sustained stressors distinguish prisons from other sites of health-care delivery and likely exacerbate the health needs of prisoner patients.

Given the research design, the results discussed in this article cannot be generalized beyond this sample. Yet, a sample size of 193 respondents across three different types of prisons enhances confidence that data saturation was reached (Glaser and Strauss, 1967). Furthermore, the findings raise important issues that build on gaps in prior work on the health-related experiences of older incarcerated men and may aid further developments in the areas of prisoner aging and health.

## FINDINGS

The results highlight a tension that exists between inmates' engagement in disease management strategies and the privilege that facilitates these behaviors. According to Marmot (2004), those lower on the social hierarchy have less autonomy over their lives, leading to worse health outcomes and shorter life expectancy. By contrast, those higher on the social hierarchy enjoy privileged status in that they have more options for full social participation and greater autonomy, both of which can be deployed to enhance health. In the context of this research, although all respondents are arguably low on the social hierarchy as a result of their incarceration, privilege is defined as respondents' access to resources, both material and social, that are achieved through discretionary means. It is also expressed as the disparate level to which informal and formal social controls are levied against them within a carceral setting.

This understanding of privilege is important, as there was a general acknowledgment among inmates of an unequal playing field regarding abilities to manage health issues. Three themes emerged that highlight the range of health promotion strategies used. Most paramount were prisoners' efforts to make connections to medical knowledge. Prisoners'

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6. Problems reported included lapses between prescription refills as a result of staff forgetting to order refills, prisoners' inability to afford co-payments, and waiting for qualifying medical paperwork to transfer between prisons.

connections to medical knowledge then bolstered actions to modify food and diet options and engage in primary and secondary health advocacy. The results show how privilege is linked to cultural health capital, ultimately fueling the application of these strategies and reinforcing prisoners' perceptions that opportunities for health management are not equal.

### ACQUISITION OF MEDICAL KNOWLEDGE

Respondents first described attempts to address their health concerns by making connections to medical knowledge. Twelve percent of respondents ( $n = 23$ ) reported reaching out to family and friends outside of the prison who had medical training or experience for assistance.<sup>7</sup> Brendan, 53 years old and White with heart and kidney problems, explained that he has multiple family members with medical credentials who are available to help him when he has a medical question.<sup>8</sup> In his words:

My mom sends me copies of medical books. I read and study them. My mom is an anesthesiologist, my sister is a nurse. I call them frequently to ask medical questions.

Respondents felt that reading about their health conditions was especially important, and they went to great lengths to obtain medical reading materials. These efforts included requesting materials from government agencies such as the CDC, looking up reading materials in the prison library, and having family or friends send in medical readings. In total, 24 percent ( $n = 46$ ) discussed gaining access to medical journals and books, government reports, encyclopedias, and Internet research. Matthew, a 60-year-old African American with high blood pressure and cholesterol, diabetes, arthritis, and kidney problems, emphasized the importance of being an active consumer of health information. He stated:

I've read a lot about case law. When I have an ailment, what I'll normally do is go to the medical encyclopedia. I try to be as informed as I can, especially as I've gotten older. *If you don't know, they [medical staff] treat you like you don't know* [emphasis added].

Matthew discussed the gravity of the situation if medical staff perceive an inmate as uninformed regarding his medical condition(s). In particular, Matthew felt that medical staff perceived lack of knowledge among inmates as a free pass to not be appropriately responsive with medical care, which is why he felt it so important to stay informed about his conditions. Other prisoners echoed this sentiment, again from the standpoint that medical staff cannot be trusted or counted on. Throughout the study, prisoners gave multiple examples of medical neglect and misdiagnosis, challenged the credentials of medical staff,

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7. Note that this count data, as well as other count data embedded in the following narratives, are not derived from a questionnaire that was asked of each respondent unless noted or reported in tables 1 or 2. Rather, counts represent the number of times respondents raised this point organically during interviews. As there is no way to know how many respondents fell into each category versus how many simply happened to bring this up during interviews, these counts should be interpreted with caution.

8. The names of all respondents have been changed to protect their identities. All names referenced are fictitious.

and provided personal accounts of being misled. For these reasons, there was a general perception among many prisoners that it would be foolish to trust blindly what medical staff say without verification or personal research. Eric, a 54-year-old White man with circulation and heart problems, stated:

The only way to get an honest answer around here about medical problems is to read up on medical books. That's it, you don't have a choice.

Eric and other prisoners used the phrase "they'll Motrin you to death" as they described case after case of prisoners who went to the medical unit for help unsuccessfully. Rather than having any medical tests or diagnostics ordered to uncover causal issues, prisoners were repeatedly given Motrin<sup>®</sup> by staff to pacify them. Other respondents emphasized the importance of being informed about medical conditions because staff will not take the time to explain things like medication side effects. Rob, a 62-year-old African American man with high blood pressure, liver disease, and kidney problems, described declines in the amount of information provided by medical staff over the years. Rob stated:

They [medical staff] used to give you a paper for every medicine that you had with listed side effects. So you could make a conscientious decision on whether you wanted to take it. Not here . . . if I didn't have medical books, pill books to look it up on my own? This stuff [my medications] would be killing me.

Rob's concerns about dire consequences are partially driven by an experience he had when staff prescribed him a new medication that was improperly paired with a medication he was already taking. Rob learned that the two medications were not compatible only after consulting medical books when he began to experience multiple troubling side effects. At that point, he decided to stop taking the new medication and reported the issue to medical staff.

Thirty-five percent of respondents ( $n = 67$ ) also reported accessing medical knowledge and sharing it with one another. This strategy is used for a variety of reasons. For one, there are prisoners who not only lack access to medical knowledge but also would struggle to read it even if they obtained it. Although it is unknown what percentage of prisoners in this sample could not read or write with proficiency, 19 percent ( $n = 37$ ) completed less than 12 years of schooling and multiple respondents mentioned literacy issues when discussing their peers. As an example, Austin, a 59-year-old African American with diabetes and high cholesterol, offered accounts of prisoners who did not understand the results of their lab work, or who had no knowledge of what medications should be used to target specific conditions. Austin explained:

I study a lot of medical stuff, read a lot of books. Most guys [inmates] can't read their lab work, so I read it for them. Tell them what to do. I got all kinds of medical books, pill books.

Others expressed needs to help one another with medical knowledge because without going to medical appointments prepared with possible explanations or references to medical terminology, many felt they would not be taken seriously. Richard, 70 years old and White with high blood pressure, explained:

I have an anatomy book in my cell, my ex was a surgical nurse ... lots of guys [inmates] come to me with symptoms before going to medical because a lot of times it feels like you're getting the run around.

Consistent with Richard's use of the term "run around," many inmates provided examples of how their medical problems escalated after their concerns were dismissed by medical staff. Andrew, a 69-year-old White man who has a neurodegenerative disorder, complained for days to medical staff about crippling stomach pains. Without so much as a physical exam, staff told Andrew it was likely "just a pinched nerve" and he was told to return to his cell and take a Tylenol<sup>®</sup>. Days later, Andrew was rushed to the hospital for an emergency appendix removal. Andrew explained that it was "so bad that they had to open me up [surgically] all the way down [my body]." Andrew added, "the doctor who did the surgery told me, 'had it been another 15 minutes I never would have made it [survived].'" Andrew required hospitalization for 14 days to recover from the trauma of the surgery.

Phil, a 53-year-old African American with diabetes, urinary problems, and arthritis, offered another account. Phil explained that it was not until citing a medical book and suggesting that an ultrasound be ordered to detect a suspected urinary tract infection that he was finally able to receive the necessary medical diagnosis and treatment for the complications that he developed after he returned to prison following a surgery. For Phil, being able to reference a medical procedure and connect it to a reliable resource granted him some credibility with medical staff, which ultimately led him to receive the treatment he needed.

Another impactful, albeit less common, strategy cited by respondents involved reflecting on previously acquired medical knowledge or experience. In total, 10 percent of respondents ( $n = 19$ ) reported having either advanced medical degrees ( $n = 4$ ), experience with military medical training ( $n = 5$ ), community medical work experience such as EMT or nursing assistant work ( $n = 7$ ), or experience with prison hospice care ( $n = 3$ ). Nicholas, 56 years old and White, has high blood pressure, osteoarthritis, and a chronic back injury. He discussed being a physician prior to his incarceration and feeling that it gives him advantages when communicating with medical staff. He explained:

They [medical staff] know I was a doctor, a professor at a medical university. So I get pretty good [medical] care.

Bernard, a 70-year-old White man with hepatitis C and heart problems, reinforced this sentiment:

For the physical exam they [medical staff] listen to your heart, check your reflexes, listen to the lungs. It's comparable to the outside [community]. The problem is what they do with the information they have. Inmates will tell them what would be key catch words to most doctors to follow a path and they don't do it.

The exception, Bernard pointed out, is if medical staff feel the patient has some sort of credibility. Bernard felt that his prior job as a critical care medical provider, as well as his ability to discuss standard courses of care with staff, offered him an advantage in comparison with other inmates, as it was more difficult for medical staff to dismiss his concerns prematurely.

The benefits of linking cultural health capital to privilege within the prison context are evident in the accounts offered. Only inmates who know how to look up medical research, obtain copies of it, read it, verbalize it, and understand its value can leverage that resource. Prisoners who can do so, especially those who have some degree of medical training, have a distinct advantage when communicating with medical staff. In Fluery-Steiner's (2008) ethnography about the treatment of HIV infected prisoners at Limestone prison, prisoners who were unable to provide what medical staff perceived as key details about their medical histories and conditions were labeled "poor historians." Fluery-Steiner (2008) astutely pointed out the consequences when this occurred:

Once this "diagnosis" is assigned, the individual's illness becomes something more akin to a ticking time bomb, rather than an ongoing medical condition to be closely monitored and treated. (p. 122)

Thus, those in this sample who could connect to medical knowledge were likely more apt to communicate clearly about their medical concerns, in a language that medical staff respected, which may have led them to be taken more seriously. The need to connect with medical staff in this manner and be taken seriously is especially critical in the context of the prison environment. Unlike community dwellers, prisoners are often perceived as an unsympathetic group. Many respondents in fact made comments about how staff view them as unworthy recipients of medical care. Jeremiah, 61 years old and White, recalled a conversation he had with his doctor when his pain following a severe injury reached an intolerable level. He said:

The doctor told me, "I don't care if you're in pain or not. My only job is to keep you alive so you can do your time." That's what he told me ... they [medical staff] don't care, they just don't care. When a medical doctor looks you in the eye and says that to you, that says it all.

Tony, 51 years old and Black, offered a similar account:

There's gotta be better personnel. You know, medical staff that care about us. A lot of people have just got it in their minds that "if you did it [the crime], the hell with you." Or, "you a prisoner, so the hell with you." They never look at, you know, putting themselves in these situations. It's, "if you get out, you'll kill my children, so the hell with you."

Thus, prisoners who could not connect with staff by referencing medical knowledge not only have the barrier of being stigmatized as criminals but also the added penalty of being seen as oblivious, both of which left men in this sample feeling vulnerable. Given that not all inmates have access to items such as pill books or family members who can answer their questions, those who do have a degree of privilege that, when paired with cultural health capital, provides them with beneficial strategies. The need to acquire medical knowledge in creative ways is especially important because medical resources in the prison libraries were limited and many were outdated. One respondent discussed how the physicians' desk references in the library used to be good sources of information, but many have since been removed as a result of what the prison cited as a "security issue." Thus, securing access to current medical journals, publications from the CDC, and other trusted health



information was highly valued. Yet, accomplishing this requires connections, either to those outside of prison walls or to other inmates who have such information. The fact that many in this sample did not report having these connections underscores the privilege of those who did.

It is important to note that respondents reference severe disadvantages for inmates who lack access to medical information, such as Andrew's and Phil's examples. Most severe is that inmates who lack access to medical knowledge may not get the care they need, leaving them susceptible to late diagnoses or no treatment at all. Darryl, 61 years old and Black, explained:

For the older guys . . . if we can't identify the [medical] problem ourselves, from our own experience and knowledge, the doctor isn't going to look at it.

### FOOD AND DIET MODIFICATIONS

Prisoners' acquisition of medical knowledge strengthened actions to protect their health through food and diet modifications. Notably, most respondents expressed concerns regarding the availability of adequate food and diet options that would allow them to manage their chronic diseases appropriately. In fact, when asked to rank aspects of the prison environment that they felt were most stressful, respondents collectively ranked food quality as the third most stressful aspect, behind only missing freedom and missing family or friends.<sup>9</sup>

A common concern among diabetics was how many carbohydrates they are fed during meals instead of more nutritious options less likely to exacerbate the disease. Prisoners regularly used the phrase, "they [staff] starch us to death," with reference to foods like pancakes, pasta, potatoes, and rice. Thomas, a 61-year-old African American with diabetes and high blood pressure, articulated that diabetics are not supposed to eat potatoes, corn, and noodles. Yet, these foods are served regularly, and there are no special diets to accommodate diabetic needs. He stated:

The way they [staff] feed diabetics is wrong—too much starches. I used to get tuna fish as a substitute [when I worked on the food line].

Thomas struggles with these circumstances and disclosed that he has lost 20 pounds since being incarcerated. Thomas has lost weight in part because he elects to skip meals frequently to avoid foods he knows will worsen his health. He understands that skipping meals is not good for his health either, but he sees it as less harmful than consuming foods that will essentially guarantee the acceleration of his condition. Notably, it was easier for Thomas to manage his diet when he worked in the kitchen because he could substitute foods like noodles with healthier options such as tuna fish. When he was given a different job assignment, however, this advantage was no longer an option.

Thomas's account shows how privilege, in this case, having a prized job in the prison, can elevate the deployment of cultural health capital. Specifically, although Thomas has a degree of cultural health capital based on his understanding of what kind of diet he needs

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9. See Rocheleau (2013) for the full 18-item scale that was used.

to manage his chronic health conditions effectively, he was left with less ideal methods for using that knowledge (i.e., skipping meals versus making healthier food substitutions) when he lost his kitchen job. Terrell, a 52-year-old African American with high cholesterol, offered a similar account regarding the advantages associated with various employment positions within the prison. Terrell stated:

The food quality all depends on where you work at. I'm in a position to get things that other inmates don't get. If you work in the kitchen, then you're around all the stuff [food]. So you can prepare it differently for yourself. See, I work in the warehouse so we get everything before it goes in. So I can get things like fresh vegetables before they're prepared and smothered in butter.

In Terrell's case, it is apparent that he has cultural health capital because he understands the benefits of eating vegetables when they are fresh, uncooked, and unseasoned. As a result of his privileged status as a warehouse worker, he can deploy this knowledge and incorporate a diet that is more likely to benefit his health. While at the prisons, I also observed the excitement that accompanied inmate visits, which I learned centered around opportunities in the visitation room for family members and friends to purchase vending machine foods for their loved ones.

Many times I observed prisoners eating wraps and salads. It became clear that this was one of the major "perks" of having a visit: being able to enjoy a meal that did not come from within the institution. Several respondents explained to me that visits can give that one weekly "boost" to your health because it provides access to a healthier meal option. It is not just in understanding the health benefits of eating wraps or salads in comparison with the prison food, however, that matters. One must also have the knowledge that these food items are available during visits and be privileged enough to have loved ones willing to visit the prison and pay for these items to mobilize cultural health capital in this manner.

Skipping meals, substituting food items at work, and supplementing meals during visits were not the only strategies referenced for combatting undesirable prison foods. Jason is 58 years old, White, and has osteoarthritis and a prostate condition. He disclosed that when he can afford it, he will make his own meals with black market ingredients. Jason also explained a process of selectively choosing which items to eat during meal times based on the relative health benefits of the items offered. In his words:

They [staff] keep talking about this "heart healthy diet," but I get servings of potatoes filled with grease. So I just go for the vegetables and fruit.

Many echoed Jason's strategy for chow time: Take the items that offer nutritional benefits and leave the items that threaten health. The most prized items were fresh fruits such as bananas and oranges. In fact, the desirability of these items was often a point of contention among inmates, as not everyone had equal access to them. For example, several men explained that those who live in cell blocks that get called to chow first can reasonably count on getting a fresh fruit item, whereas those who get called later in the day are often left with canned fruits coated in sugar water. Thus, prisoners who get called first have a distinct advantage. Given these circumstances, inmates made concerted efforts to align themselves with other inmates, who would set aside fresh fruit items for them if

they could not get in line early, or with correctional officers, who might call them to chow earlier. Multiple men discussed networking with younger inmates in particular because many of them do not yet worry about maintaining a healthy diet and are willing to part with items like fruits.

Purchasing items from the commissary was another strategy highlighted by respondents to help address nutritional concerns. Norbert, 52 years old and White with chronic back problems, explained that before he came to prison he used to drink a glass of milk each morning to help with protein and calcium intake. He clarified that this is not an option in prison. He stated:

I buy mixed nuts from commissary to get protein, because you can't get much from the food line. You have to have nutrition. If the food's not giving it to you, how the hell you gonna get it? But I can afford to do that. There's guys who can't afford to do that. And *they look like crap* [emphasis added]. You can't eat pasta coated in butter every day. Sometimes they [staff] serve pasta three times a day.

Importantly, Norbert acknowledged that although he can afford to purchase extra items from the commissary to get enough protein, there are others who cannot, highlighting his privileged status. Norbert disclosed that he has one of the highest paying jobs in the prison, giving him disposable income that other inmates do not have. In his description, it is apparent that Norbert feels that those who cannot afford to purchase healthy food items from commissary are disadvantaged, as they do not look well physically. Thus, Norbert's knowledge about nutrition and the importance of protein intake is able to be fully realized, all the while grasping that this would not be the case without his level of privilege.

Others not only commented about using the commissary as a strategy to eat healthier but also discussed how necessary this is given the diminishing food quality at the prisons. Jim, a 51-year-old African American who suffers from diabetes and asthma, explained that when he was first incarcerated, there were specific diets for diabetics, diet lines for prisoners with various health conditions, and fresh food options. These options are now gone, however. In his words:

When I first fell out [got to prison], it [the food] was much better. Everything now is processed meats. And that contributes to heart disease, cancer. There's nothing fresh, the quantity is low. You rely mainly on commissary to eat healthy.

Other respondents noted not only the availability of commissary as an option to eat healthier but also using other inmates as a resource. Ron, a 56-year-old African American with diabetes, heart problems, and an autoimmune disease explained:

So you got the commissary. You try to go there and buy the stuff you need to buy, like tuna fish. Or if you know guys [inmates] who will provide you with stuff, like oatmeal.

Many articulated advantages of networking with prisoners who work in the kitchen or the warehouse, with prisoners who can afford to purchase commissary items, or, as explained, with prisoners who can get to the food line first. To be sure, these efforts are strategic and deliberate. Many discussed making social contacts within the prison with the sole intention of being able to access better dietary options, and several discussed trades they needed to make for this to happen.

Cultural health capital is apparent in that these prisoners not only understood the types of foods they needed to benefit their health, but also they had the institutional knowledge of *how* to access better dietary options. Cultural health capital was then most deployable in circumstances where prisoners had privileged statuses, either through working coveted jobs, in having social contacts outside of the prison who were willing to visit them, in having allies within the prison, or in having access to money. The commissary is especially reflective of privilege as this resource is only an option for those who have money, either as a result of a job or because of having someone on the outside who is willing to deposit funds.

Given that jobs were an unequally distributed resource within the prisons involved in this research (43 percent of respondents were not employed), those who did not have jobs reported a great deal of stress in regard to their health management options. Charlie, a 54-year-old White man who suffers from multiple chronic health conditions including hypoglycemia, discussed the necessary components of a hypoglycemic diet—frequent meals that are low in fats—and the inability to meet those needs through the standard provisions offered by the prison. Charlie acknowledged his privilege because of his employment status in this way:

It seems like they [prison staff] don't have any game plan to deal with someone who is hypoglycemic. If I couldn't work and buy commissary, I'd be in some serious trouble with my blood sugar dropping.

## HEALTH ADVOCACY

When necessary, more vigorous actions in the shape of primary or secondary health advocacy were also used by respondents to address their needs. In the context discussed here, primary health advocacy refers to advocacy efforts orchestrated solely by the prisoner himself, whereas secondary advocacy refers to advocacy efforts that occurred after the inmate requested assistance from sources beyond the prison. Respondents shared sentiments regarding the importance of speaking up, asking questions and being assertive, as well as keeping a critical eye on the explanations provided by medical staff. John, 57 years old and White, has high cholesterol and degenerative bone loss. John described the importance of being assertive about medical care, as inmates who are not are often pushed aside. In his words:

If you need it . . . it goes without saying in here . . . you gotta prove why you need it. If you need a cane, *you better start explaining* [emphasis added].

For John, it is not enough simply to communicate what you need to medical staff. Rather, needs must be communicated persuasively and with concrete information. Other respondents cautioned not only on the importance of being able to speak up for one's needs but also on keeping a critical eye on the assessments medical providers give. Jerrod, a 60-year-old African American with diabetes, high blood pressure, and arthritis, explained:

A lot of complications that happen here are because guys [inmates] don't know how to speak for themselves. They go to medical and accept whatever they say and then the condition gets worse.

To protect himself, Jerrod explained that he does not accept what medical staff tell him about his conditions until he sees written test results and lab work. He also mentioned consulting medical journals and books about his condition so as to ensure the providers' assessments are reliable, again reinforcing the importance of making connections to medical knowledge. Another form of primary advocacy referenced by respondents was being sure to take initiative and follow up with providers after lab work, scans, or tests are ordered. Many explained that results will not be shared unless an inmate makes the effort, often multiple times, to follow up with medical staff by asking for an appointment. Justin, 59 years old and White, has high blood pressure, heart problems, and arthritis. He stated:

They'll [medical staff] do the test. But they won't follow up and call you up to go over the test [results]. You have to write to them and then they'll call you up and go over it.

Justin's explanation was reinforced in that multiple respondents expressed frustration that they had completed various medical tests or lab work months or even years prior but had never been informed of their results. Thus, having the cultural health capital to know that these results must be requested or initiated by the inmate by scheduling another medical appointment is an important aspect of getting medical needs met.

When respondents failed to get the medical attention they needed through the aforementioned avenues, they referenced filing grievances as another possibility. Caleb, a 51-year-old African American, reported generally good health but reflected on an incident where he had substantial pain after an injury. Caleb explained the ordeal he went through to obtain the medical treatment he needed. He complained to medical staff regularly about severe back pain but was never referred out for an assessment. It was not until he pursued the grievance process that he was able to receive the referral he needed. In his words:

It took a whole year, after filing a whole bunch of grievances about medical staff, to get seen at a hospital.

When Caleb was finally sent to a hospital, the doctor diagnosed him with nerve damage that required follow-up care. Caleb believed that had he not filed the grievances and worked his way through multiple levels of appeals, he would have never received the assessment or treatment his condition required. Terrance, 70 years old and White, shared a similar experience. Terrance has high blood pressure and cholesterol, arthritis, and prostate issues. As a result of his prostate problems, age, and family history of prostate cancer, Terrance expressed concerns about receiving regular preventative prostate exams. Terrance explained that it was not until filing a formal grievance that he was able to receive a prostate exam. He explained:

I got into a discussion with the doctor. When I was on the outside [in the community], I got my prostate examined two times a year. I was told they [medical staff] "don't do that in here." I complained [filed a grievance]. They finally got that done here ... it gets done, *but it's a war* [emphasis added]. Like everything in here, you need to fight for it.

When primary health advocacy efforts fell short, respondents discussed the advantages of secondary health advocacy, or the involvement of attorneys, family, friends, or

organizations in requests for medical care. Thirteen percent ( $n = 25$ ) shared examples of advocacy efforts by attorneys. David, 58 years old and White with osteoarthritis, prostate problems, and chronic back pain, offered an example of how he failed to get his concerns addressed until he sought legal counsel. David stated:

I was prescribed gel insoles for severe arthritis. They [DOC] changed providers then they [medical staff] no longer wanted to give them to me. I filed multiple grievances and appeals. It wasn't until I got an attorney involved that they said, "yeah, you can have the insoles—no problem."

David's success relied on knowing that when grievance appeals are exhausted, other options, such as initiating legal proceedings with an attorney, remain. John, 57 years old and White with degenerative bone loss and high cholesterol, offered a particularly troubling example of an inmate he knew who suffered with a broken foot until he hired an attorney. John explained:

This guy [inmate] had a broken foot for two years. They [medical staff] wouldn't x-ray it, they made him walk on it. It wasn't until legal proceedings were started that they x-rayed it and sent him to a specialist. He needed emergency surgery with five pins placed. This is the type of stuff that happens in an ongoing manner in here.

Again, without the knowledge that attorneys can be used as resources to get medical needs addressed, it is unlikely that this man would have obtained medical care. This is especially apparent because this particular inmate was unable to find success until he involved an attorney—2 years after sustaining the injury. Family members and friends were another important source of advocacy that inmates relied on when trying to increase access to treatment. Twenty percent ( $n = 39$ ) reported relying on family or friends to help get their medical needs met, including Derek, a 62-year-old African American with high blood pressure, arthritis, and tuberculosis. Derek shared an experience where he had crippling pain after a fall. Derek explained that he was unable to get the scans he needed to assess his injury and determine a course of treatment until he solicited help from his family. In Derek's words:

If you don't get family involved [in your medical care], you don't get *nothing* [emphasis added]. For me, they [medical] gave me x-rays and pills. They weren't doing anything. I was in so much pain I didn't want no one to even touch me. I needed an MRI and a CT scan, but I had to wait for Pocatello [central office] for approval.<sup>10</sup> I called my brother, sister, and mother and had them call. Then my brother had his attorney call. After that, I got the scans and they've [medical] been really nice.

Harrison, 58 years old and White with high cholesterol, pancreatic problems, and a rare autoimmune disease, shared a similar experience. Harrison discussed the importance of having someone on the outside willing to advocate on your behalf when there is a medical

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10. The names of all cities and organizations have been changed to protect the identities of the respondents and the research sites. All cities and organizations referenced are fictitious.

issue, as he believes that without such help, he would still be fighting to obtain necessary diagnostic testing for confirmation of his medical condition. He explained:

I feel like I never would have got it [blood test] without my family repeatedly calling. That's what's going on with many guys [inmates]. Without someone on the outside you aren't gonna get the care. And I learned that by talking to other inmates in here. They said, "*what you really need is someone on the outside.*"

Knowing that involving someone external to the prison could be beneficial is reflective of cultural health capital because these inmates had the necessary understanding that prison administrators are sensitive to negative publicity or optics. The power in involving outside eyes, from the perspective of respondents, reflected a core belief that prison administrators are more likely to oblige inmate requests when appearances are threatened. Many respondents believed that prison administrators care greatly about avoiding negative publicity. At its highest levels, respondents reported soliciting help from attorneys and outside organizations. Alan, 57 years old and White, suffers from a lung condition, cancer, and heart problems. Alan described a time where he was unsuccessful for a 12-month period, even after filing grievances, to get the care he needed for a large bulge in his intestine that was coupled with extreme pain. Alan explained that after enlisting the help of the IAN Group, an advocacy organization for the incarcerated, he was finally able to receive medical treatment. In Alan's words:

I got the IAN Group involved. They lit a fire under someone's butt. Because the next thing I knew I was on a bus to Oakland [for my surgery].

In the descriptions offered, the necessity of cultural health capital with regard to exercising advocacy, whether primary or secondary, is clear. First, inmates who do not understand the grievance process within the institution are unlikely to be successful at using this option to address their medical needs. Some inmates are not aware that grievance decisions can be filed at all or that decisions about grievances can be appealed at multiple levels. Prisoners who are unable to read, write, or convincingly craft an argument are also limited in their abilities to engage in the grievance process. Inmates who do not have confidence regarding their conditions or experience asking providers questions or witnessing negative outcomes other prisoners have had may also be less likely to speak up or assert themselves.

In his accounts, John also cautioned that inmates need to know how to assert their needs in the right way, highlighting another important aspect of cultural health capital. In particular, those who offend or irritate medical staff while explaining their concerns are often sent to solitary confinement for punishment. Many respondents, including John, made reference to this. John explained that he spent a great deal of time in "the hole" after his initial attempts to assert his needs to medical staff until he learned how to phrase his concerns in a manner to which medical providers were receptive. For John, the solution was framing medical complaints about *circumstances* rather than about *staff*. John was unable to find success until he learned to do this. Thus, walking the line between advocating for oneself while not upsetting staff to the point that a medical appointment ends in a severe sanction is an ongoing challenge where cultural

health capital is particularly relevant. This is an especially unique barrier of the illness experience specific to incarcerated populations.

Again, inmates with privileged statuses have a distinct advantage in their abilities to incorporate successful primary advocacy strategies into the management of their health. Importantly, medical co-payments at the time of data collection were \$5 per visit. Thus, for those who wanted to obtain lab results from medical, for example, they first had to be capable of spending \$5. The average inmate job at the time only paid \$.19 per hour, meaning a prisoner would either have to work in excess of 26 hours or have loved ones willing to contribute funds to be able to afford these appointments.

Furthermore, only those with contacts willing to advocate for them, and spend the money to do so, are able to incorporate secondary health advocacy efforts into the management of their health. At nearly \$9 per 15-minute phone call and \$25 per virtual visit, involving outside contacts in a medical issue is costly.<sup>11</sup> It is worth noting that when asked about social support, 15 percent of respondents ( $n = 29$ ) reported having zero family members they could count on and 39 percent ( $n = 75$ ) reported having zero friends they could count on, illustrating the unequal distribution of this resource. Cultural health capital plays a role in that inmates must not only have resources but also understand that using them is likely to lead to positive results. As Harrison explained, it was not until talking to other prisoners that he gained an understanding for how he could use family as a resource to receive medical care. Others had to learn how to approach medical staff without being punished. Thus, the socialization process that occurs in regard to what strategies are successful versus unsuccessful can impact one's chances of getting medical needs addressed.

## DISCUSSION AND CONCLUSION

Prisons are no longer merely institutions of confinement but critical sites for the provision of health care. The findings of this study provide evidence that older prisoners work to incorporate specific strategies within the prison setting to negotiate their health. Importantly, these strategies function within a context of privilege, as inmates who not only have cultural health capital but also the abilities to pair cultural health capital with key resources, seem more apt to find success managing their health. This is apparent because many of the solutions disclosed by respondents would not have been possible or available without their use of lay and formal medical knowledge available in the prison, nor without their knowledge of how prison health care is organized and what resources are at their disposal.

Such cultural health capital meant that these men knew how and to whom they could appeal for care when needed. This finding helps extend the literature on prisoner health-care utilization. For example, Nowotny (2016) found that incarceration length and participation in job/education programming were positively associated with inmate health-care utilization. The findings offered by the current study provide us with the possibility that access to programming and incarceration length matter because these experiences could facilitate the accrual of cultural health capital, thus, increasing prisoners' potential for health-care utilization. Although the data presented here suggest that those who have

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11. These were the costs of phone calls and Skype<sup>®</sup> sessions at the time of data collection.



cultural health capital differ from those who do not by being either trained or educated, well networked, or experienced enough with normative medical policy and procedure at the prisons, it is unclear what the source of cultural health capital is for these men explicitly. Future research is encouraged in this area, especially regarding the development of a cultural health capital inventory for incarcerated populations.

The new understanding of the subjective nature of health management among older prisoners offered here is important, especially given heightened interests in understanding how age impacts the incarceration experience. Scholars have detailed the harms of solitary confinement to older prisoners (Williams, 2016) and how older prisoners' difficulties in health-care access are tied to psychological distress (Baidawi and Trotter, 2016) and depressive symptoms (O'Hara et al., 2016). There is also growing interest in prison hospice and palliative care programming (Hoffman and Dickinson, 2011; Wion and Loeb, 2016), senior specific units (Iftene, 2017; Kerbs and Jolley, 2007), staff training on geriatrics (Masters et al., 2016), and compassionate release (Handtke et al., 2017). These interests have developed not only because of the "graying" of the prisoner population but also because there are serious concerns with prisons continuing to operate per usual while housing an increasingly older population (see Crawley, 2005; Rikard and Rosenberg, 2007; Williams et al., 2012).

The results also enhance our knowledge about how prisoners socialize with one another. Although in some cases inmates may be highly distrusting of one another (see Irwin, 2005; Liebling and Arnold, 2012), the results here indicate a great deal of trust can exist between inmates as they share knowledge, resources, and strategies about how to navigate the land mines of the prison health-care system. It is possible that age may be driving the socialization discussed here, as older inmates are generally the more stable element of the prison society. Yet, given the value inmates already place on the underground prison economy (Trammell, 2009), my results also raise important questions about how aging prisoners have the potential to influence the underground prison economy. At least among this sample, commissary and unconventional food items are relied on for health management. Yet, many cannot afford to purchase commissary items on their own or to obtain additional food items through conventional prison jobs. Thus, future work should be aimed at considering how the aging prisoner population may be increasing the desirability of the underground prison economy.

The results further build on our understanding of the pains of imprisonment. Despite incarceration's depriving (Sykes, 1958) and status-stripping nature (Goffman, 1961, 1963), as a form of punishment, incarceration is also highly subjective and experienced differently from prisoner to prisoner (Sexton, 2015). Regarding health care, the results of this study challenge the assumption that "all prisoners have access to the same health care during incarceration" (Nowotny et al., 2016: 949) and support perspectives that call attention to the tiers of inequalities within prisons. For example, differential wage scales perpetuate income and status inequalities among prisoners (see DeViggiani, 2007) and inmates have varied resources that stratify their abilities to maintain visits with loved ones (Pleggenkuhle, Huebner, and Summers, 2017).

My findings provide yet another avenue by which inequalities are reproduced within prisons. Access to health management opportunities are structured, at least in part, by cultural health capital and degrees of privilege. Respondents in this study were mostly successful at getting care, but health knowledge, food and diet, and advocacy often required proper pairing with key resources (degrees of privilege) in order for success to

be realized. This complements research findings that reveal that, despite its tremendous power to stratify, incarceration may offer health benefits on certain health outcomes for certain groups (Mumola, 2007; Patterson, 2010; Wildeman, 2012). Given how marginalized many already are prior to incarceration, it is possible that health-care availability during incarceration offers potential improvements over prior circumstances *if* individuals can pair cultural health capital with key resources.

Yet, as the results indicate, access to health care is not universally experienced or successful. Thus, it is important for future studies to be aimed at exploring how cultural health capital may be playing a role in why the health of some prisoners improves while the health of others declines or stays stagnant. Because the findings from this research tell the story of respondents who, for the most part, were at least partially able to address their health concerns, it will be important to target respondents who are suffering in the prison system but lack the cultural health capital to resolve their concerns as they may reflect differently about their health management experiences. One potential method for reaching this group may be to interview individuals residing in the medical units. During data collection, there were inmates who wanted to participate in the study but were too ill or not functional enough to leave their beds. As I did not have the clearance to conduct interviews beyond visitation areas, these men were sadly excluded.

The findings offered have important implications for policy. First, additional dietary options are sorely needed within the prison system. We have an aging prisoner population with extensive chronic health needs, and access to adequate nutrition is a basic component of standard health care. As it is more costly to incarcerate prisoners as their health worsens, there is also a financial incentive for being proactive. Furthermore, prison management is at stake. Smoyer and Lopes (2017) recently discussed how perceptions of inadequate prison food can be seen as an additional layer of punishment that fuels frustration and humiliation among prisoners. In this study, many were frustrated and angry about the lack of dietary options available to them and they believed this was likely aggravating their medical conditions.

These feelings matter because they threaten the legitimacy of correctional institutions and impact the capacity for effective prison management. As prisons become more depriving, prisoners are more at risk for rule violations and violence (Rocheleau, 2013), recidivism (Johnson-Listwan et al., 2013), diminished psychological well-being (Johnson-Listwan et al., 2010; Marshall, Simpson, and Stevens, 2000; Slotboom et al., 2011), rioting (Colvin, 1992), and suicide (Dye, 2010; Huey and McNulty, 2005; Wolff et al., 2016), all of which impact prison management. Indeed, this ever-present potential for disorder is why administrators see value in having a formal process in place for reviewing prisoner grievances (Calavita and Jenness, 2015).

Other policy implications include increasing health access and knowledge among prisoners. One option is for prisons to coordinate with community health experts and offer regular health seminars to educate prisoners about their medical conditions. Prison medical providers have large caseloads, and many respondents commented about how they wanted to ask providers questions about their conditions and medications but were not given time to do so. Health seminars put on by volunteers would help alleviate this inexpensively. Clear and transparent information should also be made available to all inmates regarding the grievance process, and there should be concerted efforts to ensure that inmate volunteers are available to assist those who cannot read or write as well as those unfamiliar with the process. Eliminating the medical co-payment system and increasing

voluntary job opportunities would also help lower the need to have privileged statuses as a prerequisite for getting medical needs met.

Although the findings from this study offer important contributions, the weight of the results must be considered in proportion to its limitations. The overrepresentation of non-Hispanic White and Black men in this sample introduces a potential source of bias as a growing portion of the U.S. prison population are Hispanic, yet they are not represented here. Thus, it is necessary to question whether the findings may have varied had Hispanic men participated while, simultaneously, fewer Black men and fewer non-Hispanic White men participated. Non-Hispanic White state prisoners, as well as Black state prisoners, are more likely to report chronic health conditions than are Hispanics (Maruschak and Berzofsky, 2015). In addition, 87 percent of state prisoner deaths in 2014 were of either Blacks or non-Hispanic Whites, whereas only 11 percent of state prisoner deaths were Hispanics (Noonan, 2016). It is therefore conceivable that the data presented here overcaptures those individuals who have the highest health-related burdens.

Had Hispanic men participated, it is also possible that language may have emerged as an especially prominent barrier regarding the accrual and mobilization of cultural health capital as there were several Hispanic men who wanted to participate but were unable to do so because of our inability to communicate using the same language. Furthermore, given that Black prisoners may be more likely to use health-care services than other racial groups (Nowotny, 2016), their overrepresentation in this sample may underreflect prisoners who still have health problems but are less frequent consumers of health services.

The underrepresentation of minimum security respondents introduces another potential source of bias. The mean sentence lengths at the minimum, medium, and super-maximum security facilities were 10.6, 18.5, and 19.7 years, respectively. Although several respondents at the minimum security prison described their conditions as “adult summer camp,” or as “camp fluffy,” inmates at the other prisons never used such flippant terms. Rather, conditions were commonly described as “hell” and “torture.”

Although prisoners at the minimum security facility certainly had health-related concerns, their concerns may not have seemed as emergent or as *permanent* to respondents. For example, some commented that they planned to address their health “when they got out” rather than attempt to remedy their needs while incarcerated. Others discussed times they just decided to “walk over” to the medical unit rather than wait to be placed on a medical call-out list. These were clearly not options for inmates at the other institutions. Minimum security prisoners also had more access to jobs, including jobs that allowed them to work offsite for the day. Thus, the underrepresentation of minimum security prisoners may have produced a data set that is skewed toward the perspective of more severely deprived prisoners who, given their lengthier sentences and more extensive restrictions, may have reported more health-related barriers than would have been reported had more minimum security inmates participated. Scholars are urged to recruit Hispanics in future studies, as well as to consider how security level may impact health-care mobilization. Doing so will help broaden the findings discussed here.

Finally, I focused solely on the perspective of prisoners. To be sure, the underresourced, understaffed, and overcrowded nature of the U.S. prison system places medical staff and administrators in a precarious position. In his ethnography on the waiting area of the welfare office in Buenos Aires, Auyero (2012) articulated that the state maintains its power and reinforces subordination of the poor in part by making them wait, which is a necessary tool when resources are scarce. Similarly, Calavita and Jenness (2015) demonstrated

how prisoner grievances can be only infrequently successful within the DOC so as not to compromise institutional safety and security. Prison medical staff are similarly situated in that, given their limited resources and constrained treatment settings, difficult decisions must be made about the prioritization of care. Moving forward, more research is needed from the perspective of providers. It is possible that care is being triaged, at least in part, by concentrating resources among prisoners who display the most cultural health capital.

Despite these limitations, the findings from this study offer a nuanced understanding of how older prisoners are grappling with health problems while aging in the prison system. In an era where health-care marginality within prisons is being described as “a perversely secret ‘part of doing time’” (Fluery-Steiner, 2008: 150), this contribution matters. The difficulties inherent in researcher access and original data collection within prisons are extensive (Chenault, 2014; Reiter, 2014; Schlosser, 2008; Umamaheswar, 2014). Yet, prisons hold information our discipline desperately needs. Furthermore, despite their valuable and necessary contributions, qualitative studies are profoundly underrepresented within the criminological literature (Copes, Tewksbury, and Sandberg, 2016; Jacques, 2014; Tewksbury, Dabney, and Copes, 2010).

These factors have stifled our understanding of the lived experiences of older prisoners. Given the aging of the prisoner population, as well as the growing responsibilities prisons have to transcend confinement, the contributions offered here are valuable. This study also complements mounting empirical interests in identifying and understanding the collateral health consequences of incarceration. Moving forward, we must expand efforts to understand the implications of incarcerating an aging population that has extensive health issues and disparate options for health management.

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