

Cover Art By Mario Jackson



VOICES FOR RACIAL JUSTICE

**Unfit for Human Consumption:
Health and Healthcare in Minnesota Prisons**

May 2018

What Came Looking For Me

By Kevin L. Reese

It was like erosion
A whale sized anchor
stuffed inside a clamshell
forced down my throat
sinking in my saliva.

It was my uncle
chained to a Buick Skylark
eating a broken bottle
that shattered like my father's eyes
at the sight of his son sleeping in womb barbwire attaching me to my mother.

It looked like my Grandma's iron pot
boiling river water and collard greens
resembling my calloused feet
pacing a prison cell, with a wishing well adjacent to a metal bunk with an
elephant's tusk, that sliced away follicles of my skin every time I tossed or turned.

It was my son, with a afro and a mustache standing in a field of snow with flip flops and no gloves holding a basketball and a bus ticket.

It happened the day Minneapolis died
and a black rainbow galloped across
the sky and me and my cousins chased it.

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COMMUNITY SUMMARY

In late 2015, **Voices for Racial Justice** heard from family members of people incarcerated of their fears and questions about the health and wellbeing of their loved ones in prison. That initial conversation drove us to engage in a community-based research process to uncover a deeper understanding of the experience of health and healthcare in Minnesota prisons.

For this project, we listened to the stories of people who have been in prison and family members of people currently and formerly incarcerated, with the goal of learning how those directly impacted by incarceration experience healthcare. Although we began the project intending to focus on receiving healthcare services in prisons, we quickly learned that those who have experienced incarceration, either directly or indirectly, have much more to say about how incarceration affects both physical and mental health.

The title Unfit for Human Consumption comes from what we learned about not just healthcare services, but also the larger experience of incarceration, including nutrition, connections to the community, and treatment by prison staff. All of this has a lasting impact on how people in Minnesota's prisons experience incarceration, rehabilitation, and reentry to the community.

Partners in this research project include:

Voices for Racial Justice, a community organization focused on nurturing a healthy ecosystem of racial justice organizing that is grounded in community culture and healing.

The BRIDGE Partnership, which includes people in prison, family members, and other community partners, working with Voices for Racial Justice to develop greater connection or a bridge between prison and the community.

Minnesota Department of Health, which offered the opportunity for this community-based research through its Advancing Health Equity grant.

Our community based participatory action research (CBPAR) process was led by a team of researchers that included VRJ staff members and community members who have direct experience with incarceration. The process included regular team meetings, development of questions and conducting interviews and listening sessions, and analyzing the narratives we gathered through that process.

COMMUNITY SUMMARY

Healthcare in Minnesota Prisons

Healthcare in Minnesota prisons is provided through the company Centurion Managed Care. One of the concerns with Centurion Managed Care has been the lack of oversight and transparency with regard to its healthcare services. For instance, there is no publicly accessible information about their contract with the Department of Corrections or about Centurion's performance, which makes it impossible to evaluate access and the quality of their services at correctional facilities.

Minnesota Department of Corrections policy follows the American Correctional Association standard, which says that a complete physical should occur within 14 or 30 days of admission, depending on whether significant health problems are identified at admission. A 2014 report by the Minnesota Office of the Legislative Auditor found that between 2008 and 2013, a relatively small proportion of people incarcerated in Minnesota facilities received periodic physical exams, and reasoned that the limited number of periodic exams may reflect an absence of requests for such exams, lack of awareness of DOC policies regarding periodic exams, or other factors.

State law requires the DOC to provide "professional healthcare," and court cases have established the right of people who are incarcerated to adequate healthcare under the Eighth Amendment of the U.S. Constitution. The OLA report found that although people who are incarcerated have a constitutional right to adequate healthcare, Minnesota law provides little guidance about what constitutes adequate care, and requires only that the Commissioner of Corrections provide "professional healthcare" to people who are incarcerated.

What We Learned

Our CBPAR team had interactions with 84 members of the community, through both one to one conversations and listening sessions. In addition, written surveys revealed a low level of satisfaction with health services, mental health services, and a sense of accessibility to humane and effective healthcare. For example,

- Of the 71 participants who filled out the survey, 88.7% disagreed or strongly disagreed with the statement "I think healthcare services provided in the correctional facilities in MN meet the needs of incarcerated persons."
- Of the 71 participants who completed the survey, 82% disagreed with or strongly disagreed with the statement "I think the mental health services provided in the correctional facilities meet the needs of those incarcerated."
- Of the 44 individuals formerly incarcerated who filled out the survey, when responding to the statement, " I visited my healthcare provider while incarcerated," they self reported as follows: 30% rarely; 21% sometimes; 21% never; 16% often; and 14% occasionally.

We learned that significant barriers exist to experiencing the adequate healthcare that communities seek:

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Of the 71 participants who filled out the survey, 88.7% disagreed or strongly disagreed with the statement “I think healthcare services provided in the correctional facilities in MN meet the needs of incarcerated persons.”

COMMUNITY SUMMARY

Financial. Both people incarcerated and their family members bear the financial burden of incarceration, including reduced family income, costs of visiting, and the costs of healthcare. Copayments for visiting a healthcare provider can be \$5.00 in prison, which amounts to 20 hours of work for a person earning .25 per hour in a prison job. Costs of medications prevent the DOC from approving certain medications for people incarcerated, which has a health impact on people needing particular prescriptions.

Timeliness of Care. Despite the DOC policy for initial physical examinations, we heard from people formerly incarcerated and family members that it was challenging to receive timely care, whether preventive, to treat chronic issues, or emergency treatment.

Nutrition. Regular meals that include fresh vegetables and fruits are a basic preventive measure that has a direct impact on health and wellbeing. Yet our community research process revealed stories of little access to fresh foods and even packaged items labeled “Not for human consumption.”

Physical Environment. We heard stories of unsanitary physical conditions, including with the beds, mold, dust, dirt, and grime, as well as poor lighting. Challenges that were present in the general prison environment were exacerbated in solitary confinement or segregation. All of these environmental factors are a barrier to health and wellbeing inside prisons.

Visiting Policies. Despite the research that shows the positive impacts of receiving visits while in prison, visiting policies make it challenging for family members to visit loved ones. Restrictions to clothing, physical contact, and time for visits are challenging for family members who must travel long distances. DOC policy limits a person to being on one visiting list at a time, which affects those with multiple family members in prison.

Humane and Compassionate Care. A theme that was most prevalent in our research was the lack of humane and compassionate care, whether for health services or in other interactions. We learned that not being treated as a human being is a barrier to all aspects of health.

Health Impacts of Incarceration

Just as the barriers to health and wellbeing are broad and extend beyond healthcare services, the health impacts of incarceration extend beyond direct physical health.

Mental Health. Limited mental healthcare resources, combined with the conditions of prison, make access to adequate mental healthcare a challenge in prison. We also heard that prison itself can worsen mental health for people incarcerated. A consistent theme our research team heard was a need for people incarcerated to be treated with respect and dignity in order for their mental health to be supported. It was also recognized that prisons are not the best places to treat serious mental health issues.

COMMUNITY SUMMARY

Rehabilitation. We heard through our research that the dual purpose of prisons as places for punishment and rehabilitation can be competing views. The barriers to health named above have the impact on whether people incarcerated can return to the community healthy and whole. We recognized that limits to rehabilitation then affect the whole community across generations.

Family Stress. The impact of incarceration on families in the community include financial burdens, caring for children, and emotional and physical stress. Consistent with other themes that have emerged, prison has a dehumanizing effect for families and communities.

Recommendations

Oversight and Accountability. A system of oversight and accountability is necessary for the provision of health services in prisons. This could be provided by state agencies, including the Minnesota Department of Health, the Department of Human Services, and the Human Rights Department.

Ombudsman. People in prison must have a voice within the system. One way to facilitate that is reinstating an Ombudsman for Corrections. The Ombudsman would have the authority to investigate complaints of injustice made against the Corrections Department and other facilities that operate under the Community Corrections Act (Minn. Stat. 401).

Community Advisory Committee for Health-care. The solutions to issues that impact people must be made in collaboration with the people who are directly affected. The DOC should utilize this strategy when designing and implementing healthcare services and other services within prisons.

Training in Bias, Structural Racism, and Trauma. Respectful and humane treatment was repeatedly named as a condition for health and wellbeing inside prisons. Healthcare practitioners and other DOC staff should participate in training to increase cultural sensitivity, recognize implicit bias and reduce the resulting behaviors, and understand the historical experience of racism in our country and the structures that remain in place.

Limit and End Solitary Confinement. Minnesota should follow research and national trends that advise limiting the practice of solitary confinement as having “little impact on the long-term safety of prisons but detrimental and irreversible effects on the health of the person subjected to the punishment.”

Removal of Copayments. The financial burden of copayments for visiting a healthcare provider is especially high for a person incarcerated with limited earnings and for families already burdened by the other costs of incarceration. The DOC should remove copayments for receiving healthcare.

Timely Healthcare Screenings and Ongoing Care. Our recommendation is that healthcare, including physical, mental, and dental screenings, as well as blood and urine laboratory testing to diagnose and prevent illness, be provided consistently and in a timely way to individuals incarcerated.

Nutrition. Food has the ability to nourish and heal. We recommend that the DOC ensure that every person incarcerated is able to eat meals that (1) are fit for human consumption and (2) contains fresh vegetables and fresh fruits.

COMMUNITY SUMMARY

Visiting Rules. We recommend that the DOC work in collaboration with people directly impacted by incarceration to create a visitation policy that is compassionate and that respects the humanity of people incarcerated.

Medical Parole. For terminally ill individuals who are incarcerated, our recommendation is that if a doctor finds that the health condition of a person who is incarcerated is so grave that they should be given an early medical release from prison, the DOC honors that request.

Conclusion

The journey of a community-based research process that centers the experiences of people who are directly affected by incarceration has been a powerful and humbling one. Our CBPAR team has developed a strong bond, only after also having experienced many challenges in the research process. Our goal has been to offer a space for the voices of people who often feel powerless inside systems to be heard. We believe that our communities and our state institutions have much to learn by simply listening to these stories. We urge the Department of Corrections and other institutions to continue this process of both working with and hearing from community members, and then developing real solutions together.



Photography by: Jenn Ackerman



Part I

Our Community-Based Research Process

PART I: COMMUNITY-BASED RESEARCH PROCESS

In December 2015, Voices for Racial Justice invited family members of men who are incarcerated to a luncheon at Walker Community United Methodist Church in South Minneapolis. The families who joined us were connected through their sons, brothers, husbands, and boyfriends who were incarcerated together at Lino Lakes Correctional Facility. But they had not met each other before.

At first, timidly, and then with animated voices and laughter, they found they shared experiences and stories in common. But then, with tears, they also heard each others' struggles with having a loved one in prison. A common worry emerged: concern about the health and well-being of their family member, and even fear that they would not receive the necessary care when facing serious health challenges. The helplessness that family members felt drew them closer together and was heartbreaking. The stories they shared -- of being in pain and afraid in the middle of the night and not receiving care, of being sent away from health services with directions to purchase ibuprofen at the canteen, of severe toothaches only relieved by extraction -- stayed with us at Voices beyond that December day.

Working with the Minnesota Department of Health

VRJ was invited to a convening of government and organizational stakeholders as part of a report project initiated by the Minnesota Department of Health in 2016. In preparation for this meeting,

VRJ gathered letters from incarcerated men and family members with whom we had been connected who wanted to share their stories of their health challenges and the poor healthcare they received in prison. The report, prepared by ReThink Health, concluded that incarceration can cause lifelong health impacts, that it can lead to intergenerational health impacts, and that significant levels of incarceration can impact community health. We agreed with the study's findings. We believed the next step should include an opportunity for people incarcerated and formerly incarcerated, as well as others directly impacted by incarceration to share their own experiences with incarceration and health -- and for them to define the solutions to these problems.

In 2016, the Minnesota Department of Health opened applications for resources to address health inequities through the Advancing Health Equity grant. We knew this could be an opportunity for us to focus on the impact of incarceration on health outcomes for those who have experienced incarceration, their families and their communities. VRJ was awarded a grant which has allowed us to engage in a Community Based Participatory Action Research (CBPAR) project. Our CBPAR project intention has been to elevate the voice and power of people directly affected by the experiences of incarceration in expressing the urgency of addressing health inequities in the corrections system and to affect change.

PART I: COMMUNITY-BASED RESEARCH PROCESS

Voices for Racial Justice

Voices for Racial Justice (VRJ) was founded in 1993 as the Organizing Apprenticeship Project (OAP) to strengthen and diversify community organizing in Minnesota. In 2014, the organization changed its name to Voices for Racial Justice to more explicitly name its commitment to racial justice and supporting the leadership of communities of color and indigenous communities. Today, Voices for Racial Justice focuses on nurturing a healthy ecosystem of racial justice organizing that is grounded in community culture and healing. Principles of this work include:

- Through shared learning experiences, we support the growth and development of racial justice organizers who bring their own lived expertise to the intersection of organizing, research, and policy change.
- Through culturally-rooted tools and research practices, we shift the narrative about who our communities are and share a vision for racial justice that can lead to changes in policy and practice.
- Through convening and network building, we offer the spaces for communities to build together in a way that heals from the trauma of structural racism.

VRJ seeks to create the conditions where racial justice organizing can thrive by working to heal from the trauma of structural racism, while also nourishing the seeds of strong leadership. All of our work reflects these values and contributes to a more sustainable environment for organizing that takes us beyond transactional approaches towards transformative practices. This revitalizes and sustains the communities we are part of so that the work of leading for change builds healthy relationships and impactful solutions.

BRIDGE Partnership

In 2013, VRJ began working with a group of men who are incarcerated, and who were seeking to develop a partnership with the community to address issues of incarceration and reentry. The BRIDGE Partnership grew out of this relationship to include community organizations and community members impacted by incarceration. The BRIDGE recognizes that addressing mass incarceration and the effects it has on our communities requires intentional change in policy and practice within multiple systems. Our focus has been to support the creation of organizing and research spaces for those directly affected by mass incarceration to be in open conversation with the community. Our hope is that in supporting these spaces we, in collaboration with individuals who are currently incarcerated, create a bridge between prison and the outside world that promotes a deep sense of relationship and community. The BRIDGE motto states: "TO BE CONSCIOUS IS TO BE AWARE, TO BE AWARE IS TO BE ALIVE, TO BE ALIVE IS TO LIVE LIFE, TO LIVE L.I.F.E IS TO LEARN AND INSPIRE FOR EVOLUTION."

BRIDGE Network

Dreaming...
Breaking down shame barriers

Humanize people
in prison—change
the narrative.

Healing
People who have to do this are doing this work

Change public
conversations around

Incarcerated
people have
different needs
than the general
population

Develop
real solutions:
Incarcerate, treat,
reintegrate, monitor

Political
solidarity—we
are part of a movement
of activists + desistents. Fully funded
ombudsman by 2019—on
governor's race.

Everyone we're in contact with is part
of telling a powerful story.

Mothers with children
in system have each other.

People in prison
get the care they need.

Accountability of D

Understanding of why
adequate health care matters
& that we need to go beyond
what is adequate

PART I: COMMUNITY-BASED RESEARCH PROCESS

In collaboration with the BRIDGE, VRJ has organized community events with over 80 community partners at Lino Lakes prison, offered community organizing, policy and advocacy training by phone and mail to men incarcerated and formerly incarcerated (who share these skills with their colleagues), and met with over 25 family members of persons currently incarcerated.

Our Research Approach

"VRJ is committed to research that is community-driven to best inform and challenge systems to advance racial equity. Given our principles of authentic community engagement, we utilize Research Justice, a research framework that identifies and centers the stakes, interests, and leadership of communities most impacted by inequity in designing process-oriented research that is accessible and nurtures community transformation."

As part of our project we conducted an environmental scan, and found different sources of information around the impact of mass incarceration. Some of those sources include the report, "Who Pays? The True Cost of Incarceration on Families" conducted by the Ella Baker Center for Human Rights. This report utilized a research justice framework to produce a national community driven report on how families of incarcerated people bear the "true" cost of incarceration through financial burdens and mental and physical health impacts. Their research corroborates findings from other sources like the ReThink Health Report - Understanding the Impacts of Incarceration on Health: A Framework, and the Office of the Legislative Auditor (OLA) evaluation report Health Services in Minnesota State Correctional Facilities.

Research Justice and Community Based Participatory Action Research (CBPAR)

The approach for this report is based on the assumption that the greatest impact in achieving justice is done by centering the voices of those most affected by mass incarceration in each phase of the research, analysis, storytelling, planning and implementation process. In addition, our approach intends to follow a process in which community members and VRJ staff are equal partners in all stages of the research process. This approach is known as community-based participatory action research (CBPAR).

Our environmental scan process included answering the question: what is research justice? This was our attempt to define and refine the research justice approach we committed to using in conducting the project. One definition of research justice describes this process as a framework and methodological intervention that aims to transform structural inequalities in research (Jolivette, 2015). In addition, research justice challenges traditional models for conducting social science research within communities of color and American Indian communities. As a strategy for knowledge construction and self-determination, research justice considers themes such as "radical love as a strategy for social transformation."

PART I: COMMUNITY-BASED RESEARCH PROCESS

Hwang (2013) articulates research justice as a liberatory action research model for generating community based knowledge. He lists principles as significant to achieving the goal of research justice. Some of the principles that we have found especially relevant throughout our project include: (a) Redefining research as something only produced by "experts" from academia into a process of knowledge creation where communities' experiences and wisdom are a central piece of the entire research process. This principle resists oppression and systemic and institutional violence by creating knowledge **WITH** communities rather than **FOR** communities.

(b) Creating the possibility for setting a collaborative agenda together with people who might not be doing the tedious work of writing and editing; (c) Being open to collaboration and to critically understanding various privileges in the room (time, material, access, emotional and mental health capacities, position and proximity to institutional resources), and to build from these privileges and capacities in order to strengthen the work; and (d) Collectively theorizing, thinking, studying and critically reflecting on how we work, negotiate and come together with our tensions and differences.

Our Research Team

This research project was led by a community based participatory action research (CBPAR) team that included VRJ staff members (Executive Director, Health Equity Organizer, and Policy and Research Director), a graduate student from the University of Minnesota, a researcher with the Northside community research team, an administrator with the Veterans Affairs Office and a mother whose son is currently incarcerated.

Our Values, Assumptions, and Principles

Voices is committed to the following values, assumptions and principles to guide our research:

- Research starts in partnerships. Our research projects, questions, focus and analysis are informed in dialogue with our partners. Partners include grassroots organizations, staff, systems and community members.
- Research is collaborative and seeks to build capacity. Through organic building and conversation with our partners, we challenge institutions, funders, and policy leaders to invest in community-based research processes that build capacity for our communities to develop the data that serves their interests and recognizes their expertise.
- Research is organizing, organizing is research. Our research is a process of building power. Community based participatory action research centers the interests of those impacted in the process of gathering data, and applying what we have learned to advance racial justice. Our research process is a base building and network building approach. All knowledge is valuable, and nobody is a "subject."
- Knowledge is vast and sacred. We care about data that is reflective of multiple forms of knowledge, including experiential, spiritual, cultural, place-based, theoretical, quantitative and qualitative. We believe in a wide range of approaches to facilitating knowledge exchange, including storytelling, popular education, reclaiming our roots, and oral histories, interactive activities, community visioning, and deep relationship building. Our knowledge is a reflection of our relationships.

“

Our knowledge is
a reflection of our
relationships.”

PART I: COMMUNITY-BASED RESEARCH PROCESS

OUR METHODOLOGY

2016 Letters from Individuals Incarcerated

After being invited to be part of a conversation with MDH in 2016, VRJ gathered letters from men incarcerated who wanted to share their experiences about the healthcare they received in prison. VRJ collected letters from 12 individuals incarcerated in various Minnesota prisons. The letters reveal their perception of the healthcare they were receiving in prison. As we reviewed the letters, we established similarities and patterns. We saw the following themes: health problems affecting individuals incarcerated, timely response by healthcare providers, and the intervention or complaints by family members to the prison system:

1. Health problems: 3 individuals incarcerated reported shoulder problems; 2 had knee injuries; 1 back problems; 1 inmate reported abdominal pain that later resulted in a kidney stones; 1 inmate reported a cold that later resulted in pneumonia; 1 reported a neck problem; 1 had a broken leg; 1 suffered a dislocated hip; and 1 inmate suffered from dry eyes.

2. Health service's response: 8 individuals incarcerated reported delay in receiving assistance or delay in seeing a specialist they thought they needed; 3 incarcerated individuals reported being denied an MRI; 3 reported that they had not had an x-ray in their medical consult; 2 reported no surgery when needed according to them; 1 inmate reported refusal of dry eye medication.

3. Family intervention: 3 individuals incarcerated received support from their relatives regarding phone calls, formal complaints, or other needs.

We created a table to summarize and display the information provided by individuals who are incarcerated in the letters (see Appendix E). The table shows more detailed information and is organized according to the topics described above.

CBPAR Team Meetings

Our CBPAR team, following the research justice principles, started by having a conversation about our vision (see picture in Appendix C) and then we moved to have weekly meetings to develop the work plan. This plan included developing interviews, questions, protocols, listening sessions, collection of data, analysis of the data, identifying trends and findings and finally a collective process to write this report.

Our CBPAR team met on a regular basis between April and December of 2017. These meetings included hands on work as well as check ins about our personal lives and challenges. Over this time, we shared meals and developed a bond that demonstrated the relationships that develop through a community based participatory action research process. We also saw that the research affected our team differently because of the personal connection to the experience of mass incarceration.

PART I: COMMUNITY-BASED RESEARCH PROCESS

Interviews and Listening Sessions

After questions and protocols were designed by our CBPAR team (see questionnaire sample in the Appendix D), we conducted a total of 31 interviews and four listening sessions.

Interviews were mostly performed by community members of the team, while listening sessions had participation of every member of the team. Listening sessions were hosted at different community based organizations as follows:

1. **Breaking Free** is an organization which works with women who have been negatively impacted by systems of sexual exploitation and prostitution. Their mission is to end all forms of prostitution and sex trafficking. With locations in Saint Paul and Minneapolis, the organization is open to women from across Minnesota and the United States. Breaking Free works with “victim-survivors” to ensure that provided services are trauma-informed, housing is obtained, education is provided to the community, victim-survivors’ experiences are decriminalized, and violence against women ends.

2. **Ujamaa Place** is a Saint Paul based organization that works with African American men primarily between the ages of 18 and 30, who have been exposed to systemic and cyclical economic disenfranchisement. Ujamaa Place provides programming based on mutual accountability. Their mission states, “everyone is important, valuable, worthy, and lovable.”

3. **The Power of People Leadership and Personal Development Training Class (POP)** is a community-driven program offered at Minnesota correctional facilities. For over a decade, POP has worked to promote positive change among communities of men preparing for reentry after living within the prison system. Participants undergo classes based around the framework of the book, *The Power of People*; four kinds of people who can change your life. Men process, learn, and connect with one another in community, and also have the opportunity to be teachers to one another. Located in Minneapolis, the Power Of People Leadership Institute is a community organization that provides regular groups and support, re-entry support, opportunity for community connections and engagement, and employment connections, as well as re-entry housing for men formerly incarcerated who have completed this program while incarcerated. The group is ongoing beyond the requirements of re-entry and meets every Tuesday.

4. **Little Earth** is a project-based subsidized housing community in Minneapolis that serves American Indian residents. Since the 1970's, Little Earth has provided services and programming that addresses issues specific to American Indian communities. Holistic work to create hope and community are at the core of Little Earth.

PART I: COMMUNITY-BASED RESEARCH PROCESS

Recording and Transcribing

All interviews and listening sessions were recorded and transcribed. All of the interviews and listening sessions were transcribed in order to best analyze key findings. We then took turns facilitating conversations to examine reoccurring themes. Our CBPAR team used Nvivo materials to identify the main stories and narratives emerging from the interactions we had throughout the project. When the time to write the report came, we added a new member to our team and her role was to capture the conversations the team had around the data collected. We follow this process, with the goal of making the writing of the report as collective and conversational as possible.

Writing and Sharing

The CBPAR process has been rich in terms of the lessons learned and the challenges we have faced in our collective approach. The interviews and listening sessions created spaces where many narratives emerged. The stories we heard could result in a much longer report. Organizing the narratives to present an accessible story has been a time consuming process. We made the decision to include as many narratives and information as possible for this report, and we are committed to developing other ways of sharing these narratives, including shorter written pieces, as well as podcasts and video narratives.

DOC Human Subjects Review Board (HSRB) Process

We learned early in our research process that the DOC does not make it easy for the public to access information about conditions inside of their facilities. In order to hear from people currently in prison, we were required to submit an application to the Human Subjects Review Board (HSRB). We recognize that there are good reasons to protect the safety and privacy of people in research projects. However, we found that the HSRB process was long and not accessible and became an obstacle to learning about the healthcare provision and experiences inside prison. We knew from our relationships in the community and with people incarcerated, that there were people in prison who wanted to share their stories and have their voices heard. The process of hearing back from the HSRB was long and raised questions about our community research process, so we opted to focus on people who are now out of prison.

The HSRB questioned the rigor of our research process and suggested that we work with an experienced researcher. We did have an experienced researcher on our team (with traditional research credentials of a doctorate degree), as well as community researchers whose expertise we valued in the CBPAR process.

PART I: COMMUNITY-BASED RESEARCH PROCESS

Our CBPAR approach is a counter narrative to the ways that academic research is done, and our experience with the HSRB process gives us a clear way to talk about why that is. In addressing the “why,” it is necessary to focus on the word “rigor.” In academic research, “rigor” is often a measure of how “scientific” a study is. Whereas the goal of academic research is to produce a report that is rigorous in its methodology, the goal of our report was to listen to the narratives of people affected by the healthcare system inside Minnesota prisons.

Rigor can also mean conscientious, careful, diligent, attentive, and thorough, which means that there is value in rigor. The reason why a HSRB exists in the first place is to protect people in prison from research that may cause potential harm. In that sense, it is important that researchers undergo some kind of process before being able to conduct research in prisons.

However, in conducting community based participatory action research, rigor in the sense of being strict or rigid is not a sufficient measure. A better measure is “emergence.” In the words of adrienne marie brown, author of Emergent Strategy, “Emergence emphasizes critical connections over critical mass, building authentic relationships, listening with all the senses of the body and the mind.”

Academic research often values only the opinions of “experts.” Our CBPAR approach honors the wisdom of community members who are most affected by mass incarceration. While we value the skills of academic researchers, we do not rely on those skills to gather knowledge and to share that knowledge with our communities. We value the different ways that knowledge is gathered, shared and practiced in our communities, and our research methods reflect that.

World Health Organization (WHO) Framework

As a grantee of the Minnesota Department of Health (MDH) Advancing Health Equity (AHE) initiative, we were required to use the World Health Organization (WHO) framework ¹⁶ to identify the socio-economic factors that shape the provision of adequate healthcare in Minnesota state correctional facilities. Our framework starts with structural racism and how current federal, state and local policies are creating and perpetuating unequal access to opportunities for a healthy and thriving life for people of color and indigenous (POCI) communities. Structural racism and its attendant systems of oppression create a socioeconomic context that leads to a disproportionate number of people from working class and POCI communities who live in poverty, lack access to multiple social and economic resources, and experience high levels of violence and trauma. The War on Drugs that began in the 1980s is an example of a federal policy that highlights structural racism. It caused a disproportionate number of people from POCI communities to be incarcerated, many of whom were already suffering from chemical dependency and mental health issues, and devastating socioeconomic conditions.

Some of the elements of structural racism identified by our research are (a) systemic conditions, (b) socioeconomic conditions, and (c) conditions inside correctional facilities:

(a) Systemic conditions: Local, State, and Federal policies and practices that contribute to the lack of adequate healthcare in Minnesota correctional facilities:

- Lack of legislative oversight of the MN DOC.
- MN DOC administrative policies with regard to visitation.

PART I: COMMUNITY-BASED RESEARCH PROCESS

- Lack of affordable and safe housing.
- Lack of equal opportunities for employment, education and healthcare.
- Federal immigration policies that separate families with its deportation machine.
- The War on Drugs.
- Drug Sentencing Laws.
- Increased rates of incarceration for POCI communities.
- Strict policing practices in POCI communities.
- Increased rates of recidivism due to technical violations while on probation.
- The perception of prison as punishment and its associated practices.
- People incarcerated going through a dehumanizing experience.
- Violence (e.g., isolation, solitary confinement [segregation], sexual abuse, psychological trauma, etc.).
- Lack of access to culturally specific medicines and healing and wellness practices.
- Visitation policies are too strict.
- Lack of education and employment preparation for life after incarceration
- Incarceration is expensive for families.
- Unhealthy physical environment (e.g., mold inside of prisons).

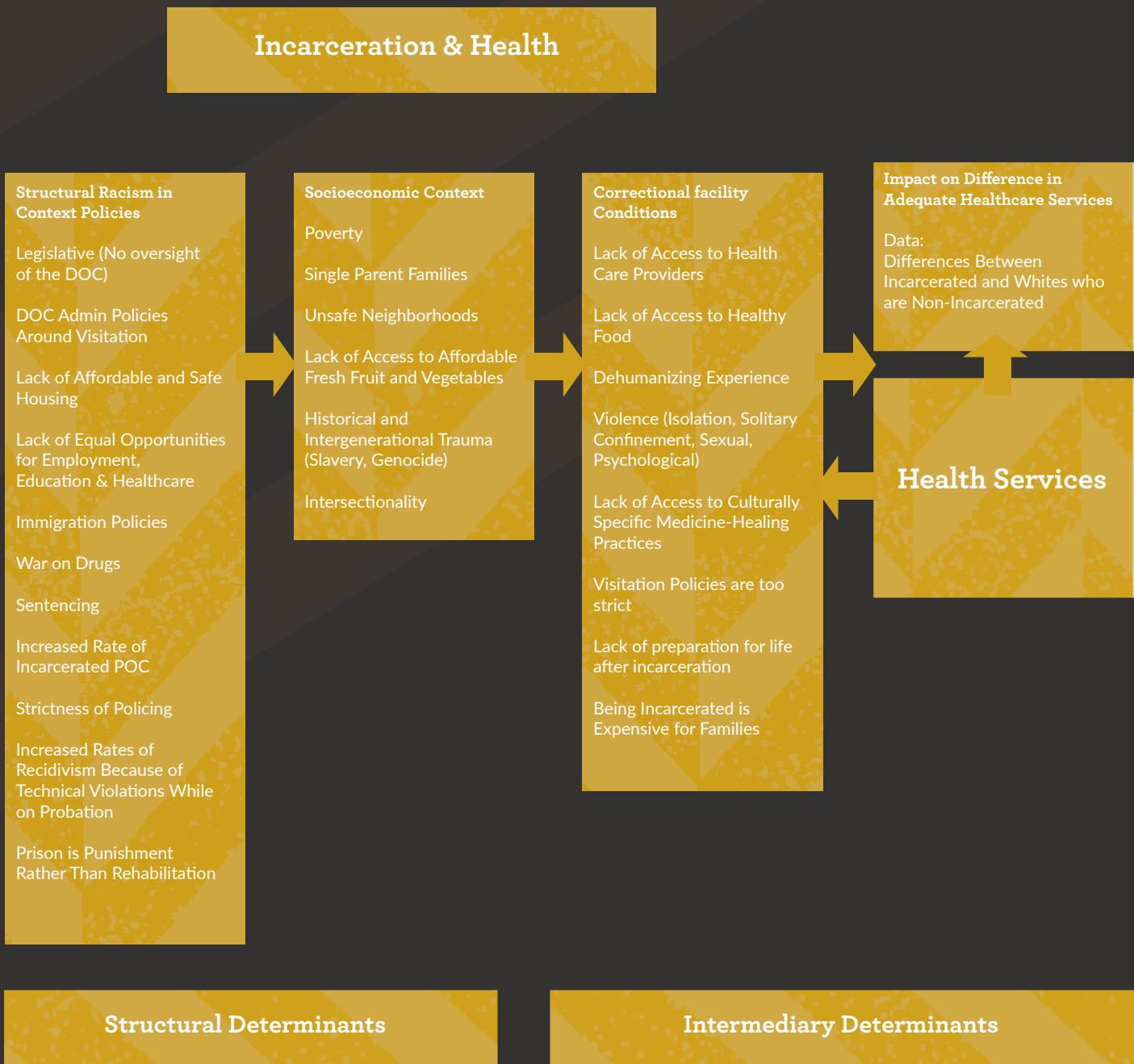
(b) Socioeconomic conditions

- Disproportionate rates of poverty in working class POCI communities
- Negative perceptions of single parent families.
- Unsafe working class POCI neighborhoods.
- Lack of access to affordable fresh fruit and vegetables in working class POCI neighborhoods.
- Historical and intergenerational trauma as a result of slavery and genocide.
- Lack of awareness and analysis of race, class and gender intersectionality.

(c) Conditions inside of correctional facilities

- Lack of access to healthcare providers.
- Lack of access to food fit for human consumption.

The WHO framework defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Our definition of adequate healthcare builds on the WHO framework (see Appendix F) which helped us identify factors impacting the health and well-being of people incarcerated in Minnesota correctional facilities (e.g., medical care, nutrition, visitation).





Part II

Healthcare in

Minnesota Prisons

PART II: HEALTHCARE IN MINNESOTA PRISONS

Healthcare Provision

"I truly believe [offenders] get a high quality of healthcare, in most cases better than the general population. I believe that offenders have adequate, if not better, access to specialists, medications, lab and diagnostic tests."

- Nurse in DOC prisons

From 2000 to 2014, the Minnesota DOC had a contract with Corizon Health Inc. This was the company responsible for overseeing medical care in Minnesota state prisons. The contract ended after 15 years when it was found that "the state prison system has had at least nine inmate deaths and numerous injuries related to poor and delayed care, according to a 2012 Star Tribune investigation." Since 2014, Centurion Managed Care has been contracted by the DOC to oversee the medical care provided in Minnesota state prisons. One of the concerns with Centurion Managed Care has been the lack of oversight and transparency with regard to its healthcare services. For instance, there is no publicly accessible information about their contract with the DOC, or about Centurion's performance, which makes it impossible to evaluate access and the quality of their services at correctional facilities. Our research team tried to access this information, but were unable to learn about Centurion's care and performance.

The OLA Evaluation Report (2014) found that "Nearly all [people incarcerated] receive a timely initial screening when they first enter prison" (p. 22). DOC policy states that a medical, dental, mental health, and sexual assault risk screening must occur within 24 hours of a person's arrival at a correctional facility (p. 22). In addition to identifying pressing medical issues, the nurses who conduct the initial health screening also discuss the person's medications and food allergies, and administer a tuberculosis test (p. 22).

After the initial screening process, the next process is to return to health services for more thorough physical, mental health, and dental examinations. The OLA Report found that while most initial physical, mental health, and dental examinations for males occurred within the time frames specified by DOC policy, examinations for females were much less timely (p. 23). The DOC's written policy reflects the American Correctional Association standard, which says that a complete physical should occur within 14 or 30 days of admission, depending on whether significant health problems are identified at admission (p. 23). The other more rigorous National Commission on Correctional healthcare standard says physical examinations should always occur within seven days of admission (p. 23).

Beyond the initial physical examination that accompanies admission to the DOC, people incarcerated have the right to request periodic physical examinations. The DOC policy allows annual physical examinations for people under the age of 19 or over the age of 50, and biennial exams for those who are between the ages of 19 and 50 (p. 24). OLA researchers found that between 2008 and 2013, a relatively small proportion of people incarcerated in Minnesota correctional facilities received periodic physical exams, and reasoned that the limited number of periodic exams may reflect an absence of requests for such exams, lack of awareness of DOC policies regarding periodic exams, or other factors (p.24).

PART II: HEALTHCARE IN MINNESOTA PRISONS

Nursing staff play a critical role in the provision of adequate healthcare in Minnesota correctional facilities. They conduct the largest share of the medical visits, and they determine whether and when visits with physicians should be scheduled (p. 29). While DOC policy states that nurses will make health decisions based on the requests of their patients, OLA researchers found that DOC had not provided sufficient guidance to nurses making decisions in response to patient requests (pp. 29, 30). “The absence of clear DOC direction to nurses on which protocols to use contradicts professional standards, as did DOC’s failure to update previous protocols or provide training on them” (p. 30).

A common provision of public and private health insurance coverage in Minnesota correctional facilities is copayments. Copayments are what an individual incarcerated is charged when he or she visits a doctor or uses some other covered service. DOC policy defines the purpose of copayments as follows: “To promote offender self-reliance and participation in his/her own healthcare decisions, and provide a disincentive for the inappropriate use of health resources.” The DOC assesses individuals who are incarcerated (except those who are placed pursuant to an income contract) a copayment when medical or dental services are provided at the initiation of the person incarcerated, based on established criteria.

People with insufficient funds or who are classified as indigent are not denied healthcare. The copay charge is logged in their spending account with a negative balance until he or she has available funds to cover partial or total cost of care. Health services maintains and forwards a log of people being assessed copayments to the facility’s financial services at least weekly.

The OLA Report (2014) examined several issues related to copayments inside of Minnesota correctional facilities. Since 2011, Minnesota law has had the following provision: “Any inmate of an adult correctional facility under the control of the commissioner of corrections shall incur co-payment obligations for healthcare services provided. The co-payment shall be at least \$5 per visit to a healthcare provider” (p. 82).

The OLA Report covers other aspects of adequate healthcare in Minnesota prisons, such as rights to privacy, after hours emergency care, special services, treatment protocols, patient tracking, services for patients with acute or chronic mental illness, mental health in segregation units, and other protocols for patients who suffer from mental illness.

Standards for Adequate Care

The Minnesota DOC operates eight state prisons that house more than 9,000 adults. State law requires the DOC to provide “professional healthcare” to these adults, and court cases have established the right of people who are incarcerated to adequate healthcare under the Eighth Amendment of the U.S. Constitution. As defined by the DOC, “health services” include medical, dental, and mental health services, as well as chemical dependency and sex offender treatment (p. 1).

The OLA Report examined the medical, dental, and mental health services in the eight DOC facilities that exclusively serve adults. It evaluated health services provided by DOC staff and through DOC’s contract with a private company, and also examined central office activities that oversee prison-based health services (p. 1).

PART II: HEALTHCARE IN MINNESOTA PRISONS

The report examined the DOC's compliance with the two main bodies that have developed standards related to correctional health services: the American Correctional Association and the National Commission on Correctional healthcare. In particular, the report examined the extent to which DOC policies were consistent with the standards (p. 1).

The report found that although people who are incarcerated have a constitutional right to adequate healthcare, Minnesota law provides little guidance about what constitutes adequate care, and requires only that the Commissioner of Corrections provide "professional healthcare" to people who are incarcerated (p. 15). The definition of adequate healthcare has been formed largely by court decisions, professional standards, and policies developed by the Minnesota DOC (p. 15).

Legal Standard

In Minnesota, there have been at least two major class action suits related to healthcare that continued past preliminary stages of litigation. Both of these class action suits were initiated by people who were incarcerated. One of the class action suits, Hines v. Anderson, resulted in a consent decree that set medical care standards in Minnesota's maximum security prison from 1977 to 2008. From 1999 until the termination of the decree in 2008, the decree applied exclusively to the current maximum security facility (Oak Park Heights). The second case, DeGidio v. Pung, alleged violations of the Hines consent decree and sought additional relief in the wake of a tuberculosis outbreak at Stillwater prison (OLA, 2014, p. 16 note 8).

While courts have found Eighth Amendment violations and established the outlines of rights to healthcare for people who are incarcerated, it is difficult to show Eighth Amendment violations (p. 16). Treatment must be "so inappropriate as to evidence intentional maltreatment or a refusal to provide essential care" (p. 16 note 9). A difference of opinion among medical practitioners is not sufficient to demonstrate an Eighth Amendment violation, nor does medical negligence constitute an Eighth Amendment violation (pp. 16-17). "Also, since the federal Prison Litigation Reform Act was passed in 1995, there have been significant procedural bars to prisoners filing lawsuits in federal court" (p. 17)

Professional Standard

Court decisions are not the only measure of adequate care. Professional standards can also provide measures of adequate healthcare. Professional standards establish generally accepted "best practices" for policies, procedures, and systems, and may be used to accredit individual correctional facilities in states wishing to pursue accreditation (OLA, 2014, p. 17). At the time of the OLA Report, in Minnesota, the Department of Corrections had not sought facility accreditation for many years, but had adopted policies for its facility operations based partly on the corrections profession's standards (pp. 17-18). However, since the publication of the OLA Report, the Department of Corrections central office received accreditation from the American Correctional Association in 2015, and individual prisons will be seeking accreditation during the next three years. The two main bodies that have established professional standards related to correctional healthcare are the National Commission on Correctional healthcare and the American Correctional Association (p. 18).



Part III

Findings

PART III: FINDINGS

COMMUNITY VOICES

Demographics

For the purpose of this project, our CBPAR team had interactions with 84 members of the community. 36% of individuals (31 of the 84) participated in one to one conversations and 63% (53 of the 84) were participants in one of the four listening sessions the team conducted.

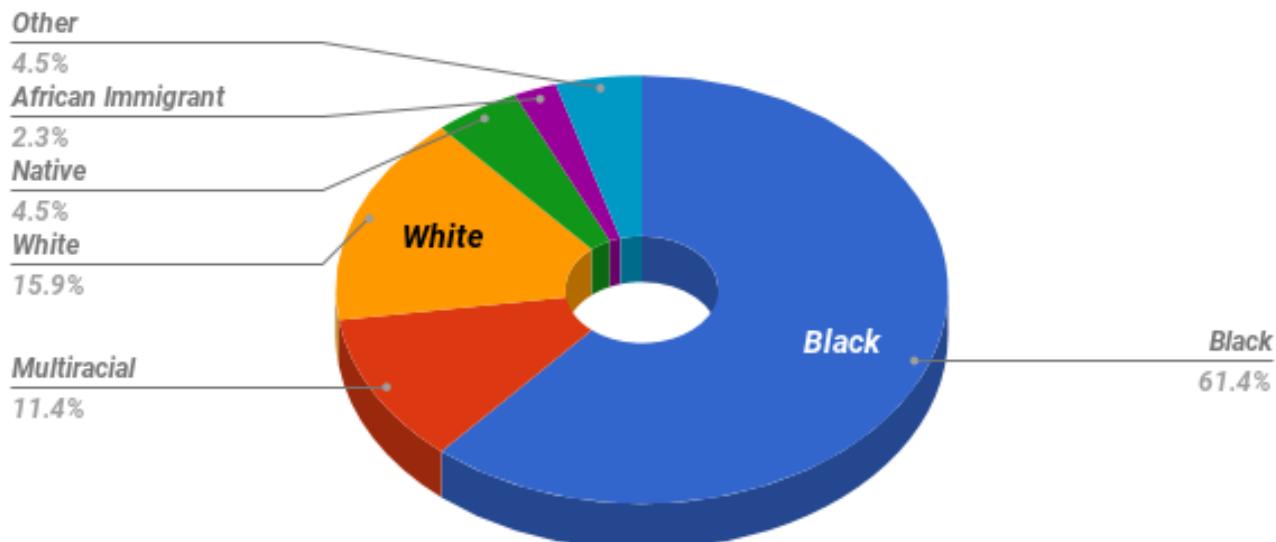
All participants of interviews and listening sessions were invited to fill out a survey intended to collect demographic and some quantitative data (see Appendix D for questionnaire sample). Out of the 84 different people who participated in the project, 100% of those who participated in the one to one interviews filled out the survey (31 out of 31), while only 75% of those who participated in the listening sessions (40 out of 53) filled out the survey.

The following graphs illustrate the demographics of the community participants.

Ethnicity and Race: 55% of all participants self-identified as Black, 17% as multiracial, 14% as White, and 10% as Native American.

Ethnicity/ Race

(Formerly incarcerated n=44)

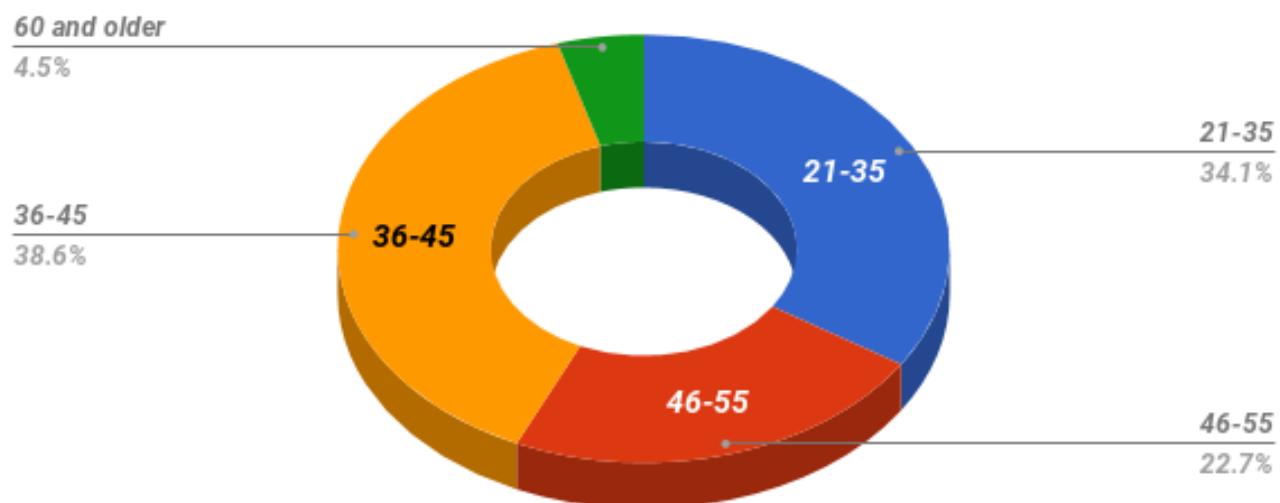


PART III: FINDINGS

Age: 33% of all participants were between 21 and 35 years old; 31% were between 36 and 45 years old; 23% were between 46 and 55 years old.

Age

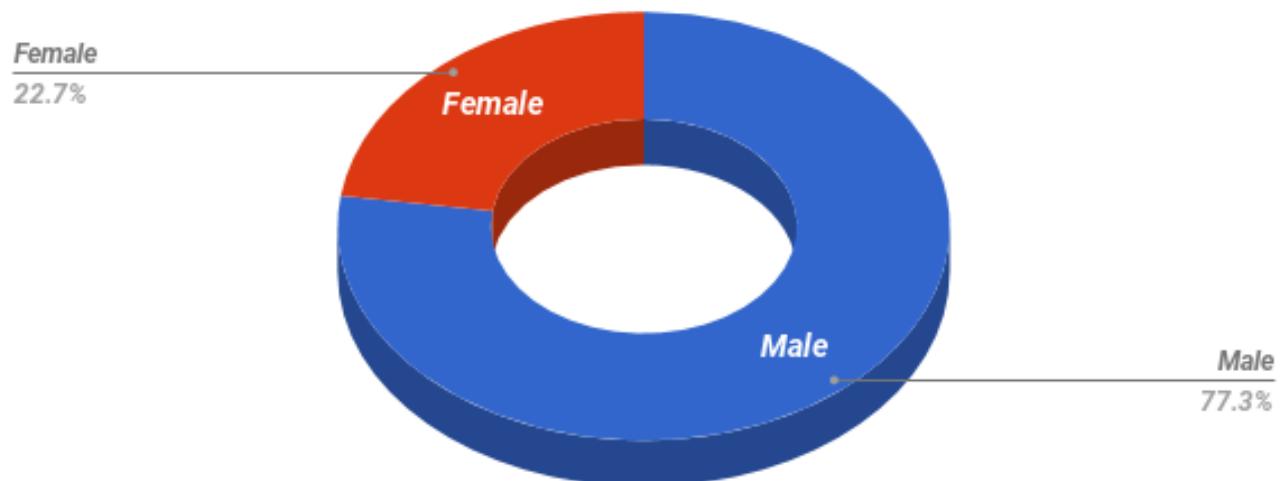
(formerly incarcerated n=44)



Gender: 52% were males and 48% females.

Gender

(formerly incarcerated n=44)



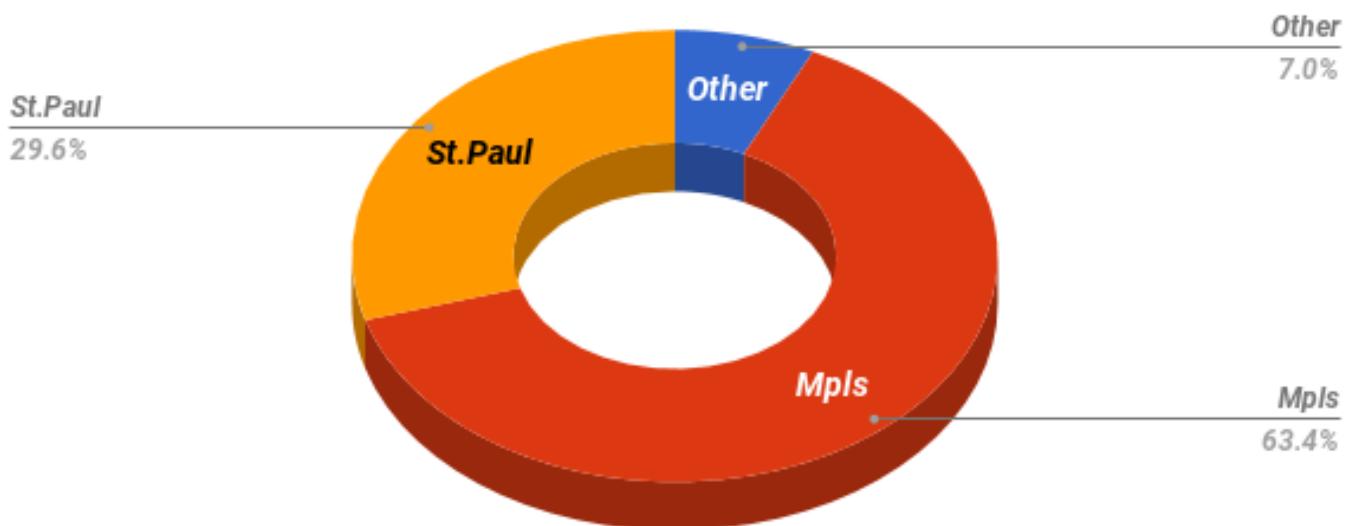
PART III: FINDINGS

When considering the gender distribution of participants who were formerly incarcerated, there is a higher percentage of males (77%). This situation is the opposite when considering the gender distribution of family members where 89% are females. Although we know the number of our sample does not allow us to make generalizations, we found this contrast to support the fact that while men are disproportionately imprisoned, women are disproportionately challenged with the burden of supporting families and communities without men. At one of our listening sessions, one woman physically pointed out a male working at the community center. She told us he was the only masculine figure/role model to the children participating in the after school programs.

Place Considered Home: 63% of all participants considered Minneapolis home, while 30% called Saint Paul home. 7% of participants were from the suburbs and rural Minnesota

Place considered home

(formerly incarcerated and family members n=71)



PART III: FINDINGS

Community Research Barrier

One of the challenges our team faced was connecting with people in prison. Before we learned about the Human Subjects Review Board (HSRB), we sent 110 questionnaires to individuals who are currently incarcerated. Most of the questionnaires were returned to us by the DOC without being filled out with the exception of 5. The 5 questionnaires that were completed were by men who are currently incarcerated. We were planning to use these 5 questionnaires in our report. In the questionnaires we explained that all responses would be used in a confidential way. Prior to filling out the questionnaire all who received it signed a consent form.

In our efforts to be transparent with the HSRB committee, we asked them what process or procedure our team would need to consider and complete in order to use the 5 questionnaires that were filled out. The response we received was that just by us asking that question caused the HSRB to continue to have concerns about the rigor of our proposed research. This was another indication of just how challenging it was to connect with people incarcerated.

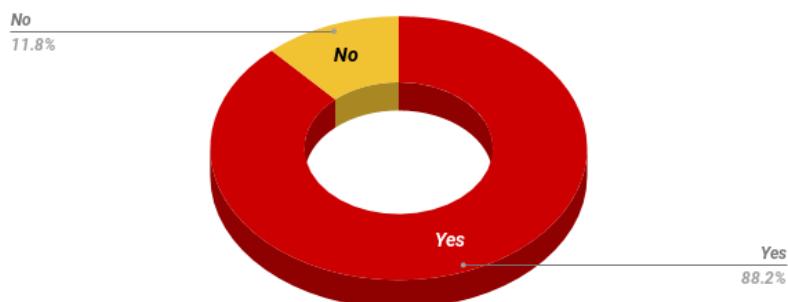
Summary of Responses

Participants completed a questionnaire about their perceptions of the healthcare services provided at correctional facilities in Minnesota. These graphs illustrate the themes that emerged. In addition, excerpts from the 12 letters we received from individuals incarcerated in 2016 add context to these experiences.

Professional Healthcare: Out of the 71 participants who filled out the survey, 88% responded yes to the statement "I understand what professional healthcare is."

"I understand what professional healthcare is?"

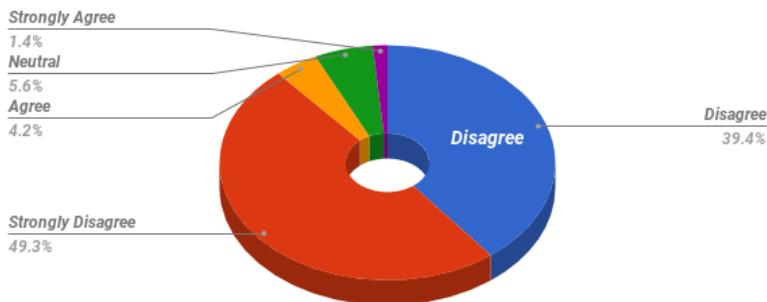
(formerly incarcerated and family members n=71)



Perception of healthcare services provided in the correctional facilities: Of the 71 participants who filled out the survey, 88.7% disagreed or strongly disagreed with the statement "I think healthcare services provided in the correctional facilities in MN meet the needs of incarcerated persons." This trend was similar among participants who were formerly incarcerated (91%) and family members (85%).

"I think health care services provided in the correctional facilities in MN meet the needs of incarcerated persons"

(formerly incarcerated and family members n=71)



PART III: FINDINGS

The perception of healthcare services provided in the correctional facilities among individuals who are currently incarcerated provides an additional level of context. For example, one person who is incarcerated wrote, "...I believe that the people who are responsible for my healthcare should have thought of me as a human being, and not a number or dollar sign." This was a common perception among individuals currently incarcerated, formerly incarcerated, and family members. Another person currently incarcerated wrote to us,

...in my experience the custom has been that you are criminal first and a patient 2nd. The psychological effect of years of that does something to your morale, it will make you believe that you are a criminal first and a human being second."

Another perception among individuals currently incarcerated was that the private contractor in charge of providing healthcare services was more interested in money than in their patients. For example, one person who is incarcerated wrote, "What I have seen is for-profit health service companies do their best to not have to pay for the necessary health service needs of the men and women who live in these places." Another person, in agreement with this statement, wrote, "Since the private sector has taken over, things like x-rays, M.R.I., were common for men who usually come to prison injured from some ailments. Now you can't even get your teeth cleaned, it's been almost 10 years since I had my teeth cleaned."

Overall, among individuals currently incarcerated who wrote letters to us, their perception about healthcare in prison was not favorable. "...D.O.C. health staff...seem to only be concerned with the care of the 'operating budget' rather than with the care of the patients that they are, legally, morally and -supposedly- humanely responsible for," wrote one person currently incarcerated.

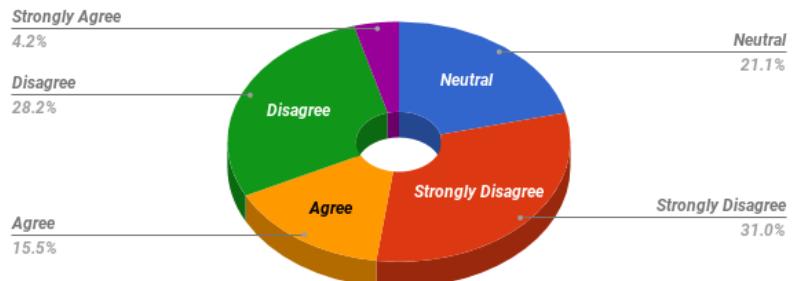
Another person talked about the negative changes in healthcare he had seen since the time he was first incarcerated: "Over the years, healthcare in prisons has declined tremendously. I've never witnessed so many deaths and lack of commitment to help us maintain our health while in prison."

Perception of healthcare services provided for general population: Out of the 71 participants who filled out the survey, 60% disagreed with or strongly disagreed with the statement "I think the healthcare services provided in MN meet the needs of the general population." This trend was similar when looking at people who are formerly incarcerated (56%) and family members (61%).

These percentages show a contrast with the higher percentage (88.7%) of all 71 participants who strongly disagreed with (49.3%) and disagreed with (39.4%) the statement, "I think healthcare services provided in the correctional facilities in MN meet the needs of incarcerated persons."

"I think the health care services provided in MN meet the needs of the general population"

(formerly incarcerated and family members n=71)



“

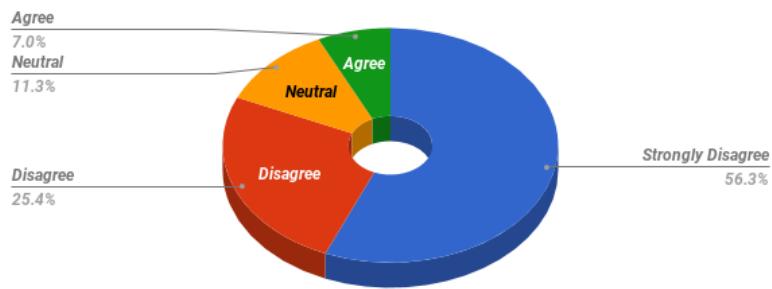
**What I have seen is
for-profit health
service companies do
their best to not have to
pay for the necessary
health service needs of
the men and women who
live in these places.”**

PART III: FINDINGS

Perception of mental health services provided at MN correctional facilities: Of the 71 participants who completed the survey, 82% disagreed with or strongly disagreed with the statement, "I think the mental health services provided in the correctional facilities meet the needs of those incarcerated." This trend was similar among people who are formerly incarcerated (82%) and family members (82%).

"I think the mental health services provided in the correctional facilities meet the needs of those incarcerated."

(formerly incarcerated and family members n=71)



Frequency of visits to healthcare provider while incarcerated: Of the 44 individuals formerly incarcerated who filled out the survey, when responding to the statement, " I visited my healthcare provider while incarcerated," they self reported as follows: 30% rarely; 21% sometimes; 21% never; 16% often; and 14% occasionally. Among men who are currently incarcerated, some of what they wrote in their letters shed light on the quality of their visits with healthcare providers. One person wrote, "It's hard to decipher what's more painful: the brilliant pain in my unhealed shoulder, or the absurd health coverage I received from the professionals entrusted with my care. Both will serve as a constant reminder of the reality of my incarceration." Another person wrote, "No matter what the diagnosis is you'll probably receive Ibuprofen." "I've seen men walk on broken bones and it wasn't until it became unbearable that anything was done," wrote another person. And lastly, "The only time they'll see you right away is to pull your teeth not to save them."

"I visited my healthcare provider while incarcerated"

(formerly incarcerated n=44)



“

No matter what
the diagnosis is
you'll probably
receive Ibuprofen.”

PART III: FINDINGS

BARRIERS TO ADEQUATE HEALTH

Financial

"Prisoners can buy glasses from a catalogue, but the selection is limited and the glasses are very cheaply made and break easily. There is a limit to how much an inmate can spend on outside glasses of \$150. This is really an unreasonable amount because if your prescription is for a strong correction, the lens alone will often cost more than this limit."

-Mother of individual incarcerated

In addition to the emotional toll of having a loved one in prison, family members shared the financial toll of accessing healthcare while incarcerated.

Copayments

One financial barrier to adequate healthcare is the system of copayments. One sick call charge of \$5.00 can cost a person who is incarcerated 20 hours of work if they are being paid .25 per hour. The following three stories that were shared with us during interviews and listening sessions by family members of men and women currently, and formerly incarcerated helped us understand the barriers to adequate healthcare caused by copayments:

"Yeah, there's a copay that's not affordable if you're making a quarter an hour, which most people, when they get to prison, they make a quarter an hour, and then, if you're an indigent you don't have anyone sending you money. How are you gonna afford a five, or 10, or \$15 copay. That's ridiculous. Especially, what if your thing is not resolved, and you need to keep going back and keep paying those copays, so it's absolutely not affordable."

"I just feel like, first...the healthcare thing goes, you know, a lot of people are incarcerated, and a lot of people come from the streets when they go to prison, and they really don't have family there to support them. Most people are pretty much doing their time by their self, and if you're sick they have a five dollar charge that you automatically have to pay before they would even see you...To me that's ridiculous because, you know, sometimes people can barely buy hygiene stuff."

"...with mine, if I didn't pay, and I already had someone come from outside, bring my medications because I had refills, they didn't want that. They wanted me to...pay the five dollars to them to refill it for me, so I refused that. I said I wouldn't want y'all's medication. It's like, so, "Well, you're going to have withdrawal." I said, "As long as you can have my mom or whoever else, or my power of attorney person, bring it in to me, I will take my medication." I had to fight this until they said, "We're going to throw you in the hole if you don't take your medication." I said, "I will take my medication under one condition, this one day, have somebody bring my medication up here, because I have free refills. I'm not giving y'all five dollars, and it's not five dollars for one...It's for each." I had four, so I have to pay them \$20 to refill all of mine."

While the stories shared above talk about copayments being a barrier to adequate healthcare, the OLA Report (2014) only made the following recommendations with regard to copayments: "The Legislature should clarify in Minnesota Statutes 243.212 DOC's authority to adopt exemptions to the statute's general copayment requirement of \$5.00 per visit." The DOC responded with the following statement: "The department supports clarification of the statute and agrees with the report that best practice is to exempt mental health visits from the copayments" (p. 131).

PART III: FINDINGS

The OLA Report also stated that the DOC should ensure that “Copayment policies are well understood by facility staff and consistently applied; and - Orientation materials given to offenders at each facility contain a complete and accurate overview of DOC’s copayment policy” (p. 131). The DOC agreed with this recommendation and stated “The copayment policy was recently revised for clarity and consistency and issued on 8/6/2013. Training will be provided for nursing and medical records staff...Orientation materials will be reviewed at every facility to ensure complete and accurate information is provided” (p. 131).

Unfortunately, the OLA Report made no recommendations with regard to copayments that would address the concerns of the stories shared with us. One person we spoke with seemed to take a more balanced view of the financial challenge to provide adequate healthcare in prisons.

He concluded that as a state, “We shouldn’t be giving our incarcerated people less care than we’re giving to other people who are financially challenged.” What he didn’t say, however, was that, as a state, we should be providing people who are incarcerated with the same level of care as people who are middle class or affluent:

“I know there’s a lot of challenges. People who are incarcerated can’t get health insurance, so the state is eating the cost, so it’s kind of a challenging question for me, because I know the logistics, but I think that it should be the same standard of care at another lowcost clinic that serves people who can’t always afford healthcare, so Red Door, Clinic 555, Healthcare for the Homeless, all of those should be a similar standard of care. We shouldn’t be giving our incarcerated people less care than we’re giving to other people who are financially challenged.”



Photography by: Jenn Ackerman

PART III: FINDINGS

Costs of Medications

Another financial barrier to adequate healthcare in prison is the cost of medications. In 2014, OLA evaluators made the following recommendation to the DOC: "DOC should periodically solicit information from the Minnesota Multistate Contracting Alliance for Pharmacy to determine the competitiveness of pharmacy prices paid by the department's contractor." The DOC agreed with the recommendation and said "The department will work with its new healthcare vendor and Multistate Contracting Alliance for Pharmacy on a comparative analysis. The department has made a preliminary inquiry on a number of medications" (p. 132). As of today, we are still learning what the outcome of the DOC's response will mean in terms of the cost of medications to people incarcerated.

One person who is formerly incarcerated shared with us her thoughts on why the DOC doesn't allow certain medications to be given to a person and the health impacts that such a policy may have on people who are incarcerated:

"Sometimes...If they may think that you didn't do something or you didn't provide something or just because the DOC doesn't allow a certain medication to be given to a person, because of whatever reason, usually it's because of financial reasons. They don't allow certain medications, because it doesn't fit in their budget. They have a budget that they have to go by. So does it matter that you were already taking this medication on the outside, every day, and you're doing okay; you're incarcerated now. You no longer can take that medication.

It becomes a problem, because a person that's used to being okay taking their medication every day or however they take it, and it's making them feel okay...Of course when you stop, change or you can't take it anymore, you're going to have some results from that and you're going to be on an imbalance. **Trying to explain that, there's no consideration for that. They have a policy that they go by, and that's all that matters".**

In response to the question of what would make adequate healthcare possible in prison, one person we spoke with, who is formerly incarcerated, said "One would be the allowance of being able to have a better medical budget so people could get their adequate medications that they were already taking to currently help with their conditions." This is an important point because we learned that while the financial policy and budgetary decisions of the DOC affect the cost of medications, the perceptions of healthcare providers also affect who is allowed to receive medications. For example, one woman, who is formerly incarcerated, shared " If you're sick or something's wrong with you, a lot of times they think it's a game because we're inmates, and they don't really respect and take [us] seriously. I think it's a really big issue."

She went on to say "You know, no one wanted to help me, and I was mad because we have kids. We're mothers too, you know what I'm saying? We're not things. We're humans, you know?" Again, it was this theme of not being treated as a human being which came up and seemed to affect many aspects of the DOC's ability to provide adequate healthcare to people who are incarcerated. It was especially difficult to hear her share her personal experience of what not being able to be seen as a human being during her incarceration meant to her:

PART III: FINDINGS

"For me, the four and a half years that I was there, I know there was an incident where a doctor was there, and he did maybe 40 hysterectomies in two months on girls in the prison, and it's just...like there's no respect." To her, while the costs of medications was discussed as an important barrier to adequate healthcare, what seemed to be a more important barrier was being able to be respected as a human being. In other words, the costs of medications were not just financial costs.

Timeliness of Care

"It needs to go back to being annual medical check-ups, not biannual. It needs to go back to being annual dental check-ups, not biannually. That something that needs to happen now. It's outrageous, that situation. That needs to end now. If this don't [change] nothing else would change anything...it needs to change that. To wait two years to go and just get a medical check-up, it's crazy. To wait two years to go and get a dental check-up, and it's a very surface dental check-up that they do. It's not even comprehensive. It's very surface. That needs to end. Both of those things need to end now."

-Person formerly incarcerated

The timeliness of healthcare is a barrier to adequate healthcare in prison. In our discussions with people formerly incarcerated, we were told, "They need to get rid of that two year wait for check-ups. It's outrageous. They definitely need to get rid of that two year wait for dental check-ups. That's outrageous. Oral health impacts all of the other health, so you got cats running around with poor oral hygiene. They're way more susceptible to being sick and all kind of stuff. If they don't do anything else, they need to get the dental back down to a year."

One person we spoke with is a caregiver to vulnerable adults who are unable to care for themselves. She shared with us the kind of care that is offered to such adults, the timeliness of such care, and contrasted that with the kind of care and the timeliness of care offered to people who are incarcerated. One of the main points that she made by offering such a contrast was that the kind of care offered to vulnerable adults at his facility is based on preventative care, or care designed to prevent illness. It was an interesting point, and one that our community based participatory action research team discussed at length. In thinking about providing adequate healthcare in prison, we wondered what it would mean if preventing sickness or illness was the organizing principle. It was a question influenced by what we learned from our conversation with the caregiver, who said,

"...I'm in the business in my career where I am a caregiver to people who are vulnerable adults and cannot care for themselves adequately without assistance. I have policies and procedures and guidelines that I have to go through in order to keep my residents healthy... the state prison system does not go by those guidelines. It would be regular dental cleaning, regular dental check up at least annually and then follow up on anything needed. Also, preventative care appointments, physical lab, regular lab and blood draws and... I know that wasn't done".

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Our community conversations show that the community experience of timely care in prison is different from what the OLA report states: "Nearly all [people incarcerated] receive a timely initial screening when they first enter prison" (p. 22). And not only different, but that, in addition to timely care, care needs to be comprehensive and ongoing. A family member of a person incarcerated shared the following story:

"Well I think initially giving them a check up and then continue with it because that can change in there. Make sure they're healthy. You never know if they're diabetic or if their thyroid is messed up or whatever, because...sometimes I think when they act up they give them more medication. I don't think that's always necessary because then you make a person become a zombie"

In other words, it is not just providing the initial check-up, or timely check-ups that is the only issue. Timeliness of care is certainly critical, but what we learned from our conversations is just as important is what happens during those check-ups.

We learned that providing adequate care in prison should be guided by a desire to ensure that people who are incarcerated return to their communities healthy. In talking at length about this point, a family member of a person incarcerated shared,

"I would hope, or I'm hopeful that they would maybe pay a little more attention to their action...in the perspective of making them, not just keeping them at bay while they're there so they don't cause trouble, but they come out healthy human beings...prison shouldn't be, it shouldn't be just a stale stage in their life where they're not progressing, they're not learning... and then they come out like crazy ass animals because they weren't treated like human beings, they weren't taught to grow or how to handle to make themselves to not be the same person that came in there or worse."

It seems that no matter the issue, whether costs of medications, copayments, or timeliness of care, the discussions we held in the community with family members of persons incarcerated and with persons formerly incarcerated always came back to the issue of treating people incarcerated as human beings, and how not treating them as human beings affected their ability to receive adequate healthcare, including timely care.



Photography by: Jenn Ackerman

PART III: FINDINGS

Nutrition

"I was telling her my son ballooned up to about 360 pounds and the food...My son even developed kidney stones in there. It is what it is. It's constant chaos. It's a whole different life. He was lactose [intolerant] and he wasn't supposed to be eating bread. Now he has developed kidney stones in prison. That must have been painful because he...you have to eat. There's no preventative, because you have to eat what they give you."

- Little Earth
Listening Session

When our CBPAR team asked community participants about health related to incarceration, we repeatedly heard of food in prison described as being unappealing, unhealthy, and even “unfit for human consumption.” One story was shared with us during an interview which discusses the need for better nutrition:

“The food. Some of the food where I was at in Duluth is not for human consumption and it clearly said it on the packages. Guys that actually worked in the food warehouses, worked in the kitchen, they know this. You might hear it again, but you gonna hear it from me. They had food marked “Not for human consumption.” They were giving us old pudding from 2007. I mean, it clearly said it on the label. It was expired food. And then along with the other food, most of the meat was not for human consumption. So there’s a few things, you know. Just making sure the food is good. I mean, and that can come in and then a lot of stuff can enter your body through bad foods. You can get parasites and if you already got diabetes or MS, you get a parasite from a piece of chicken that you done ate or a piece of fish or whatever you done ate, what’s that gonna do to you?”

And then you go to the doctor's and say, 'Hey, I'm not feeling good I got this. I got that,' and they don't want to give you a referral to go see a doctor. That's why I said, you just got to have a listening ear and a open mind when it comes to that. Especially if you know that you're giving inmates old food or food that's marked not for human consumption."

“Give them better food. Better food, fruits, vegetables, that’s about it,” he concluded.

During our research team meetings, we wondered how it was possible for prison officials to receive supplies from the Duluth Prison Farm that were clearly stamped on the outside of the boxes “unfit for human consumption,” and then send that to the food service department. In other words, people incarcerated in Duluth were forced to eat whatever was delivered, or they had to buy their own food out of their own pockets from vending machines, or through the commissary.

After hearing that, we went back to the OLA Report to see what if anything had been said about nutrition. There was nothing. Yet nutrition is an important and critical aspect of adequate healthcare. The DOC food service policy states “An experienced full-time Minnesota state-certified food service supervisor manages food services at each facility, but exact titles may vary.” The policy also states “The facility food service supervisors must operate facility kitchens using management practices that adhere to governmental health, safety, and labor codes [italics added]; follow appropriate budget, purchasing and accounting practices; and provide nutritionally-balanced meals using standard menu plans [italics added].” The voices of people formerly incarcerated and their family members provide a sobering critique of food service within DOC correctional facilities.

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but you gonna hear it
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PART III: FINDINGS

Physical Environment

“...so it was difficult, really difficult psychologically and even physically laying on their beds for all of the years. It’s hard on the neck. It’s hard on the back. You become sluggish. It’s difficult, but I was athletic. It’s still difficult though.”

-Person formerly incarcerated

The physical environment of prison can be a barrier to both physical and mental health (water, cleanliness, but also the physical environment in solitary confinement). One family member we spoke with, in talking about how solitary confinement affected her loved one who was incarcerated, kept referring to solitary confinement as “the hole”: “Like, when he got locked up? He just, when he first got there, he was just, like, going crazy. Not caring. Always in the hole. Just didn’t care. Like, I’m in here, so if anything can just trigger him off just because he’s there. He was in the hole a lot...”

One member of our research team took a tour of the Oak Park Heights Correctional Facility. Oak Park Heights is a maximum security facility in Minnesota. It is also the only facility with a mental health unit. As part of an effort to learn more about the correctional facilities, we were invited to take a tour of the facility, but only one of us could go. During the tour, our team member told us that he visited the solitary confinement units. While he and some of the other members of the tour group were packed inside one of the units, someone asked about the use of solitary confinement in Minnesota.

The officer leading the tour quickly responded, “We don’t have solitary confinement in Minnesota.” He was referring to a statute that passed in the Minnesota Legislature in 2016 that gave authority to the Minnesota Department of Corrections to establish procedures regarding the operation of segregation units in adult facilities. The change was subtle, but the officer wanted to make sure we all knew what it was. He wanted us to know that the language of “solitary confinement” had been changed to “segregation.” The units, we were told, were still lonely, decrepit, gray, dull, and isolating.

We heard many stories about unsanitary physical conditions inside of prison, including with the beds, mold, dust, dirt, grime and poor lighting. All of this in conjunction with “prison life” in general, including the behavior of some of the guards, impacted the wellbeing of people incarcerated: “Well, let me see. Like being locked down a lot. That nearly threw me off and emotionally threw me off.

How the guards act in there, that throws you off mentally and emotionally. Just the whole scenery, just the colors on the wall, it’s just plain in there. It’s just like...I don’t know. It’s just plain. You don’t have no light. It’s real detrimental on somebody’s mental wellbeing and emotional wellbeing.”

“

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PART III: FINDINGS

Visiting Policies

"Prison is just hard, period. I didn't go visit my son because he said after the visit, he had to sit for two hours in a room to wait to get...searched before he can go back into the general population...That's what they do, because you could bring drugs in there...He said, "Mom, don't come no more, because it's terrible after you leave. I have to wait..." He said sometimes three or four hours in a room waiting to get searched. I only did one time."

-Mother of person incarcerated

Visiting loved ones who are incarcerated is a necessary part of staying connected to community and improves mental health. People who are incarcerated and are visited in prison are unlikely to return to prison once they are released, according to a 2011 Minnesota Department of Corrections study. The study examined the effects of prison visitation on reconviction rates among 16,420 persons incarcerated released from Minnesota prisons between 2003 and 2007. It found that persons incarcerated who were visited were 13 percent less likely to be convicted of a felony in the future and 25 percent less likely to return to prison for a technical violation.

Based on both statistical and anecdotal evidence, researchers concluded that visitation can be the difference between continuing a cycle of incarceration or starting a life free of incarceration.

Yet even in the face of results which show a positive correlation between visitation and low rates of returning to prison, significant barriers remain. We learned that when a loved one visits a family member who is incarcerated in some correctional facilities in Minnesota, the person who is incarcerated has to go through a whole process of being searched when they leave their cell to go to the visiting room, when they come into the visiting room, and when they leave the visiting room.

One person shared, "Yeah, because every time you go down there you've got to take off all your clothes so they dehumanize you. Then all of a sudden you can't hug longer than a certain amount of time. You can't touch somebody. That's the thing that keeps you kind of, like you just get to see this person's face and talk to them but you're not able to, you know... It's just really blurry. It's a really blurry time. It's dehumanizing."

"Psychologically for me it's really been horrible. My son knows some of it. I've gone up there and I've had mental breakdowns in his presence because in that visiting controlled session you don't want to get up and end the visit because five minutes later I might feel better and wish I could still see him. Instead I'll go through what I'm going through there. I'll watch him fight back his emotions because I'm having mine or vice versa."

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We learned that when a family member or a friend visits their loved one who is incarcerated, the only times they are allowed to touch is when they arrive and when they leave: "When you first get there, you're allowed to hug and when you're about to leave, you're allowed to hug and a kiss on the cheek. Besides that, there's no physical contact allowed in that room." Listening to these kind of stories made many of us on our research team realize just how much we take for granted outside of prison. The desire to touch a son or a daughter who is incarcerated during visitation was a theme that many family members discussed at length. One person shared the difficulty of seeing her loved one for only one hour during visitation after he had been incarcerated for 15 years:

"It's difficult just because they have so many rules in that visiting room. The fact that he can't even hold my hand and there's 15 years of stuff that we have to talk about that he doesn't know and that can get emotional. He can't even try to comfort me in any way. He just has to watch me struggle and it's hard to watch him struggle with his own emotions. That hug mat is the only place where physical contact is allowed, and the amount of time that we have to talk is not enough especially after not seeing him for 15 years. There's so much that's not going to be able to be talked about until he gets out, and that's like if he gets out. Just knowing that there's only an hour to talk about everything that you want to talk about and then when you get that five-minute warning at the end, it tells you only have five minutes left to talk. It just scrambles your entire thought process." Like the last few minutes, you're just sitting there trying to regain your thoughts. Then, it's time to say goodbye and that's it."

One mother, shared a lot about the psychological impacts of just not being able to communicate like a human being with her son for fear of being reprimanded, or even thrown out of the visiting room. "**I think they could do more to make a visit a visit,**" she said. Rather than a visit, she said it felt like the correctional facility was constantly "**reminding you that that person's incarcerated ... that you're incarcerated. We're reminding both of you that this is a prison and don't do this and don't do that. His daughter, I'd bring her up all the time,**" she shared; "**and she'd go running around and wanting to play. She had to stay in that three feet area in front of us and if she kept moving they could make us leave the visit. If they cry too much they could make you leave the visit. A baby is going to be a baby right? Then he could play with her and do elevator games and all kinds of imaginary stuff until she was six. Now she can no longer sit on his lap and she couldn't understand it. How do you explain it?**"

Now she was like, "**What do you mean I can't play with my daddy? I can't yell and scream and jump on his lap and do the elevator game? He can't be the oak tree?**" He used to be an oak tree, he used to do elevator games, he used to be a machine, he used to be a robot. All these things that you can do with a kid that you can do within a four feet space, he would do with her and it was beautiful watching her grow through it. Then she got to an age where she couldn't do any of that. He would always explain to me, "**Don't let her go down there.**" He would try to be firm because he couldn't get it through my head, "**Mom, just don't let her go down there.**" He was like, "**You never know. The reason everybody's here, I'm who I am but everybody isn't who I am. If at any time any one of these inmates could snatch any child and use them as a hostage in a visiting situation.**"

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Later, in reflecting on this experience, she told us how amazing it was for her to see her son's creativity with his child in a place such as prison. "In a space such as 3 feet with such limits, it was wonderful to see them both disappear into wonderland as if the space and place and everyone in it had disappeared and a magical playland had appeared in the imagination of his daughter."

She also brought us back to reality when she explained, "and one day she turned 7 and suddenly it was over. DOC policy at the time was no more laps and play time once the child turned 7 years old."

The overall challenges to visiting a loved one in prison were summed up by one of the family members of a person incarcerated in the following way:

"I can't have a felony record. Have to have an ID. Have to be able to get there. Have to make sure, if I do get there and use my gas to get there, I've got to make sure I have gas to get to work and to do the other things I need to do with my life as well. Just going through the process of visiting. Most of the COs are nice, but there's one guy that's just rude and disrespectful. You're anxious on your ride there, hopeful that that person's not working, everything goes okay. Am I wearing the right stuff? Because they'll turn you away if you're not wearing the right stuff. Then your window of time is so short that, to have a conversation, you need more time, especially if you get into a real good, deep conversation. What else? The no physical contact. You can't really have your true authentic expressions. Then you've got that feeling of when you've got to leave, and you leave and you've got the drive home, and then when can you see him again?"

The sentiment expressed above captures some of the financial challenges associated with visiting family members who are incarcerated, not to mention the extremely high costs associated with being incarcerated. "I can't even imagine how much harder it was for people who couldn't have people come. You know that whole socio-economic piece where your family lives in Mankato and they can't come visit you but, then it also costs, back then \$15 a call to call long distance. Now it's different, it's all one fee or whatever they charge the same per minute no matter where you're calling, which I think is ridiculous also. It's a free call out of the facility. Why are they able to charge those, it's like \$.50 a call or something."

"The visiting is too short. It's like me and you right now, we're closer together than you ever will be in a visiting room, unless you're in one of those reduced...what do they call it... minimums. I don't know what they do in there. They've probably got a vending machine. We sit five feet apart. I'm hearing impaired and a couple of times some of the staff, once they learn that, would bring me this microphone device, but my problem is white noise so the microphone device amplified everything around me. I read lips a lot because it's the mixture of noise. I can hear things other people can't hear. My hearing issue isn't the volume, it's the decibel, it's the clarity of what I'm listening to. Sitting five feet away from a person trying to have a conversation, I'm constantly leaning way in. I'm a short person so I'm leaning way in, they're constantly telling me to sit back. I'm constantly feeling like I've only got this hour and I can't even communicate."

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Humane and Compassionate Care

"Really caring. Really actually caring about these guys like they're human. You know, like actually talking to them. Asking them how they feel, about whatever medications they're taking. You know, having people there that's really, really gonna care about what they're giving people."

-Person formerly incarcerated

When designing our interview questions, we thought it was important to ask people who had been incarcerated if they thought they had been treated with compassion, respect, and dignity by DOC staff in the correctional facility. We also thought it was important to ask them if they believed that their family members had been treated with compassion, respect and dignity by DOC staff in the correctional facility. The need for compassionate care was a major theme that came up over and over again during our conversations. The need to be seen and treated as a human being and not as a "criminal," a "felon," a "drug addict," or an "animal," was a message that resonated with us.

"I had a really bad experience getting a pap smear, where she saw that I was HIV positive in my file, and made a huge point of telling the person who was assisting to glove up. There's universal precautions. Everyone gloves up, so for me to hear that, that was just a really stigmatizing thing, and I'm a pretty good advocate for myself, but how many people aren't, and I think that there's a culture among the people that provide healthcare to incarcerated people that everyone's drug seeking, and that that can really impact people not being taken seriously."

During another conversation, we were told that caring ought to be a part of what it means to be a "professional": "I think that, if they actually had caring...caring and considerate, and actually thoughtful people that were the doctors and nurses working in the health services part..." One person we heard from told us point blank, "I think that first of all, they need to have people who are compassionate for the individuals that they're serving. And by that compassion it would make them more apt to provide the services needed."

One person, a family member of a person incarcerated, talked about her experience visiting a loved one:

...they have no care or compassion. Their discretion, I've seen people turned around because they're not wearing appropriate items...I mean that I remembered with the one lady who had on like a blazer that was too tight. And they considered her shirt being too low cut. However, she was a bigger breasted woman, so had she had not had breasts it wouldn't have appeared to be low cut. She was black as well too, so I think there might have been some racial bias involved...

In discussing the overall healthcare services provided at the facility in general in terms of treating people with compassion, one person, who was formerly incarcerated, said, "Yeah, they gonna need some training for that. That's heart change stuff. That's something that's so basic, I didn't even [think] of it. I'm thinking of the practical stuff, but that's just some heart change stuff in terms of seeing a person [as] a person, and not as a thing, or an object, or an annoyance, or a problem, or an inmate...When I cross that door, they need to be looking at the people that's crossing that door the same way as if I went to Abbott Northwestern..."

“

Really caring. Really actually caring about these guys like they're human. You know, like actually talking to them. Asking them how they feel, about whatever medications they're taking. You know, having people there that's really, really gonna care about what they're giving people.”

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In talking about compassionate care, what people actually meant was that healthcare service providers in prison should “actually care and not treat you like a number.” One person talked about his interaction with medical doctors in prison. “It’s...you’re a number ... There’s no getting close to anybody really, not like that, no. It ain’t like you’re my doctor and I come, ‘Doc, hey,’ it don’t work like that. You’re dictated to. You got a issue, this is the problem, this is the solution. Here, take this, move on.”

Overall, it seemed like the prevailing feeling among people who were formerly incarcerated was that “...them doctors don’t want to help you. It seemed like they don’t want to help you. They want to get you in there fast and get you out of there fast. It seemed like they don’t want to do their job.” And in response to the question, “Would you say you were treated with compassion, respect, and dignity?” the general response was “No, I wasn’t. Definitely wasn’t.” One person we interviewed went even further in his answer and said, “I was treated like a convict.”

Not all responses were negative. In recounting an experience with a mental healthcare provider, one person we spoke with said “Yeah, the mental health lady I saw was great. There was one nurse that I feel like...had a life changing event...and had compassion. But, most of them were there to do their job and they have more patients than they would in a normal clinic and they’re just trying to run people out of there, in and out.” When we followed up with a question asking her to expand on why she thought the “mental health lady” was different from the norm, she told us,

She just was a real professional. It didn’t matter to her if she was seeing me in Shakopee Prison or at the Allina Clinic. I feel that she treated me just like she would anybody that she worked with. Like I said, the nurse, you could tell she had a personal something, a personal connection that gave her more compassion. She just treated us like we could be anybody. Like what happened to us could happen to her sister, her brother, her son or daughter or whatever.

Some of the people we interviewed told us that the ability or inability of healthcare providers in prison to show caring behavior towards patients incarcerated was not always a result of their just being incarcerated or being viewed as “criminals” alone, but also was a result of the race of the person incarcerated. In speaking about this, one person who is formerly incarcerated shared,

“ Yeah. So they’re treated different and I guess that’s known too, that they’re treated better than like your drug convicted black guy. So again, treating them like they are human beings more supportive of their needs. We know that they’re at a point where they...we know they’re at a point where they are serving their time, but they should at least be afforded the opportunity to be treated like people.”

“

Yeah, they gonna need some training for that. That's heart change stuff. That's something that's so basic, I didn't even [think] of it. I'm thinking of the practical stuff, but that's just some heart change stuff in terms of seeing a person [as] a person, and not as a thing, or an object, or an annoyance, or a problem, or an inmate...When I cross that door, they need to be looking at the people that's crossing that door the same way as if I went to Abbott Northwestern.”

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Embracing the humanity of people who are incarcerated is not an insignificant aspect in providing adequate healthcare. During a tour of the Oak Park Heights Correctional Facility, one of the guards actually said to the group, "Do you want us to return a human being to your community, or an animal?" He was implying that some of the men in segregation were animals. Our research team had a heated discussion about this. One person on our team said, "I don't care what a person has done, he or she is still a human being. I cannot accept reducing someone's humanity..."

During one of our interviews, a family member of a person incarcerated seemed to be willing to compromise this point. It was not that he didn't recognize the importance of embracing the humanity of people who are incarcerated. It was that he was willing to turn the humanity of people who are incarcerated into a financial issue:

...if you can't think about the humanity of it, please think about the financial piece of it because it saves the taxpayers money, it saves the healthcare system money. Whether they believe it or not, these are human beings. No matter what faith tradition you follow, we all know that how we treat others is a reflection of who we are. Some of us may not care, and okay, I get that, but those things usually visit back upon us in some way. It could be our family 10 years from now, so consider that.

HEALTH IMPACTS OF INCARCERATION

Mental Health

"They need to implement mental health therapy in there. They need to implement brain injury care. My brother ain't the only person locked up that has or has had a brain injury that has not been treated. I know somebody now that still has a brain injury issue from eight years ago. They're still not the same. You're not giving them the tools to exercise their brain. You're not providing that all, and you're not going to send them off because they're incarcerated. They don't allow them leaves for funerals or nothing. You guys literally have your hand around their neck and your foot up their ass 24 hours a day, 7 days a week. When I say 'Jump,' you say 'How high?' That's how they treat them, no matter whether they're sane or not. That's not cool. They're still people."

-Family member of a person incarcerated

During the course of this project, we learned that the DOC has only one dedicated mental health correctional facility at Oak Park Heights, which is its maximum security facility. Yet the DOC operates eight state prisons that house more than 9,000 adults.

So the question our community based participatory action research (CBPAR) team asked each other during our internal research meetings is how it is possible for the DOC to provide adequate mental healthcare if they only have one mental health facility?

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This is a valid question. One woman who spoke with us shared "...There's 600 women in prison. They maybe have five psychiatrists, or five therapists, or five whatever, and then they have these huge caseloads, and then people are just not getting the mental health..." With mental health, we learned that there are so many factors to consider, such as what might cause a mental health condition in prison. For example, one family member of a person incarcerated shared the following story about her father and what resulted in a mental health condition for him while he was in prison:

...I think keeping in mind with the different conditions that people are dealing with while they're in there, and who they are around too. I know when my dad was in jail he was also in the same, I know he was in the same prison, like jail, with the people that killed my mom. So that was kind of the trigger for him... respect the fact that stuff like that can bring out a lot of problems for people mentally.

To truly consider the different conditions that people are struggling with while incarcerated, a system is needed, and really, an attitude that would enable healthcare providers to take the time to learn about the people with whom they are interacting and treating. One woman, a mother of a person incarcerated, offered the following recommendation:

...I think that even though somebody is sentenced to a punishment for a crime that they've been convicted of, I think that it's smart for the DOC to say, "You know what, let's evaluate these people coming in. Let's see what their needs are, let's see what their issues are coming in.

What are they coming with? If they're coming with something strong and impactful, let's try to apply that somewhere so that while they serve their time it contributes to a positive environment, safety for our employees, and safety and positiveness for other inmates. If they have shortcomings let's address those so that it doesn't contribute to the negative impact of incarceration or the lack of safety for our employees." I think having a mental health evaluation and maybe just a social evaluation of a person coming in, where are you coming from? Who are you? What do you have to bring with you? You're doing 30 years, what can you do? What do you know how to do? What can you contribute while you're here?

The questions posed at the end of this story are powerful. To ask, "Who are you?" means that you are actually interested in how a person describes him or herself.

Asking such a question leads to a much different interaction than telling a person who they are, or treating a person like a "criminal," an "offender," an "animal," a "convict," or a "felon." It is much easier to take a person seriously when the interaction is based on principles of engagement that embrace one's humanity. One man who is formerly incarcerated spoke to us at length about this. He said that the attitudes of many of the prison healthcare staff made it difficult for them to listen to the actual patients that come in to see them. "Sometimes they don't do that," he said. "I don't know. I think those are some of the main things I could think of.

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The attitude[s] of the staff, and listening to the patients, because if you don't listen then they think they've seen it all before and that everything is the same as one thing, and it may not be."

He went on to share, "Like, if they have any type of illness or they say they're going through this, just be there for them, cause that's mostly what most of the people with mental illness, they just want somebody to be there to help them treat the illness...Or, whatever it is that they're going through. Some people don't take that type of stuff serious." Many stories were shared with us that supported this observation that people who are mentally ill and are incarcerated are not taken seriously by healthcare providers.

Additionally, we heard stories that suggested that too many people in prison suffer from mental health issues and that prison is not the right place for treatment. "I think the main thing with prisons, and even jails are that they have people with real mental health problems that shouldn't be in there," said one person, who is formerly incarcerated, during an interview. "I think that's the biggest thing. Like the care for other kind of people, because they're coming in there and they're going to jails and committing crimes so they can have a place to stay, or something like that. And they're mixing with...I don't think they should be there...they should be at a different facility...like a mental health facility."

From our conversations with community members, it was clear that many thought the DOC should work on getting more psychiatrists and therapists into prisons to help people who are incarcerated and are dealing with mental health issues receive the help they need. "Cause somewhere down the line," we were told, "they never had it for them to be on the right track of saying, 'No, you can't touch a

child.' They lost that skill. It is a disease. That person's not right in the head. The medications that they're throwing out to these people...Well, all medications don't work for the same person." These words, spoken by one who is formerly incarcerated, stressed how important it is for healthcare providers in prison to take the time to ask questions of their patients, such as "Is this the right dosage for this person? Or are they too heavy and the dose is not getting all the way in they system?"

"It's just not working," he continued. "Our system is failing our mental population." This was a sentiment shared by many who attended our listening sessions. They saw that the prison healthcare system was unable to address the "whole of a person," we were told. The prison healthcare system was unable to "hear their concerns about their health and address them in manner timely fashion," said another person. "Make them feel like they've been heard," he continued. "And stop trying to move them so far away from their family where they feel isolated and alone. Because that affects their mentality as well."

Most groups we heard from in the community felt that the prison healthcare system is "failing our sick ones that's locked up." The answer they come up with to make the prison healthcare system better for people who are incarcerated was simple:

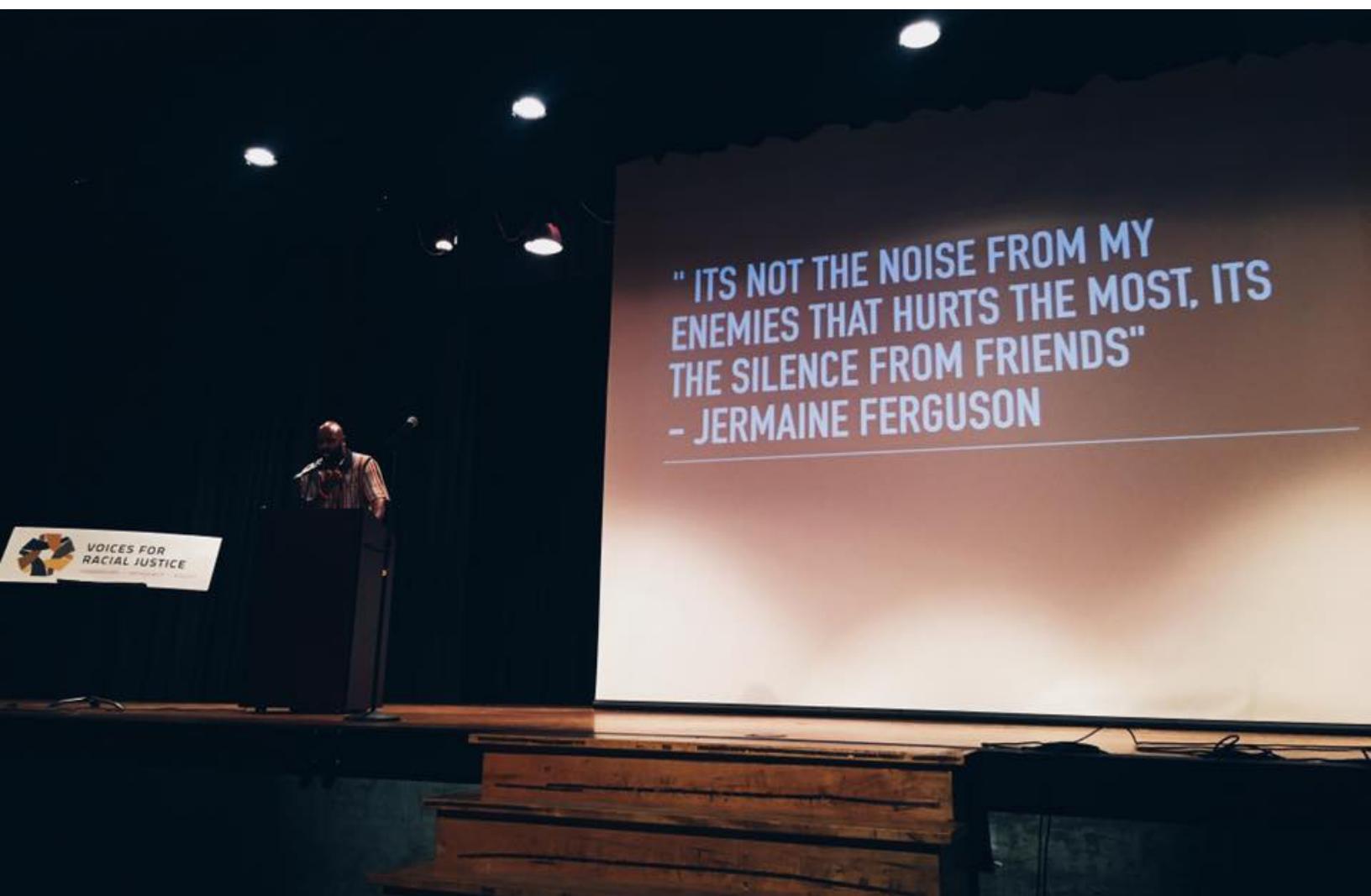
Talk to this person. See what can help them get better in their head. What made them do it? How can we prevent it from happening again than just locking them up? Cause you don't know what's inside of a murderer's mind until you actually talk to the murderer. 'What can help you?' 'What can we do?' By talking to me trying to help someone with a mental disability, what can I tell you that can help them? You have to go and talk to that person."

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In other words, to see if therapy or if a certain medication will help, family members of people currently and formerly incarcerated told us that healthcare providers in prison need to provide comprehensive healthcare:

“...take they blood. I think you need to do testing on them. I mean the whole physical, and I’m sure that doctors do, but then when you get them on this med, it’s not like keep prescribing it to them every month when they run out. No. Let’s see if this person’s really taking it...Do your job...It’s things that needs to be done and asked, and if everybody was just not looking at they job as a 9-to-5, but looking at it as, ‘I’m helping and I have the heart to help this person, and that’s my job to do,’ that’s what you need to do. If not get out the field. I think that’s all I have to say on that.”

Mental healthcare must be a priority, and in the words of one person we spoke with who was recently released from prison, “I think that it can be addressed. It can be talk therapy, but it doesn’t have to necessarily be talk therapy with a licensed therapist. It might be with culturally specific groups, so maybe there’s some Native American health people that come in and we do circles with the Native community.” The need to have mental health treatment that is culturally specific and sensitive to the needs of people who are incarcerated and identify with different racial and ethnic groups is fundamental to the provision of adequate healthcare in prison.



PART III: FINDINGS

Rehabilitation

I sat in jail, and what would help too, a person who sit in jail like me, and was very, very observant in the days that I had to sit in there for so long, I saw the same 40 girls...come back... come in and out of there, so you know there's a problem in the system if you guys are having these same 40 girls come in here, and they haven't got it right from the first time. They have drug problems. They have mental health issues, so what do you expect us to do if we have those issues, and we're not getting...help, and we're coming back to jail? You need to help us with that.

- Breaking Free Listening Session

In the debate about prisons and their purpose in our society, there are those who argue that they should be utilized as places for punishment, those who argue that they should be utilized as places for rehabilitation, and those who argue that they should be both. In our interviews, we came across these competing views as well. One person, in describing how prison affected his brother, told us that prison ought to be a place that functions as a place for rehabilitation and a "restart because that's what's really going to help people change":

"I think that being locked up does something to people. I know that they can come out of it, but it takes a lot of loving and a lot of patience, and a lot of reassurance that, 'This is okay. You are your own person.' My brother has reached that point. He has reached that point where he knows that he's his own person. He's doing okay, but I think that the way our prison system is designed, it's just unhealthy. While people want to penalize, I think it's supposed to be something where it's a rehab and a restart because that's what's really going to help people change.

I don't know when we got away from that, or if it was just a myth that we thought that it was supposed to be about helping people change, people taking a time out."

We spoke with a person who was recently released from prison and shared the thoughts of some of the people he currently knows in prison who told him "I may kill somebody else when I get out because you have made me feel like I'm less than somebody, and you've taken my pain and bastardized it." Many people shared similar stories about being incarcerated and feeling like the experience of incarceration had no real impact on their life trajectory once they got out. We heard stories from people who went to prison with some kind of chemical dependency and were actually hoping to get help in prison and make a new start in their lives.

They expressed anger at being taken away from their families, out of their communities, and put into prison where they were made less responsible instead of more responsible. One person shared that prison "just kind of gave me a license to continue in that lifestyle instead of giving me a reason to do something different. The other thing about that is that I feel like if my chemical dependency or mental health needs had been met at any point during my incarceration, any of them, that the trajectory of my life potentially could have been different...After being incarcerated as long and as many times as I was, I had some criminogenic thinking that needed to be addressed. None of that happened while I was incarcerated."

PART III: FINDINGS

After listening to these stories, our CBPAR team debriefed during one of our research meetings. It was clear for us to see why one of the key findings in the report led by the Ella Baker Center for Human Rights, Forward Together, and Research Action Design, was that the negative health impacts of incarceration can have “intergenerational and community-wide effects, leaving neighborhoods struggling under the multiple burdens of poverty, debt, trauma, and loss of opportunities” (p. 37). It was also clear to us that rehabilitation is an important component of what it means to provide adequate healthcare in prison.

During an event that some members of our CBPAR team attended a couple of years ago at Lino Lakes Correctional Facility, a youth who was incarcerated at the time and was speaking on a panel with other men who were incarcerated was asked to talk about some of the challenges of being incarcerated. He told us in the audience that he felt like there needed to be more of a system of education, more training for employment, or just more training period so that people who are incarcerated would learn to prepare for a new life and avoid whatever it is that would bring them back to a place like prison. He told us that he spent whole days in prison “doing nothing” when he and other men incarcerated could be spending more time being productive learning new technological skills and other things that would make their re-entry back into society more successful.

It is important that the DOC and its healthcare providers understand that providing adequate healthcare is more than just providing medicines and routine physicals. It is certainly that at a basic level, but health needs to be viewed as well-being: spiritual, mental, physical and social well-being. The need for spiritual well-being, for example, was a constant theme in our conversations. During one of our community listening sessions, a group of men we spoke with who were formerly incarcerated spoke of “God,” “religion,” and “spirituality” as being that which allowed them to cope with life in prison. In some conversations, we learned that having a strong spiritual foundation enabled one to transform the experience of being imprisoned: “In a system designed to strip them of their abilities to hold up their manhood, with self respect and the ability to use their skills to gain employment, the institution has for some done just the opposite.” It was clear here that even though prison was designed to “strip” one of his or her abilities, having a strong spiritual foundation was a “necessary requirement to help re-support what has again been mentally broken down [and] can be draining and de-encouraging.”

“Well I know for sure it’s increased his spiritual well-being,” said one family member. “He definitely does pray a lot and faith and hope. And I think that’s probably his main source for getting through while being imprisoned. And again I think because he’s a man, they probably have a hard time due to their, what is that called? You know, their ego, that he’s having mental and emotional problems. So I don’t know about any of that, but again, I think because he’s a man that there will probably be some ego issues with letting me know his real state of mind.”

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Health needs to be viewed as well-being: spiritual, mental, physical and social well-being.”

PART III: FINDINGS

Another family member explained that when his brother first went to prison, he was “bearing like a lot of...we lost my mother and ... he couldn’t take it mentally, and he felt really isolated...” As a result of feeling so isolated, he would lash out from emotional problems. “But they kind of treat like, they punished him for it instead of really helping him.” We were told that when he went to prison, he was trying to deal with the loss of like his wife, and his children. “I mean he came out and was like he has PTSD [Post Traumatic Stress Disorder]...” Stories like this make it clear that prisons have to find the balance between being places for punishment and rehabilitation. We heard too many stories from family members who described their loved ones who were incarcerated as either being more unhealthy and less socially engaged once they returned home due to their inability to make a new life for themselves.

Family Stress

“Okay first of all, his being locked up brings on anxiety. You’re always worried about them. Who they’re interacting with, in authority and other inmates. And then, on the other hand, if I already have a high blood pressure issue anyway. And I know that over time back and forth I’ve had my high blood pressure get worse when he’s behind bars.”

- Mother of son who is incarcerated

The mother who provided the quote above talked about being in survival mode all the time.

“Well, yeah. I don’t have any spiritual or emotional well being...For as long as he’s [in], the long term is that I’m always anxious about him. Because it impacts his ability to find work once he gets out. Find housing once he gets out. To mend his family once he gets out. So the impact is lifelong.”

One family member told us candidly that if her son would have come home tomorrow, she would have done everything to encourage him to get mental health counseling because while he may think, “No, I’m fine. I’m just glad to be home and free,” she would probably think, “No, I think that the environment that you’ve lived in has probably traumatized you in some way just because of how it’s designed.”

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Well, yeah. I don't have any spiritual or emotional well being...For as long as he's [in], the long term is that I'm always anxious about him. Because it impacts his ability to find work once he gets out. Find housing once he gets out. To mend his family once he gets out. So the impact is lifelong.”

PART III: FINDINGS

A few of the challenges to health during incarceration and beyond incarceration are the “stress, stigma, and high costs of incarceration,” all of which “impact the health of all family members, including children of individuals incarcerated.” Such negative health impacts can have intergenerational and community-wide effects. We learned this firsthand during our conversations with family members of persons currently incarcerated.

One family member shared a story about his loved one in prison who still tries to take care of his child from inside. “The treatments he was going through in there kind of helped him open his mind a little bit more to think about the decisions he was making and everything, but being away from his kids has been a big one. He kind of from the inside goes out of his way to still try to provide for his kids and explain to them why he’s there. It’s all kind of stuff. He feels bad about that. He feels bad that he can’t be out here to parent. Then when his kids mess up, all he can say is... Basically he talks to them, but all he can do is let their mom deal with it because he’s not physically here.”

One evening, our research team got the chance to see an exhibit of the impact that incarceration has on the children of parents incarcerated. We were invited to hear Shaka Senghor read excerpts from his book, *Writing My Wrongs: Life, Death, and Redemption in an American Prison*. The reading took place at the main library in downtown Minneapolis. Next to the auditorium where Shaka was to speak was an exhibit that featured the children of parents incarcerated. The room had a few tables lined up next to each other in a long rectangular shape. On top of the tables were large posters of the faces of children whose parents are or were incarcerated. Underneath their faces were quotes spoken by the child.

The look in the eyes of some of those children is unforgettable. Some could not have been older than six or seven, but the look in their eyes felt like we were looking into the eyes of children who had lived a thousand lives.

Family members talked to our research team about the trauma inducing experience of visiting a loved one who is incarcerated. It is almost impossible to imagine what kind of pain that is. In August, 2016, Voices for Racial Justice, in collaboration with community partners, hosted an event at North Community High School in North Minneapolis. The event featured speakers who were community members formerly incarcerated and their families, and family members of people currently incarcerated. During one part of the event, a panel of mothers whose children are incarcerated spoke. One of the mothers on the panel talked about how difficult it was for her emotionally to visit her son who is incarcerated. She said that all she wanted in life is to be able to hold her child’s hand, and that to not be able to do that was something no mother should ever have to experience: “I could not touch his hands. I remember distinctly. It is the hardest part of every visit . As children you always hold their handsas adults you just want to do that and remember, and in prison it’s the one thing you can never ever do.” After sharing that, there was not a dry eye in the entire auditorium.

Her words put into perspective for many of us on the research team what we were learning when hearing how much stress was caused by the act of visiting a loved one who is incarcerated. The need for human interaction and human touch was a huge part of what we were hearing, as well as the inability to have it. One family member shared the following story in reference to visiting:

PART III: FINDINGS

...everytime you go down there you've got to take off all your clothes so they dehumanize you. Then all of a sudden you can't hug longer than a certain amount of time. You can't touch somebody. That's the thing that keeps you kind of, like you just get to see this person's face and talk to them but you're not able to, you know. It's just really blurry. It's a really blurry time. It's dehumanizing...

We heard similar perspectives from people formerly incarcerated. During one of our listening sessions, someone shared how devastating "jail life" was for her, especially the aspect of not touching and not being able to touch. She shared that being in jail made her feel like her whole life was shattered, and the stress that caused her family. "I cried every day that I was in jail," she said. "Every day":

I just think it's...I think that the mental health piece is really huge because there's a lot of people that's doing time in prison right now that are way crazy when you went to prison, by the time you spend time in there, you're going to be a little off, because it's such a... very strict place, you know? There's no...Like, you're my friend. Your mother dies. I can't hug you. I can't say, "Sorry that this happened to you," and just console you and give you a hug, or none of that. I think it's really traumatizing to not be able to have that contact. I went without a hug or a handshake for four and a half years...Yeah, everybody needs that...When you get out, and you go to hug somebody you're affected...walking around people all the time...bump into somebody by accident... You're trying to...look around, so then when I got out I was always walking around people, or trying...not to touch people. It's traumatizing.

The need to be held, or to hug was a theme that seemed to cause a lot of stress not only among family members but also among people formerly and currently incarcerated. During our listening session at Breaking Free, an organization that works with women who have experienced sexual abuse, one woman shared a story about how the inability to touch created stress for women who are pregnant and incarcerated:

You know what...I thought was really sad, though, was like when you see...where the pregnant girls have their babies, they have 24 hours...first of all they can't notify anybody that they're in labor...Nope...They go straight out there. They have 24 hours with their babies. If somebody don't come and get that baby in 24 hours, their baby's going straight to the state...Then they come back, and like she said, we can't console her. You see this woman just car[ried], first of all, you're pregnant in prison. That's hard enough. Then you have a baby that you can't hug, or touch... Then you come back to prison without your child, and you can't get, all you can do is just sit there... I just feel really bad. I just feel so sad for them... You cannot hug... Say your roommate, because you have been roommates with this girl for her whole preg-nancy, you know, and then she come back and she's not pregnant. She's crying... She don't have her baby. You can't hug her. You can't sneak a little hug, you know... You really can't console her. It has to be when nobody's looking.

PART III: FINDINGS

During our listening session at Little Earth, an American Indian housing complex in south Minneapolis, a mother, whose son is incarcerated told us in talking about the stress she endures, "You get depressed. What are you going to do?" She described the stress that she feels: "There'sa missing link. There's division. A family can't be whole and restored if there's a missing linkthere. You're always worrying, 'Is my daughter actually ever going to get out of prison?'" Shetalked about feeling guilty at not being able to do anything for her child. "The little visiting thatyou do get is you can't even buy them a Snickers bar for Pete's sake...I believe that's what my mom died from was she worried about her son. You can only take so much when it's your child.":

Many community members who were formerly incarcerated talked about the depression they brought with them to prison and how it affected them emotionally. They talked about how life outside of prison in some of their communities depressed them, the stress it caused their families, and how the constant re-living of certain experiences while incarcerated added to their depression. One person was vague in naming exactly what depressed them, but shared powerful insights about incarceration, visitation, death and slavery:

"Yeah, that's why I had depression coming into the facility. The prospect of being a juvenile in there because I was one of the juveniles younger than 18, and potentially dying in prison. I've had friends who came in, they was juveniles too, and they are dead now. They committed suicide and other things in prison. So, the prospect of dying in bondage, like a slave never seeing family really again because in all 17 and a half years, I saw my family one time. They came from St. Louis one time, and that was only my mom, and my younger brothers, and my aunt. That was it..."



Part IV

Lessons

PART IV: LESSONS

Consider Whole Human Beings

As the CBPAR team conducted its research, it became clear that asking questions about the impact of incarceration on health opened up many answers. Some focused on the provision of medical care in Minnesota prisons following the analysis done in 2014 by the Office of the Legislative Auditor. But many responses looked to the entire system and experience of incarceration -- and the resulting impact on overall health and wellbeing, not only of those incarcerated, but of our entire communities.

Within the framework of health equity, researchers, advocates, and policymakers are increasingly looking to the “social determinants of health” and applying an approach of “health in all policies.” This research project applied the World Health Organization framework that describes health as “a state of complete physical, mental and social well-being.”

Equipping prisons with professional healthcare providers who are prepared to handle the many different ailments that people have is absolutely a part of creating an environment that is conducive to adequate healthcare. Although a traditional research analysis might not consider the stories we heard that touched on issues beyond provision of medical care, our process confirmed the necessity of allowing those experiencing systems to tell their stories of the impact of those systems. Just as we apply a structural racism analysis in our work at Voices for Racial Justice, this research process reiterated the need for a holistic approach in assessing how systems affect health and well-being.

The experience of prison should not be what we heard described by a formerly incarcerated person during one of our listening sessions at Ujamaa Place, an organization in St. Paul that works with young black men. In reflecting on his experience of being incarcerated, he said,

“My reactions after being incarcerated is just basically, you know what I’m saying things happened. Like, I ain’t get no visits, I’m far away, people getting beat up...and dying off of horse playing... All that crazy stuff...You on lockdown, you eat what they give you, and everything they give you is...cold. And it’s like basically I don’t never want to see no kid, or no other person go through...what I been through.”

In developing solutions to the negative impact of incarceration on health, it will be important to look beyond the provision of medical care, to the other issues raised by those we interviewed, including nutrition, visiting, and humane treatment. The title of this report references the nutritional barrier to health of food being “unfit for human consumption.”

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Through our community-based research process, we learned that many other experiences of incarceration, including how medical care is provided, how visiting is controlled, how human interaction is limited, are also unfit for human consumption.”

PART IV: LESSONS

During one of our community listening sessions, some community members complained about their living conditions. They were frustrated about the mold in their apartments. Their complaints reminded us of an earlier conversation we had where we learned about mold in prisons and the health effects associated with it: "...some kind of crazy allergy that is still here now set in, in there. My eyes be itchy and red. I don't know what it is or what happened, but I got crazy allergies in there...I don't know, but I was in Stillwater and St. Cloud for some years. So, these are really old facilities, really dusty, really grimy, really moldy, all of that stuff, and so, this stuff developed in St. Cloud, which is the oldest prison. And so, man, I don't know where it came from. I just know I ain't have them before I went in."

In our listening sessions and interviews, we learned that in talking about the physical environment of prison and the challenges it can pose to adequate healthcare, the challenges are more than just poor lighting, or mold, or dull colors, or grime. They are also poor nutrition, insensitive guards, difficult experiences during visitation, and even healthcare staff who are not equipped to handle the kind of issues that they're confronted with. One person we interviewed told us, "They really need to bring in more people. Expertise...The people that they do bring in for healthcare aren't in all the time when they should have somebody there daily. Attendants, everybody." Related to this, someone shared the following comment:

"Psychologically, I would say the therapists or whatever you want to call them, check their background because I don't think they have a certified background. I think they're just putting people up in there that...are rookies. When it goes to the psychological thing...I think with health I think the need to hire some real doctors because people die. You know what I'm saying? People die in the joint. They need to go through some type of education or go through some more training or something. They need to do something to better that because it's just like, man, I think it's just crazy how these dudes are just...I don't know. It's just crazy man. It's hard to explain."

PART IV: LESSONS

Community Based Research

The CBPAR approach we have followed throughout this project has offered many opportunities for reflection and growth as individuals and as an organization. As described in our research process, our research team intentionally comprised not only staff of Voices for Racial Justice, including experienced researchers, but also community members who had direct experience with incarceration. This nontraditional approach is at the center of research justice: both making information and data about our experiences available to our communities and recognizing the validity of the lived experiences of community members in defining and designing research.

Among the challenges of this research approach are the amount of time, relationship-building, and trust-building it requires. Too often, communities find themselves the subjects of research, in transactional relationships with researchers, leaving a sense of being observed or used rather than truly understood. Countering the trauma of this experience means taking the time to build the relationships and trust for community members to engage as themselves in the research and to see it as a valuable process.

As a team, we experienced challenges and tensions in this process. For example, one member of our team who has a son in prison realized through the process of listening to others that her son's experience in prison was worse than she thought. To protect the well-being of his mother, he often glossed over what had been difficult when talking to his mother.

As a team, we had to pause and honor the impact of this work on our researchers. We learned that a CBPAR process can become intensely personal.

In addition, our team approach included collaborating across race, ethnicity, gender, and generations. As in any diverse community, we had to intentionally work to understand different working and communication styles. We sought to create a healthy and equitable power dynamic with our team, but faced the inherent challenge of being a nonprofit organization where some team members were full-time paid staff and others were contracted community members.

Our work at Voices for Racial Justice has been inspired by the book *Emergent Strategy* by adrienne maree brown, describing a way of change-making, focused on how complex systems are made up of many simple parts, aligning and changing and aligning again. The process of this research project has been a form of emergent strategy, informing how our organization and our partners in the community practice the world we envision. As we recognize the trauma of incarceration, we were also seeking to build energy and power out of trauma. As brown describes in *Emergent Strategy*:

"Transformative justice, in the context of emergent strategy, asks us to consider how to transform toxic energy, hurt, legitimate pain, and conflict into solutions. To get under the wrong, find a way to coexist, be energy moving towards life, together."

PART IV: LESSONS

What brown describes as transformative justice connects with the healing justice framework we are committed to in our work at Voices for Racial Justice. Healing justice also refers to practicing our work with communities in a way that does not replicate trauma, but instead offers the space and conditions for healing. These community-based approaches -- research justice, transformative justice, healing justice -- play an important role in both dismantling systems of oppression and structural racism and building an alternative way of being in community. Our CBPAR process has been an opportunity to practice a different model, balance the many challenges and tensions that arise in something different, and continue learning and emerging.



Part V

Recommendations

PART V: RECOMMENDATIONS

Our community research process offered the space for participants to share their visions and recommendations for making our prison system one where people incarcerated receive not just adequate healthcare, but actually experience the treatment, opportunities, and humanity that will make true rehabilitation possible. As we shared in our lessons, we see the importance of hearing from those experiencing these systems and we recognize the larger context of how prison life can impact health and wellbeing. These recommendations address both healthcare and other policies and practices that affect health.

Oversight and Accountability

After hearing from community members about their experiences with healthcare and general treatment within Minnesota prisons, we believe, in alignment with the Office of the Legislative Auditor report, that a system of oversight and accountability is an important step for the state to take. State agencies, including the Minnesota Department of Health, the Department of Human Services, and the Human Rights Department, should provide oversight and accountability related to the healthcare provided in Minnesota prisons.

Ombudsman

As part of an effort to develop greater transparency and accountability, we recommend that the Minnesota State Legislature reinstate an Ombudsman for Corrections, which did exist from 1972-2003. The Ombudsman was appointed by the governor and would have the authority to investigate complaints of injustice made against the Corrections Department and other facilities that operate under the Community Corrections

Act (Minn. Stat. 401). This role provides an important way for people incarcerated to have a voice within the prison system.

Community Advisory Committee For Healthcare

The solutions to issues that impact people must be made in collaboration with the people who are directly affected. We believe the DOC should utilize this strategy when designing and implementing healthcare services and other services within prisons. One of the people we spoke with made the following recommendation:

"My primary recommendation is if somehow the Department of Corrections, its leaders, its decision makers, could create just an open space to talk. Just to talk about the ramifications. I think they all have social settings where they probably talk to social workers, social health people, mental health people, in their work settings about 'What could we do...to fix this or stop this, minimize this, correct that?...' I think the impact is more when people are communicating directly. Decision makers and rational community members who are experiencing things, who are able to somehow translate the things that are negatively impacting their employees and the inmates and positively impacting their employees and the inmates."

Training in Bias, Structural Racism, and Trauma

Respectful and humane treatment was repeatedly named as a condition for health and wellbeing inside prisons. We recommend that healthcare practitioners and other DOC staff participate in training to increase cultural

PART V: RECOMMENDATIONS

sensitivity, recognize implicit bias and reduce the resulting behaviors, and understand the historical experience of racism in our country and the structures that remain in place. This recommendation is put into perspective by two stories that were shared in our interviews:

“To my understanding, they treat them less than humans. And...of course there’s always those good officers that are cool. But I think the majority of them are probably racially biased... Looking down on them less than, without understanding the societal issues that they were faced [with] for pretty much more of survival...”

“Just I think more knowledge or more culturally competent providers. And I think that they [should be] not only culturally competent, but sensitive to the needs of offenders, and not just seeing us as criminals, and viewing us [as] people that need help and have health conditions.”

Limit and End Solitary Confinement

Minnesota should follow research and national trends that advise limiting the practice of solitary confinement as having “little impact on the long-term safety of prisons but detrimental and irreversible effects on the health of the person subjected to the punishment.” One participant in our research suggested an alternative to solitary confinement of single cells which provide a way for inmates to remain in the community while also restricted. This would allow for some engagement, stability, less transferable illness, less isolation, access to their own things, and less movement while still restricting them from other activity if needed or warranted due to DOC policies.

Removal of Co-Payments

The financial burden of co-payments for visiting a healthcare provider is especially high for a person incarcerated with limited earnings and for families already burdened by the other costs of incarceration (reduced family earnings, travel to visit family members in prison, etc.). A natural consequence of this cost, is delaying or avoiding care. After hearing from participants in this research project, we recommend the removal of co-payments for receiving healthcare.

Timely Healthcare Screenings and Ongoing Care

Our recommendation is that healthcare be provided consistently and in a timely way to individuals incarcerated. This may include physical, mental, and dental screenings, as well as blood and urine laboratory testing to diagnose and prevent illness. Timely preventive care and treatment for sickness and injuries will support people incarcerated in rehabilitation and returning to our communities able to work and engage in healthy ways.

Nutrition

Food has the ability to nourish and heal. We recommend that the DOC ensure that every person incarcerated is able to eat meals that (1) are fit for human consumption and (2) contains fresh vegetables and fresh fruits.

“

Just I think more knowledge or more culturally competent providers. And I think that they [should be] not only culturally competent, but sensitive to the needs of offenders, and not just seeing us as criminals, and viewing us [as] people that need help and have health conditions.”

PART V: RECOMMENDATIONS

Visiting Rules

We recommend that the DOC work in collaboration with people who are currently incarcerated and their family members, and people who are formerly incarcerated and their family members, to create a visitation policy that is compassionate and that respects the humanity of people incarcerated. While some of the current precautions and rules that the DOC has placed on visitation, such as dress codes or regulating what one can bring inside a facility, may be necessary to enhance safety, we believe that hearing from and working with people directly impacted by incarceration will support the DOC in implementing a better visitation policy that meets many of the needs named by the people who participated in this report. For instance, the rule allowing a person to only be on one inmate visitation list should be reconsidered because it is separating families and children where multiple family members are incarcerated, particularly in Black and Latino families.

Medical Parole

For terminally ill individuals who are incarcerated, our recommendation is that if a doctor finds that the health condition of a person who is incarcerated is so grave that they should be given an early medical release from prison, the DOC honors that request.

Conclusion

CONCLUSION

The journey of a community-based research process that centers the experiences of people who are directly affected by incarceration has been a powerful and humbling one. Our CBPAR team has developed a strong bond, only after also having experienced many challenges in the research process. Our goal has been to offer a space for the voices of people who often feel powerless inside systems to be heard. We believe that our communities and our state institutions have much to learn by simply listening to these stories. We urge the Department of Corrections and other institutions to continue this process of both working with and hearing from community members, and then developing real solutions together.

We are grateful for the funding support of the Minnesota Department of Health, the Bush Foundation, and the Blue Cross Blue Shield of Minnesota Foundation.

Marginalized

By Jeffery Young

Some things are never
kept indoors.

They stay forever
in the rain.

Partially collapsed kiddy pools
quietly joyless in backyards.

Hidden, filled with rain,
collecting water logged
twigs, insects, withered leaves.
Towed away in the unseen
undercurrent.
Becoming drowned casualties.

Worn scarecrows sadly sag
in neglected fields
eight burgundy-orange autumns old,
now eager friends of thieving crows.

Sleek black conquerors play king of the hill
on tattered tweed shoulders.

Raucous mocking caws coalesce
with the silhouetted scent of
old mulch decaying.

Like the aging penitent
in the penitentiary
beleaguered by the rain's
rapid pitter patter
pelting chasmed pavement that
crumbles,
dissolves,
into
what?

Some things are never
kept indoors.

They stay forever
in the rain.

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Appendix A: Project Participant Quotations

Compassionate Care

- “I felt fortunate to have HIV, because I got adequate healthcare through the HIV specialist. I was lucky, so that's crazy where you're like, 'I'm so lucky I have this life threatening condition, because at least I get to see a doctor.'”
- “It seemed like them doctors don't want to help you...They want to get you in there fast and get you out of there fast. It seems like they don't want to do their job.”
- “I felt like it was just garbage.”
- “Really caring. Really actually caring about these guys like they're human. You know, like actually talking to them. Asking them how they feel, about whatever medication they're taking.”
- “the only thing i know that he's gotten is like a very good physical, i have to say that. That has identified his allergy issues and he needs a inhaler when his asthma is bad.”
- “They provide the basic . if you have a headache have a broken bone or if you have a diabetic lapse or something and you need that kind of care then oh well we'll provide you with that but you're going to have to sit there and figure it out on our own otherwise . i don't think that's cool because a lot of people need to be rehabilitated and they're not rehabilitating folks. They're locking them up, throwing away the key and then they have to deal with mediocre everything in there. Their phone systems don't work correct their health care is just shot. Their food is even shot. They get paid a lot of money to house these inmates . Why can't you provide them with adequate everything they need?”

They are already doing their time.”

- “They look at them like they're all trash . some of them in there aren't even criminals. There were just people that couldn't fight for themselves. That didn't know what to say or how to say it. Didn't know their rights, didn't know the statutes. There's a whole bunch of people like that in there. Some people are mentally insane , but they're not getting the help they need either.”
- “You gotta go through the situation. Like I said , I had a roommate who had a surgery on his neck , and once they felt that he was ok to go back to the prison , they immediately got him back to the prison, which he was going through all kinds of pain and you don't have your medical, your pain medicine with you.”
- “They come into work with a bad attitude. How many times he's paid for things, or how many times his family including me has paid for things for him that he didn't receive or didn't receive on time because of their checks that they do. Contraband checks. Or them taking things, saying, "Oh, this is inappropriate." How is it inappropriate when it's his child? His child playing basketball with his shirt off is not inappropriate. That's his child.”
- “... the recommendation of the nurse sent someone to solitary confinement. She thought that he was holding medication. Because she suspected this, he was sent to solitary. She was incriminating him, because he was already a convicted person. All that health professionals have to say is, 'i think/i thought' or just suspect something - there's no court. That predisposition of trust is gone. They have to be really sick to go seek help.

That trust is already null and void, which already removes any idea of compassion."

- "I see this as the main issue for the entire system, because if you develop a system where you dehumanize people - it creates a narrative that you don't need to invest because they are criminals and they will be criminals forever. I think we have to address this, and it needs to be about narratives - people convicted of a crime are human and deserve to be treated as such."

Solitary Confinement

- "It's very unsanitary in there, especially in the hole [in the hole]."

- "Like being locked down a lot. That nearly threw me off and emotionally threw me off. How the guards act in there, that throws you off mentally and emotionally. Just the whole scenery, just the colors on the wall, it's just plain in there...You don't have no light. It's real detrimental on somebody's mental wellbeing and emotional wellbeing."

Visitation

- "He hasn't touched another human being in almost 10 years."

- "Sometimes your name will get called for a visit and you're waiting two hours to go to your visit."

- "They've messed up one time and I know people right now that haven't had a physical visit in 10 years because they messed up one time on their visit."

- "The no physical contact. You can't really have your true authentic expressions."

- "Your anxious on your ride there, hopeful that that person's not working, everything goes ok. Am I wearing the right stuff? Because they'll turn you away if you're not wearing the right stuff."

- "Once a month for eight years. My disability limits my ability to sit so three hours travel each way plus the entire visit sitting took a toll."

- "You have to get strip searched after visiting, which is pretty demeaning...this whole squat and cough thing...Sometimes, I would decline visits"

- "Your window time is so short that , to have a conversation, you need more time, especially if you get into a real good , deep conversation. What else ? The no physical contact. You can't really have your true expressions, then you've got that feeling of when you've got to leave , and you leave and you've got to drive home, and then when can you see them again."

- "Sometimes people were being harassed that were coming to visit as far as what they were wearing or goofy stuff like that."

- "Like if they felt somebody had on a maybe too tight of clothing or too short of skirt or something like that , or her shirt showing too much of her shoulder , anything like that, they have to go, they had to go to a local walmart and buy an outfit or something like that ... they weren't prepared for that ,and it would cost them money if they had to go and buy

- "You have to get strip searched after visiting, which is pretty demeaning...this whole squat and cough thing...Sometimes, I would decline visits."

- “His daughter , I'd bring her up all the time and she'd go running around and wanting to play. She had to stay in that three feet area in front of us and if she kept moving they could make us leave the visit. If they cry to much they could make you leave the visit. A baby is going to be a baby right? Then he could play with her and do elevator games and all kinds of imaginary stuff until she was six. Now she can no longer sit on his lap and she couldn't understand it. How do you explain it? Now she was like “what do you mean i can't play with my daddy?”
- “I think in the State of Minnesota the psychological impact is overlooked as to how children and people are... what they go through coming to visit and what the inmate has to go through. They have to go through to sections I think where they're strip searched. They've got to take off their clothes twice to come. He used to tell me, “Mom just don't come because i don't even feel like going through it.”
- “For a long time until they started telling us we really didn't know. We thought they called you out of your cell and they sent you down the hall. You're already in prison, you shouldn't have anything metal on you but there's contraband. People bring stuff in and bring stuff out. They've got to go through a strip search going out of their cell and then into the visiting room and then when they leave they've got to do it again. They've got you bend over and cough twice. That's humiliating, if I've got to strip every time and I already know that I am in a secure facility, but this is what I've got to do to see my family.”
- “I think they could do more to make a visit a visit. Instead it's like we're reminding you that the person's incarcerated , we're reminding you that you're incarcerated. We're reminding both of you that this is a prison and don't do this from the very beginning...”
- The visits too short, they have nothing to engage with and often times you have the psychological mindset you're going to see somebody. Some friends go visit friends , for me I'm mom , I'm going to visit my son, my first born son, the height of my life, the leader of my family. He's the everything guy. Even in his 15 years of incarceration he has motivated, inspired, and guided my family. I've got an hour to adjust myself, I've got to lean in to hear everything he's saying, I've got to lean back and it's just an hour. I go through all these psychological, physiological changes.”
- “The one time well the first time we went we were like 60 seconds late from the , you must be in the doors by then and literally had to wait three hours. And then you have to get off their property . So the discretions of the facility officers are, seem severely scrutinized. Where they don't even have any care and compassion about the distance or the cost or that you now have crying kids here who see they cannot get in.”
- “Yeah distance was a big one. My parents lived in central Wisconsin at the time , so it was quite a drive for them. Like three and a half hours, probably and then, when I went to boot camp up north, I got maybe one visit the whole six months, because it was so far away.”
- “Yeah they strip you down . Even going out to a visit they strip you down. When you're coming back from a visit they strip you down. Sometimes no lie your name will get called for a visit and you're waiting two hours to go to your visit.”
- “No challenges with [visitation]. No, i didn't have any visits. I would prefer them not to.”
- “He's seen his kids about three or four times in three and a half years.”

- “Just knowing that there’s only an hour to talk about everything that you want to talk about and then when you get that five-minute warning at the end, it tells you only have five minutes left to talk. It just scrambles your entire thought process.”

- “Yeah because every time you go down there you’ve got to take off all your clothes so they dehumanize you. Then all of a sudden you can’t hug longer than a certain amount of time. You can’t touch somebody. That’s the thing that keeps you kind of , like you just get to see this person’s face and talk to them but you’re not able to you know it’s really blurry. It’s a blurry time. Its dehumanizing”

- “I brought the kids down for a visit, and they were denying me a visit because I had sandals on. I’m like, “What? Can’t he see my toes?” Luckily I went out to the car and I had a pair of tennis shoes in the vehicle, so I ran out and I changed my shoes. I got back in. Couldn’t pass the scanner because I had a wire bra on. I was like, “Oh, my god.”

Impact of Incarceration

- “I feel like prison made me worse.”
- “Just make me feel less of a man.”
- “Just the whole experience of being incarcerated has a physical, mental, emotional impact on someone’s life.”
- “Both men had to totally re-establish relationships with their children and their siblings and find a new way to walk in the community.”
- “Even the programs that they offer isn’t equitable between one correctional facility to another correctional facility.”

- “I don’t have any spiritual or emotional wellbeing. I’m just in survival mode all the time.”

- “It’s very dehumanizing not to be able to touch.”

- “I have a speech disorder now...I had a beautiful voice, and just through having different trauma, I now have a speech disorder where my voice sounds shaky, and it sounds like I’m about to cry, and it sounds emotional, and there’s no physical reason that I’m doing that.”

- “When I first got out, I would recoil if someone tried to touch me, because you can’t touch each other, and they’re so strict about it, so when my family was going to give me hugs, I was pulling back, and that was hard.”

- “...some of the impact also is self isolation, to keep yourself in survival mode”

- “The only thing good for me, the whole four plus years I’ve been in prison was I was sober, but then I wasn’t getting the mental health things that I needed while I was in prison” On Family Members:

- “I already had chronic illnesses and so I feel that things did not improve and I am now disabled, and sought mental health services for myself to cope.”

- “Because it impacts his ability to find work once he gets out. Finding housing once he gets out. To mend his family once he gets out. So the impact is life long.”

● “His being locked up brings on anxiety. You always worried about them. Who they’re interacting with, in authority and other inmates...I already have high blood pressure issue anyway. And I know that over time back and forth I’ve had my high blood pressure get worse when he’s behind bars.”

● “The long term is that I am always anxious about him, because it impacts his ability to find work once he gets out , find housing once he gets out to mend his family once he gets out . so the impact is life long.”

● “There’s a missing link. There’s division. A family can’t be whole and restored if there’s a missing link there. You’re always worrying.”

Nutritional Health

● “They had food marked ‘Not for human consumption’. They were giving us old pudding from 2007. I mean, it clearly said it on the label...It was expired food. And then along with the other food, most of the meat was not for human consumption.”

● “The first one came home obese and never had a history of obesity.”

Environment

● “I was incarcerated at Duluth at this time that floor got took up...and there’s probably gonna be a thousand other guys that were there at that time [2012 to 2015], that got something in their system. And they had to go in there and they had to have a team actually come in, spray and clean down the up the floor with masks on, why are you letting us walk through there to workout?”

● “There’s a lot of mold in the shower rooms where I was at.”

● “One of the units that I was staying in, just now got shut down ‘cause it had asbestos in it.”

● “I feel like with the DOC, it’s a system that’s designed. It’s almost like marketing. Marketing human beings to actually get their facilities paid through the government. So of course they’re gonna make a way for you to ... If you’re not mentally strong enough or educated for you to be around that same environment, but 100 times worse than it is on the outside that caused you to get in there, because they want you to feel like there’s no way out”

Reentry/Recidivism

● “Lack of direction. If you don’t have the proper support, you know. If you don’t know how to use the resources they do give you coming home, then I think that’s what makes it easy to possibly fall back into a lifestyle that’s not productive. You know, legally productive.”

● “They call it the Department of Corrections but they don’t do a lot of correcting, it’s a lot of housing and a lot of punitive stuff but not a lot of rehabilitation. It seems like there’s a better way to spend our resources.”

● “... as you starting over , if you never worked , then you gotta work. There’s always a...you got the half-way house to help you. One thing about the half -way house I can say is, the half -way house actually has some good resources. So, it’s just all about getting reacclimated and adjusting to being normal.”

● "...So once they see you its professional care of course , but it's seeing you in a timely fashion for, I've seen people have real problems with stuff and not seen at a proper amount of time because of all the protocol you have to go through in order to be seen."

● "It's a mindset, because prison is a whole different life. You can't come out to a society that you're institutionalized. There is such a thing as being institutionalized. That's what happens. You get out with \$100 gate money. What skills do you have, except for hustling. You know how to hustle real good."

Recommendations

- "I think you'd have to disrupt the whole system."
- (responding to what will make the services adequate or professional)- "Dental, because it's my understanding right now they only get that for emergencies . so there's no type of hygiene care, or preventable you know preventable care."
- "Oh and Vision that's another one ... In there it's pretty much only by request."
- " You have to have your family support, 'cause I've done about five years without any support, just about half the time without any support. And it really gets to you, especially in prison. Especially if you're around people that go to visit. Like visiting is very important in prison. And case workers look at that, too."

● "When I was working in the healthcare system as a provider, with people not incarcerated, it was very clear that the trust you have with a provider is super important. Because when patients go to the doctor, we already have an idea - what we have. We already have checked with auntie, cousin, neighbor, internet - have an opinion about what we need for treatment. If that human connection doesn't happen between the patient and the provider - if the trust is not built. What I was seeing in this narrative was even worse, because if you are dehumanized and there is no compassion or respect or dignity - that human connection is impossible."

● "Providing adequate, qualified, trained medical staff to provide healthcare. Separating the policing nature of making sure someone is following/being the 'inmate you're supposed to be' - granted that their security is a concern too - there has to be a way to keep that in mind without getting rid of compassion."

General

- "They're too busy trying to lock everyone up, because it's a business."
- "Well, justice is blind, but that bitch can smell money."
- "You're supposed to be tried by a jury of your peers and I don't know how white people are native people's peers. They're not. The odds of us going into a jury and finding somebody who's Native American on that jury is nil to none."

Appendix B: CBPAR Team Reflections

CBPAR team members reflected on the research process as we were nearing the end of the project. These are provided here as anonymous reflections.

1. Reflecting upon my experience while conducting interviews and being involved in the listening sessions with family members of currently and formerly incarcerated loved ones as well as formerly incarcerated persons themselves for the VRJ Healthy Equity and Incarceration Report, I have a better understanding of the larger scope of how mass incarceration fractures not only those directly impacted but how it weakens the very fabric of families and communities. Although I had seen first-hand how my own family and the families of friends have been affected, I now know that the individual and overall impacts of incarceration are much deeper and more intricate than I previously thought.

I was blown away by not only the things that were shared but also by the fact that many of these had not been shared with their loved ones. In an attempt to protect and not burden those they cared for, both the previously incarcerated and family members of incarcerated loved ones, would not or could not bring themselves to share the extent of the pain they endured from all many elements that are part and parcel of the system of incarceration. In truth the very systems of communication, and designated time allotted for communication, are barriers to having significant conversations about health and well-being.

It has become very clear to me that every facet of incarceration has an impact of the overall health of those incarcerated.

The health of family members of the incarcerated is impacted not only while they suffer for the duration of their loved one's sentence but also while they piece their lives back together after returning home. And the cycle continues with recidivism. The trauma upon the community is the sum of the multitude of families impacted by incarceration.

Now more than ever I believe that incarceration is in no way conducive to positive health outcomes. The system of mass incarceration could not exist in the manner that it does if those who enforce it saw those incarcerated as human beings and provided them with the medical and mental health care that they themselves would demand if they were in the shoes of an incarcerated patient. I have never heard of a sentence given that included forfeiting health as penalization, but unfortunately this is overwhelmingly true for many of the currently and previously incarcerated Human Beings.

2. Being a part of the process of putting together this report has reminded me of the beautiful and necessary nature of community. At times, a 'project' or 'task' can feel in one's head like just that - a project. Time with the research team working on this, however, became routine time in community, in service to the larger community, which is so valuable. Qualitative, anecdotal, and community led research is so powerful, and is the basest sense of evidence that we can have as we tackle our social and societal problems. Design thinking teaches us that impacted stakeholders are the most valuable experts in collaboration for a brighter policy future, and it is vitally true in the case of rethinking and transforming how we rehabilitate in this nation. This process has been an important reminder to reflect on privilege and to keep thinking about incarceration.

Mass incarceration is so clearly tied to racial and social justice, and yet these institutions at times fade into the background in important conversations. Prisons are not invisible. Millions of people (and millions more when you account for families, friends, loved ones, people who work in corrections, etc. are impacted by the prison industrial complex, and we must continue work to envision and build a future of transformative rehabilitation and justice, and a more loving community writ large. With gratitude for the process and the people. <3

3. To be part of this Community Based Research Action project has been a humbling experience for me. One of the most beautiful things of this work has been to be part of a multiracial, multi-ethnic and multi-generational research team. The intentional partnership created between community members directly affected by the issues of mass incarceration and the staff of Voices for Racial Justice staff has been a unique experience and adventure, where we all have learned and growth a lot.

For instance, we have experienced the deep impact and pain and trauma that this experience has had on the different members of the team. It is clear that each member of the team has been impacted at different levels, and even though individuals currently incarcerated are the ones dealing with the most direct experience, formerly incarcerated and all the family members of currently and formerly incarcerated are also very deeply touched and impacted by this experience as well. But despite all of the odds of this experience, it has been life giving to experience the power, the solidarity, the tenacity, the resilience, and the willingness of every member of the team to overcome every single obstacle we have to deal with.

4. Sometimes my heart stops, but I don't die. I won't die. I remember. "Do you want me to send you an animal back to you or a human being?" Who are you calling an animal? Dear corrections officer, are you willing to say that in a public forum? That's what I want to know. I want you to subject your statements about human beings being animals to a public forum. PLEASE!!! "Minnesota doesn't have solitary confinement...we have segregation!" As if the distinction makes any difference. Who cares about the distinction? I toured the facility and felt like I was at the zoo. I saw my brothers looking at me behind small glass rectangles on metal doors. I was looking at them too. I wanted to know what happened. I heard somebody on the tour with me tell the corrections officer, "Thank you for all that you do." She whispered it.

She didn't share those thoughts with the rest of the group. Why not? Was she being sneaky? Is she an imposter? Why didn't you share your thoughts with the rest of us lady? But you act like you're with us. You act like you care about ending mass incarceration. Do you? I'm sure you do, but just in a different way. Are you willing to subject your statements to that correctional officer to the public square? Are you? If not, shut up! Why did you tell that officer "Thank you for all that you do?" Only you know. Or do you?

5. Upon invitation to work on the Heath Equity Report, which would delve into discovering what adequate care was according to the Minnesota constitution, I first thought I would learn more about health care in prison and secondly, it would ease some of my concerns about my son's health during his incarceration. Lastly, I would be able to conduct some one to one interviews with people dealt with incarceration first hand and that would enlighten me to incarceration on a personal level, the project seemed simple.

I had dealt with my son's incarceration, he had been incarcerated for 15 years and I had learned so much already, or so I thought.

I was wrong , I was very wrong in assuming that what I would do would be simple or ease my concerns about my son's health while incarcerated but it was far more than a learning experience. It had taken a very tough emotional toll on me. My first few interviews revealed to me the reality of incarceration so clearly hidden from society and the main stream and even from families who have loved ones incarcerated. It revealed to me, through others, that my son had been, until now, unable to share and transfer the emotional and psychological aspects of incarceration between each other. This came forth as others whom had no personal relationship to me in the process of the work the disclosure between the two of us of our incarceration experiences. In doing so a connection of trust was made that gave room to share and feel and express in a space not privy to those outside of it.

The discoveries of those suffering beyond that of the punishment of their " deprivation of Liberty " of which I quote because it was a term I learned in the process of this work, that a sentence of time for the conviction of a crime is exactly that. Instead, I was finding that not only were people being deprived of liberty but of sanity, of nutrition, humanity, compassion, dignity, and adequate health care. Instead they are subject to expired food, food that is labeled "not for human consumption," subject to isolation during grief and mental strife when they should be given compassionate care and counseling , deprived of appropriate medications for serious acute or chronic and mental health conditions due to budget constraints misdiagnosed or improperly or not diagnosed at all for medical conditions, mental health and mental illness is unaddressed and healthy people and staff are subject to this and

people who suffer from it are inhumanely treated because of it and mistreated. People are coming away from incarceration unhealthy, physically and mentally due to the trauma of incarceration because of unaddressed physical and mental health care needs, and a lack of proper nutrition, not just standardized and good healthy and unexpired consumable food but foods that people with acute or autoimmune or chronic illness should be consuming most of which is caused while and due to incarceration methods. The gravity of the findings in the conversations I have had and the voices I have heard in our sessions is painful to hear and being that these people are no longer incarcerated and have nothing to gain from telling their stories except to retraumatize themselves, leaves me to believe each one of them and leaves me gravely concerned for all incarcerated people.

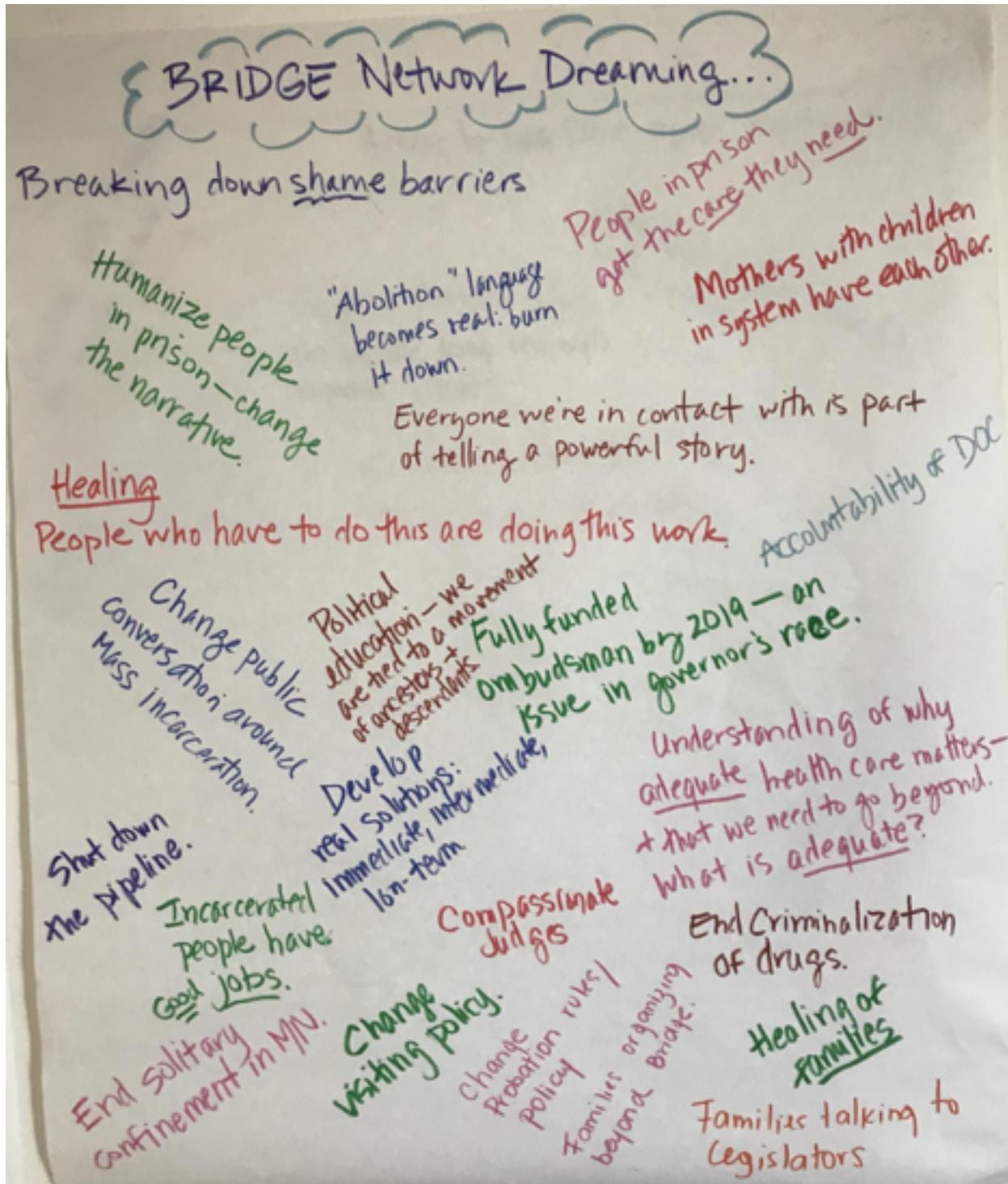
The faces I have seen, the feelings and emotions and blank stares I have witnessed and obvious pain in these interviews takes no expert to see or define.

The Department of Corrections is, or so I thought, to correct or rehabilitate and yes hold accountable , however how are we to be ok with destroying, destructing and dehumanizing and then release and expect people to return to society and reestablish, rebuild and contribute to community and society in a better state of mind. I found myself very concerned not only for my son but for all people incarcerated and also for the people who must work in a system that promotes the treatment of fellow human beings in such a way because we are all subject to each other and 90 percent or so of all of the folks who do time in will come back to our communities ...

Little do we know how much we contribute to the society we live in while we let the conditions such as these continue, this work was heartbreaking and terribly revealing and opened my eyes in ways I had not imagined especially on a psychological level. Hearing about programs in prison was helpful many were a plus, yes we have come far from punishment in historical review but considering the mentality of prison and the current modalities of operations as it pertains to health care and preventative health this work has presented to me that the DOC is not turning out better human beings but is in fact breaking people down mentally... there have been some who have found themselves in prison they return to society lost and those who have entered prison whole often return to society struggling to maintain due to the mental conditioning and lack of proper health care, The DOC would do well to revisit ways to provide proper preventative care with regular physicals to address chronic and acute conditions and provide basic and proper nutritious foods and take a strong look at mental health and provide onsite counseling and mental health care in order to ensure that persons who are incarcerated are healthy in mind and body so that when they are released they are able to return to society and be productive rehabilitated and connected and for the most part healthy people in mind and spirit.

Appendix C: Vision Picture

Early in the research the CBPAR team had a conversation about our vision for this project and addressing the issue of mass incarceration. This is an image of the notes taken during this conversation.



Appendix D: Sample Questionnaire for Participants

The Impact of Incarceration on the Wellbeing of Currently and Formerly Incarcerated Persons, their Families, and the Community

Background

Voices for Racial Justice works to promote racial equity and end racial disparities in Minnesota. We are engaged in a community based research project about the impact that mass incarceration has on health. This project is funded by the Minnesota Department of Health (Advancing Health Equity Initiative). Our expected completion date is before the end of 2017.

Context

To understand the impact of incarceration on health, we are interested in hearing from those closest to the experience of mass incarceration: currently and formerly incarcerated individuals and their families. We are also having conversations with those who work in the corrections system.

Methodology

In addition to these conversations, we will host community listening sessions to hear the stories of people most impacted by incarceration. It is our hope that these listening sessions will provide answers to two central questions: (1) How has incarceration impacted your health and wellbeing? And (2) how do you define adequate and professional health care services?

This conversation will support the creation of new narratives and solutions to the issue of mass incarceration and its impact on the health and wellbeing of currently and formerly incarcerated persons, their families, and the community.

Thank you for your willingness to be part of this project. This project is part of the intentional effort to build a network with individuals from the community who are interested in solving issues around mass incarceration and other social issues.

Voices for Racial Justice Team

Please contact Voices for more information.

NOTE: When sharing the stories and information collected throughout this project we will NOT use real names.

Directions: Please fill out this questionnaire to the best of your abilities. The questionnaire is voluntary and all information gained will be anonymous unless consent is given. Participation in this project is voluntary. Your decision whether or not to participate will not affect your current or future relations with the Minnesota Department of Health ,the Department of Corrections, the State of Minnesota, or your participation with Voices for Racial Justice. If you decide to participate, you are free to leave blank any question or withdraw at any time without affecting those relationships.

1. Demographic information about your family member

Is your family member currently incarcerated or formerly incarcerated? _____

--- If currently incarcerated, which correctional facility is he/she at? _____

Total sentence: _____ How long time has he/she served already? _____

If formerly incarcerated, which correctional facility(s) was he/she at? _____

How much time did he/she spend in the correctional facility? _____ When was he/she released from the correctional facility? _____

What is the relationship between you and your currently/formerly incarcerated family member (e.g., son, mother, significant other, close friend)? _____

A. What is the ethnicity/race of your incarcerated family member? (Check all that apply)

_____ African American/Black _____ Latinx/ Hispanic
_____ African Immigrant _____ White European American
_____ Native American/Indigenous _____ Asian/ Asian American Other _____

B. Did your currently/formerly incarcerated family member and/or his/her parents relocate to the U.S from a different country? ___ Yes ___ No If yes, from where? _____

C. What language(s) does your currently/formerly incarcerated family member speak? _____

D. What is the age of your currently/formerly incarcerated family member? _____

E. What gender does your currently/formerly incarcerated family member identify with? (Check all that apply)

_____ Female _____ Male _____ Other
_____ Transgender _____ Genderqueer _____ Decline to state

F. What sexual orientation does your currently/formerly incarcerated family member identify with? (Check all that apply)

_____ Two Spirit _____ Heterosexual _____ Gay _____ Lesbian
_____ Bisexual _____ Queer _____ Other _____ Decline to state

G. What health condition(s) (mental, physical, and/or learning) did your currently/formerly incarcerated family member identify as having prior to being incarcerated? (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Post- Traumatic Stress Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Learning Disability _____ |
| <input type="checkbox"/> Inflammation | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Autoimmune Disease _____ |
| <input type="checkbox"/> No prior health conditions | <input type="checkbox"/> Other _____ |

What health condition(s) (mental, physical, and/or learning) did your currently/formerly incarcerated family member identify as having during your stay at the correctional facility? (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Post- Traumatic Stress Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Learning Disability _____ |
| <input type="checkbox"/> Inflammation | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Autoimmune Disease _____ |
| <input type="checkbox"/> No prior health conditions | <input type="checkbox"/> Other _____ |

What health condition(s) (mental, physical, and/or learning) your currently/formerly incarcerated family member identify as having after leaving the correctional facility? (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Post- Traumatic Stress Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Learning Disability _____ |
| <input type="checkbox"/> Inflammation | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Autoimmune Disease _____ |
| <input type="checkbox"/> No prior health conditions | <input type="checkbox"/> Other _____ |

H. What area/region/city of Minnesota does your currently/formerly incarcerated family member consider home? _____

I. Zip Code (Home) of your currently/formerly incarcerated family member _____

2. Demographic information about yourself

A. Ethnicity/Race of you: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Latinx/ Hispanic |
| <input type="checkbox"/> African Immigrant | <input type="checkbox"/> White/European American |
| <input type="checkbox"/> Native American/Indigenous | <input type="checkbox"/> Asian/ Asian American |
| Other _____ | |

B. Did you and/or your parents relocate to the U.S from a different country?

Yes No If yes, from where? _____

C. What is your age? _____

D. How do you identify your gender? (Check all that apply)

- | | | |
|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Female | <input type="checkbox"/> Male | <input type="checkbox"/> Other |
| <input type="checkbox"/> Transgender | <input type="checkbox"/> Genderqueer | <input type="checkbox"/> Decline to state |

E. How do you identify your sexual orientation? (Check all that apply)

- | | | | |
|-------------------------------------|---|------------------------------|----------------------------------|
| <input type="checkbox"/> Two Spirit | <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Gay | <input type="checkbox"/> Lesbian |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Queer | | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Decline to state | | |

F. What health condition(s) (mental, physical, and/or learning) do you identify as having? (Please check all that apply)

- G. Diabetes Mood Disorder
H. High Cholesterol Post-Traumatic Stress Disorder
I. High Blood Pressure Learning Disability _____
J. Inflammation Sleep Disorder _____
K. Depression/ Anxiety Autoimmune Disease _____
L. No prior health conditions Other _____

M. What area/region/city of Minnesota do you consider home? _____

N. Zip Code (Home) _____

3. Experiences of family member(s) within correctional facilities

Is your family member: _____ currently incarcerated? _____ formerly incarcerated? (check all that apply)

Has your incarcerated family member ever been transferred to other correctional facilities? ___ Yes ___ No

How many times? _____ What are/were the reasons for being transferred to other correctional facilities? _____

I understand what is adequate and professional healthcare? ___ Yes ___ No (Check one)

1. I think the health care services provided in the correctional facilities meet the needs of incarcerated persons in Minnesota. (Circle One)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
-------------------	----------	---------	-------	----------------

2. I think the health care services provided for the general population (people who are not incarcerated) meet the needs of people Minnesota (Circle One)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
-------------------	----------	---------	-------	----------------

3. I think the mental health services provided in the correctional facilities meet the needs of incarcerated individuals in Minnesota. (Circle One)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
-------------------	----------	---------	-------	----------------

4. My family member visited healthcare providers while incarcerated. (Circle One)
Never

Never	Rarely	Sometimes	Occasionally	Often
-------	--------	-----------	--------------	-------

4. Questions for conversations with family members

Before we start our conversation it is important to keep in mind that in the United States, “prisoners have a constitutional right to adequate health care.” Minnesota law, however, provides little guidance about what is adequate care and requires only that the Commissioner of Corrections provide “professional health care” to incarcerated persons. As mentioned, one of the goals of this project is to define what adequate and professional health care means.

1. When thinking about the health care services that incarcerated persons should have, what characteristics or conditions will make those services meet the needs of incarcerated people (in other words, what will make the services adequate and professional)? _____

2. Has your family member been treated with compassion, respect, and dignity by the health care provider(s) in the correctional facility? Please explain.

3. How has the incarceration of your family member impacted his/her overall mental, physical, emotional and spiritual well-being?

4. How has the incarceration of your family member impacted your own overall mental, physical, emotional and spiritual well-being?

5. When thinking about the impact that incarceration has had on the wellbeing of your family member, what was the immediate impact? Have you seen any lasting or long term impacts? If yes, what are they?

6. What kind of healthcare services have your family member received while incarcerated?

7. How often were/are you able to visit your family member? What are/were some of the challenges in visiting him/her?

8. If your family member was in solitary confinement, could you talk about the impact it has had on his/her wellbeing?

9. What recommendations do you have for the DOC to keep incarcerated persons healthy?

10. What would make you interested in developing and/or deepening a relationship with us to work on issues of mass incarceration? (Check all that apply)

Health Care Services
 Visitation
 Employment Services

Mental Health Services
 Housing Services

Re-Entry
 Solitary Confinement
 Deepening Community Relationships

Reinstating Ombudsman Office for Department of Corrections Other _____

Contact Information: Name: _____
Email: _____ Phone: _____
Could we contact you in the future? ___Yes ___No

Appendix E: Letters from People Incarcerated

In March 2016, we received letters from people incarcerated about their experiences with healthcare in Minnesota prisons. This table summarizes the information in those letters.

Preliminary Qualitative Analysis of Twelve Inmate Letters Describing Their Experiences in Healthcare Inside Minnesota Prisons

Methodology:

This report is a qualitative analysis of twelve letters sent in March of 2016 by inmates of several MN prisons to Voices for Racial Justice. This was as an attempt of VRJ to include the voices of incarcerated individuals in MN correctional facilities, as part of the ReThink Health report project run by MDH. These letters revealed the poor health care they receive in prison. We read letters comparing them in terms of content and structure to establish potential similarities and patterns. We were able to establish the common topics in the letters: health problems affecting inmates, time to response by health personnel, treatments if provided, consequences of the treatment or the lack of treatment and, finally, the intervention or complains by family members to the prison system. We elaborated a table to summarize and display information provided by inmates in the letters. The table shows a transcription of information written by inmates, organized according to the topics described above.

Results:

The findings were as follows:

1. **Health Problems:** 3 inmates reported shoulder problems; 2 had knee injuries; 1 back problems; 1 inmate reported abdomen pain that later resulted in a kidney stone; 1 inmate reported a cold that later resulted in pneumonia; 1 reported a neck problem; 1 had a broken leg; 1 suffered a dislocated hip; and 1 inmate suffered from dry eyes.
2. **Health Service's Response:** 8 inmates reported delay in receiving assistance or delay in seeing a specialist they thought they needed; 3 inmates reported being denied an MRI; 3 reported that they did not have an x-ray in their medical consult, 2 reported no surgery when needed according to them, 1 inmate reported absence to dry eye medication.
3. **Family Intervention:** 3 inmates received support from their relatives regarding phone calls, formal complaints, or others.
4. **About Sending Kites:** 3 inmates sent kites.

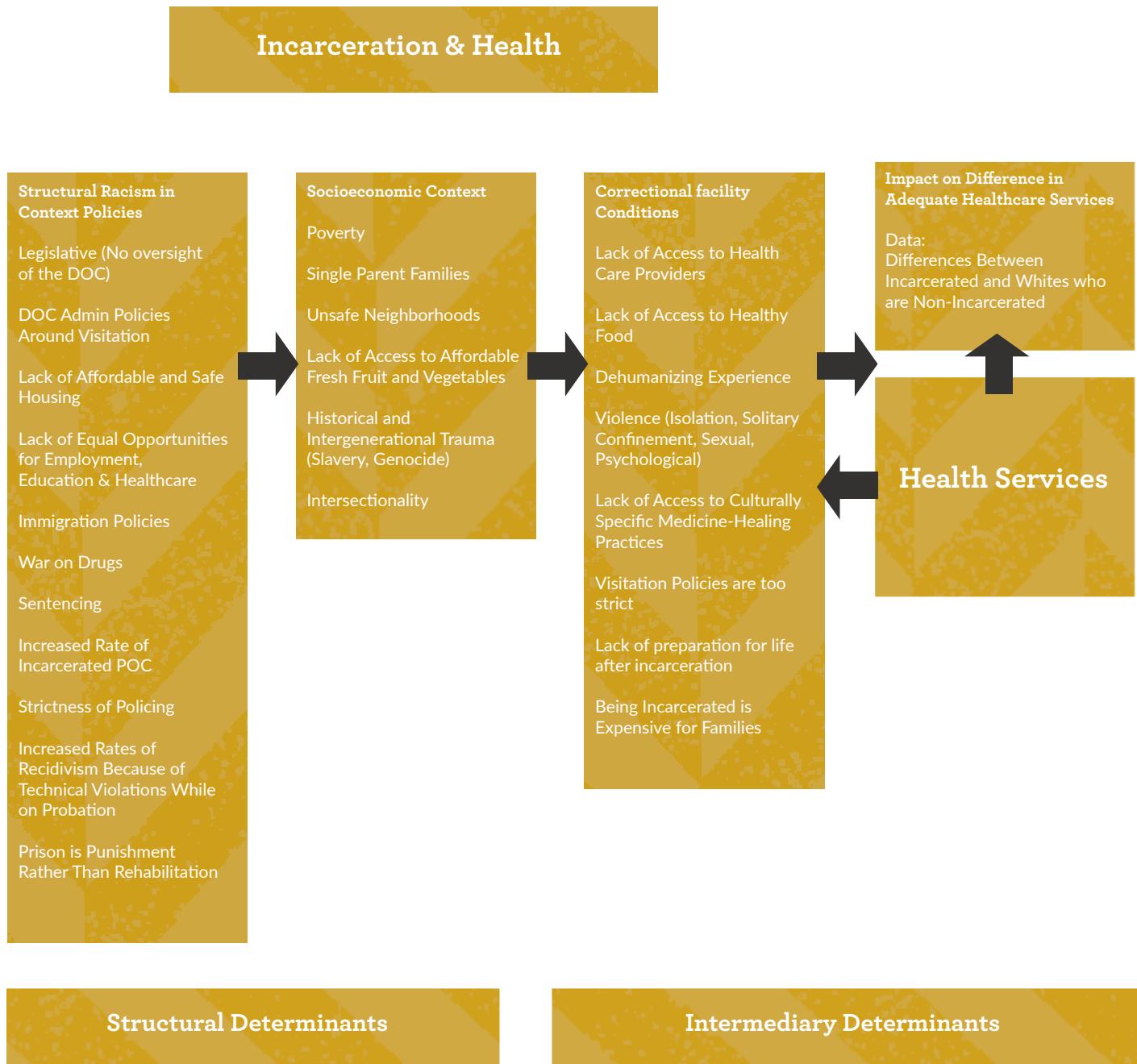
Selected Quotes:

Finally, we include extracts of some letters, which in general exemplify the reality of the healthcare system inside prisons.

1. "...I believe that the people who are responsible for my health care should have thought of me as a human being, and not a number or dollar sign".
2. "Over the years healthcare in prisons has declined tremendously. I've never witnessed so many deaths and lack of commitment to help us maintain our health while in prison." (L1)
3. "I've seen men walk on broken bones and it wasn't until it became unbearable that anything was done." (L2)
4. "Since the private sector has taken over, things like x-rays, M.R.I, were common for men who usually come to prison injured from some ailments. Now you can't even get your teeth cleaned, it's been almost 10 years since I had my teeth cleaned." (L2)
5. "No matter what the diagnosis is you'll probably receive Ibuprofen". (L3)
6. "The only time they'll see you right away is to pull your teeth not to save them." (L3)
7. "The implicit bias of "criminal" I believe prevents the doctors and nurses to give me adequate medical attention" (L4)
8. "...in my experience the custom has been that you are criminal first and a patient 2nd. The psychological effect of years of that does something to your morale it will make you believe that you are a criminal first and a human being second". (L4)
9. "What I have seen is for-profit health service companies do their best to not have to pay for the necessary health service needs of the men and women who live in these places". (L5)
10. "I will have done twenty-three years behind bars when my sentence is over. Most of my family has passed on. I just want to get out and be healthy, and be the person I have worked to become, and not be irresponsibly damaged by the experience". (L5)
11. "This is extremely frustrating given the fact that with proper treatment I would not be in most of the pain I am in now..." (L8)
12. "...D.O.C. health staff that seem to only be concerned with the care of the "operating budget" rather than with the care of the patients that they are legally, morally and-supposedly- humanely responsible for." (L8)
13. "Also the reputation of health services being that it's a joke and all their going to give you is some ibuprofen and an ice pack with a 5 dollar bill." (L10)

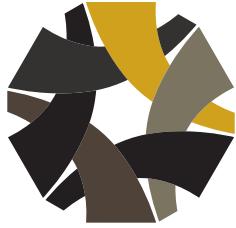
14. "While the D.O.C. continued to use every delay tactic they could trying to avoid surgery I was prescribed ibuprofen for the pain." (L10)
15. "It's hard to decipher what's more painful: the brilliant pain in my unhealed shoulder, or the absurd health coverage I received from the professionals entrusted with my care. Both will serve as a constant reminder of the reality of my incarceration." (L12)

Appendix F: World Health Organization Framework



Structural Determinants

Intermediary Determinants



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