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Life in Prison:
Biopolitics, Ill-Being, and the Neoliberal Penitentiary

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Abstract

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In the US today, 2.3 million prisoners have a constitutional right to healthcare. At the same time, policies driven by neoliberalism and White supremacy have ballooned US prisons, incarcerating largely the working and workless urban poor. This dissertation investigates this juncture through a case study of prison healthcare in Washington state prisons – both its everyday practice and its administration. To do this, I employ policy analysis alongside interviews with state actors, prisoner advocates, and formerly incarcerated women and trans folks. I make three claims.

First, I argue that the prisoner’s ostensible right to healthcare depends upon a particular form of what I term ‘carceral biocitizenship.’ Both prison policy and prison healthcare enable and result from a double ontological violence: first, the incarcerated person’s biological being is divorced from its political context or agency; second, the incarcerated person’s biological needs are devalued according to a penal hierarchy of human value.

Second, I argue that nutritionist ideologies have been central in enabling the project of mass incarceration. Over the past two decades, Washington state has combined nutritionist ideology with neoliberal rationalities to slowly marketize its prison food system, producing a malnourished prison food system harmful to prisoner health, well-being, political life, and dignity. Now, the state is finally reforming its prison food. Yet, bureaucrats have taken nutrition science as the *only* paradigm for ‘healthy’ food. As a science based in White, middle-class food habits, however, nutrition science privileges (cis)sexist, classist, and racist ideals of health. Reform efforts that seek to improve prison food within state-sponsored frameworks reinforce the carceral state and its biopolitical control.

Third, I argue that prison creates a care deficit marked by carceral isolation, expropriation, and organized abandonment. To compensate for this crisis of care behind bars, the prison then coerces and expropriates incarcerated people’s unpaid care labor as stopgap. For their part, incarcerated women and trans folks respond to this care crisis through myriad practices of counter-conduct aimed at survival, autonomy, and the pursuit of a good life in a bad life.

In my conclusion, I address the implications of this analysis for prison abolition.

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Abbreviations

ACA	American Correctional Association
ACFSA	Association of Correctional Food Service Affiliates
ADLs	Activities of Daily Living
AHA	American Heart Association
ARNP	Advanced Registered Nurse Practitioner
BMI	Body-Mass Index
CI	Correctional Industries
CO	Correctional Officer or guard
CRC	Care Review Committee
DGA	Dietary Guidelines for Americans
DOC	Washington State Department of Corrections
DOH	Washington State Department of Health
DSM	Diagnostic and Statistical Manual of Mental Disorders
EO	Executive Order
FDA	Food and Drug Administration
FPE	Feminist political economy
HNGs	Health Nutrition Guidelines
HS	Health Services
HSD	Human Subjects Division
HSR	Health Status Report
IRB	Institutional Review Board
LWOP	Life without the possibility of parole
MCS	Multiple chemical sensitivity
NCCHC	National Commission on Correction Healthcare
OB/GYN	Obstetrician and gynecologist
OCO	Office of the Corrections Ombud
OHP	Offender Health Plan
PAR	Participatory action research
PIC	Prison-industrial complex
PLRA	Prisoner Litigation Reform Act
PRA	Public Records Act
PVW	Prison Voice Washington
RDC	Reception Diagnostic Center
RDI	Recommended Daily Intake
RDN	Registered Dietician-Nurse
RPP	Residential Parenting Program
SNAP	Supplemental Nutrition Assistance Program
TEC	Treatment and Evaluation Center
USDA	United States Department of Agriculture
WCCW	Washington Corrections Center for Women or Purdy
WSIRB	Washington State Institutional Review Board

Carceral Care: Mapping the Biopolitics of Health in a Neoliberal Prison

If you really want to understand a system and make significant change (and not just manage symptoms), you must look away from what appears to be the immediate crisis and toward the crisis that is at work even when the system is functioning well. This crisis constitutes the system itself; the system cannot function without its internal crisis...Crisis is not what happens when we go wrong; crisis is what happens when we go right.

- Eric Cazdyn, *The Already Dead*

“I asked for them to X-ray my jaw after I got assaulted. They didn’t do it.” In 2010, Morgan was a prisoner at the Washington Corrections Center for Women (WCCW), nicknamed Purdy (see figure 1), when she was attacked by a fellow prisoner. “I got assaulted ... my arm, everything ... I was laying on my side.” The woman stomped her boot into Morgan’s face nine times, breaking her jaw. “So, she went straight to the hold” and Morgan “went straight to Health Services¹,” where a nurse examined her while a nearby guard stood watch. “My face was like swollen. They gave me ice. They put me on like three days of not working. And they sent me on my way.” Morgan laughs as she tells me all this, her guffaws inflected with rage.² “They wouldn’t X-ray my face. They never took pictures.” Indeed, it would be years later, after leaving Purdy, before a medical professional confirmed that Morgan had indeed had her jaw broken³. “They didn’t give me anything else. The nurse felt so bad the next day that she actually came up to my unit and brought me medicine. Brought me Ibuprofen. Because I was such a mess.”

Morgan lay in her bunk in pain for three days, after which she was forced to resume her prison job and programming. Yet, her pain persisted. “My jaw was *stuck* ... and I was having all this

¹ “Health Services” can refer to the Washington State Department of Corrections Health Services, to prison healthcare workers, or, as Morgan does here, to the prison clinic as a place.

² “Almost all great literature on [bureaucracy] takes the form of horror-comedy” (Graeber, 2014: 53).

³ Morgan also later learned from a guard that prison staff had either lost or destroyed the video recording of her assault.



Figure 1. Washington Corrections Center for Women from above.
Source: Washington Department of Corrections

pain radiating down my neck and stuff.” Desperate and hurting, Morgan called her mother, Teresa, who worked as an Advanced Registered Nurse Practitioner (ARNP). “She’d call me,” Teresa explained. “‘What can I do for this and what can I do for that?’ And I’d say, ‘Ask the nurse or the doctor if you can do this. Tell them to give you muscle relaxers’” (personal interview, 2017). Morgan followed her mother’s advice and, after sending several kites⁴, she received a prescription for muscle relaxers “and those helped,” Morgan told me. Health Services (HS) still refused, however, to X-ray Morgan’s face.

“Even if your foot is hanging off of your leg and you say ‘Can I get X-rayed?’ [they will say] ‘The X-ray person will be here in two weeks from Thursday. We’ll see if we can fit you in.’ They’ve got the X-ray machine right there, but they won’t ... They’re gonna X-ray you

⁴ A “kite” refers to any written or electronic communication between an incarcerated person and a prison employee.

before they send you off to the hospital. If it's an emergency or something that's *bad* they'll X-ray you. That's about it."

When she visited the prison clinic, staff would tell her "'Meh. You're fine.' They were trying to convince me that I was okay. Dude, my jaw's locked up right now. It's not moving. It's been kicked *nine* times, and I can't like open it all the way."

Morgan made sure to "leave a paper trail." She kept meticulous records; every kite sent and received, every grievance filed. "So, you kite them," Morgan explained. "You put your room, your name, your DOC number, who it's going to; and then they respond. You get back a carbon copy ... supposedly ... So, everybody's supposed to have a copy. We get a copy. You keep a copy. And the original goes to whoever gets it." Despite this bureaucratic fidelity, Morgan made little progress. "I am sitting here telling you. I am appealing it. I am doing a grievance. I'm saying I've sent kites. I've asked for appointments. And you're ignoring me. I mean, I have tons of grievances that I did 'cause I couldn't get medicine. Or I couldn't get them to help me." At times, a grievance would seem promising, but there was always some policy justifying her rejection. "So, I'd grieve it. Then someone else would review it and then they'd try and help, but then they'd say, 'Well, we're not doing this 'cause you're not covered under this medical plan. You're just gonna have to wait until you get out⁵.'"

Morgan found other ways to soothe her pain.

"I actually had to get medicine on the black market because [the prison] wouldn't help me. I was really sick one time. My head was horrible, and it was after my jaw was broken. Someone had a migraine pill, and I was like 'Give it to me.' So, if you find something that you can get

⁵ During this time, custody staff continually failed to protect Morgan from her assailant, despite a Keep Separate. Rather than follow this order, guards suggested putting Morgan in solitary confinement, a suggestion that only failed after Morgan appealed to the prison administration.

better with, then you *keep* that. Because you know you're not getting anything from [the prison]. Nothing.”

After six months “thinking the prison would fix [my jaw] and they never did,” Morgan had had enough. “I was like “That’s it. We’re good. We’re done.”” Morgan wrote to twenty law offices, heard from a few, and finally found an attorney.

A year after her release, Morgan’s case finally went before a jury. The trial provided a showcase of clinical and bureaucratic dysfunction. When Morgan’s attorney asked one prison doctor, “Don’t you trust your staff?” she replied, “Well, I *should* be able to trust them.” “All the policies, the DOC procedure, that they supposedly have,” Morgan explained, “nobody followed ’em. It was just a train wreck. *Nothing* matched up.” The jury ruled in Morgan’s favor. “They lost,” Morgan relished. “They lost because they lied, and they covered it up, and they finally got caught.”

Despite this legal victory, however, Morgan’s pain persists. “It’s still not fixed ... five surgeries later, still not fixed. When my jaw starts to go out of joint, it pushes my jaw and like scabs. It like all comes, like flares back up.” Tracing a line across her jaw, Morgan explains how her jaw healed crooked. “So, it’s weird how it like just keeps getting worse. So, going to trial and all of the things that happened, it’s still like ... my surgeon said, ‘I don’t know if it’ll be fixed.’ We don’t know.”

What’s Wrong with Rights? Administrative Violence and the Biopolitics of Prison

In hearing Morgan’s story, you might ask *how could this happen?* You might feel shock and outrage. *How could this happen?!* This was not Morgan’s response, however. Nor was it the response of most formerly incarcerated people I encountered. Such a question is more likely to come from the free-world subject for whom prison remains a distant reality. The uninitiated voter, the bleeding-heart lawmaker, even the prison administrator herself, neither criminalized nor incarcerated, clutching her pearls. *This is not normal* she might exclaim. *This is not meant to happen ... especially not in the Pacific Northwest of all places!*

Liberalism cannot account for its own failures (Lowe, 2006; Ranganathan, 2016). Within the framework of liberalism, *injustice* is viewed primarily as an aberration. Liberalism "compares the ideals of the French Revolution—freedom and equality—with their inadequate realization" (Adamczak, 2017: 79) and then attempts to correct what it sees as merely a momentary glitch. With injustice framed as necessarily aberrant, *justice* becomes a simple matter of righting course. Here, consumer choice, access, and individual rights prove popular pharma in liberal thinking. Indeed, those passingly familiar with the U.S. prison system may ask another question. *Don't prisoners have a right to healthcare?*

This appeal is common in popular discourse on prison healthcare, appearing in *New Yorker* exposés (Coll, 2019) and prison healthcare company websites (King, n.d.). As Carolyn Sufrin summarizes, people in prison or jail are "the only segment of the U.S population with a constitutional right to healthcare" (2017: 7). Indeed, the historiography of prison healthcare often begins in the courts with the landmark 1976 Supreme Court case *Estelle v. Gamble*. In 1973, J.W. Gamble⁶, a prisoner at the Texas State Penitentiary in Huntsville, sued his prison doctor, the warden, and the Texas Department of Corrections for cruel and unusual punishment. While the Court ultimately ruled against Gamble, they affirmed that "prisoners [must] be provided with medical care and that deliberative indifference by prison personnel to a prisoner's serious illness or injury violates the Eighth Amendment" (1976: n.p.). *Estelle* established what Sharon Dolovich calls the state's "carceral burden," under which "the state assumes an ongoing affirmative obligation to meet the basic human needs of the people exiled" from society (2009: 892).

⁶ On November 9, 1973, Gamble was working in the prison textile mill when a 500-pound bale of cotton fell on top of him. Gamble was sent to the prison clinic where, after first being dismissed, he was diagnosed with lower back strain, prescribed pain relievers and muscle relaxers, and given a cell pass to miss work for two days (Coll, 2019). After his back pain and high blood pressure persisted, Gamble was placed in the hole for refusing to work, where he stayed for more than sixty days. All the while, prison guards stonewalled Gamble's attempts to see a doctor. Sadly, Gamble was murdered by a fellow incarcerated person several years after his suit.

Estelle and its ensuing wave of prisoner rights litigation initiated what Sufrin terms the “judicialization of the right to health” for people incarcerated in the U.S. (2017: 51; see also Biehl et al., 2012). Over the 1970s and 1980s, courts became “deeply involved in delineating the nature and scope of” prison healthcare (Sufrin, 2017: 51), fleshing out three core rights: the right to access care, the right to receive prescribed treatment, and the right to a professional medical judgment (Rold, 2008). At the same time, courts have placed serious limits on the state’s carceral burden. To qualify as unconstitutional care, prison staff must have been “deliberately indifferent⁷” and have inflicted “unnecessary and wanton ... pain” (Wells and Eaton, 2002: 84-85) resulting in harm “serious” enough to violate “contemporary standards of decency” (Bach, 2013: 21). As such, the courts have defined the prisoner’s right to healthcare as a *negative* freedom from biomedicalized punishment, not a *positive* right to life-affirming care. This distinction hinges on a decidedly liberal imaginary that recognizes individual, intentional acts of violence but finds structural violence to be unintelligible⁸. The result is that prison staff are incentivized *not* to notice harmful conditions because “[i]gnorance cannot be prosecuted” (Sufrin, 2017: 52; see also Burgess and Murray, 2018; Dolovich, 2009) and states are incentivized to outsource liability to private healthcare companies (Wharton Public Policy Initiative, 2017).

In 1996, the judicialization of prison healthcare rights came to an end. Just two years after it passed the Violent Crime Control and Law Enforcement Act, which instituted federal mandatory minimums and three-strikes sentencing, ballooning mass incarceration (Murakawa, 2014), Congress

⁷ Courts have defined deliberate indifference as “action or inaction taken in conscious disregard of a substantial risk of serious harm” (Farmer v. Brennan, 1994). Whereas the Supreme Court ruled Gamble’s mistreatment merely “inadvertent,” deliberate indifference occurs when, for instance, prison healthcare staff intentionally refuse needed medical care or guards “intentionally den[y] or dela[y] access to medical care or intentionally interfer[e] with treatment once prescribed” (Dimitrakopoulos, 2007: 312).

⁸ Legal scholar Jonathan Simon attributes this liberal conception of harm to the limited record under the Court’s review in *Estelle v. Gamble*. Gamble’s complaint addressed only his individual mistreatment and neglect. Moreover, in determining what evidence to consider, the Court divorced Gamble’s individual experience from his structural and institutional context, namely “the health needs of typical prisoners or the adequacy of Texas prison healthcare infrastructure” (2013: 277).

passed the Prison Litigation Reform Act (PLRA). The PLRA was aimed at curtailing prisoner lawsuits, which advocates of the bill painted as frivolous and out of control, despite the fact that lawsuits per capita were actually fewer between 1986 and 1996 than in the decade prior (Booker, 2016; Schlanger, 2015; Vanheuverzwyn, 2009). The consequences were swift and drastic. Prisoner lawsuits fell from 24.6 per 1,000 in 1995 to 10.2 in 2012.⁹ In the early 1980s, 40% of state prisons were under court supervision. By 2005, only 20% were (*ibid*). Most notably for my arguments here, the PLRA further exiled people in prison from the legal system by requiring they exhaust all administrative avenues¹⁰ within the prison (*e.g.*, grievances) before turning to litigation. The legal world of rights was replaced by administrative realm of rules.

In light of this reality, asking *don't prisoners have a right to healthcare?* becomes less helpful, rendered practically moot by what critical trans theorist Dean Spade calls the paradox of rights. "[R]ights mediate emergent social groups, and rights claims often serve as the resistance framework of such groups, yet declarations of universal rights often actually mask and perpetuate the structured conditions of harm and disparity faced by those groups" (2015: 10). Reforms focused on constitutional law, personal discrimination, and individual rights tend to "change only what the law says about what a system is doing, but not its actual impact" (*ibid*: 49). Moreover, while Morgan was able to seek redress through the courts, "most people who experience discrimination cannot afford to access legal help" (*ibid*: 40).

If we want to understand and intervene upon those sites most responsible for large-scale violence, then we must acknowledge "the limitations of demands for individual rights" and move beyond a narrow focus on "intentional, individual bias or violence" (*ibid*: 7). If we want to

⁹ In Washington state, the rate halved from 23.8 per 1,000 to 12.6.

¹⁰ In Washington state prisons, the grievance process has three levels, often taking weeks or months. In addition, prisoners face many informal barriers, including high rates of illiteracy, bureaucratic confusion and fatigue, and retaliation by guards.

understand the systemic crisis that makes individual crises like Morgan's possible, we must turn our attention to what Spade calls administrative violence. Homeless shelters, foster care, the welfare state, agencies like Social Security, health insurance, public bathrooms, and importantly, prisons and jails; these are "the administrative agencies that are responsible for the bulk of government activities that impact the distribution of life chances" (*ibid.*: 15, 73; see also Beaugrand, 2011; Gupta, 2012; Gunneflo, 2012; Tyner, 2014, Tyner and Rice, 2016). As a framework, administrative violence thus relocates our analytical attention from the juridical spaces of rights-based law (*e.g.*, courts and legislatures) to the messy, mundane crucibles of biopolitics (*e.g.*, bureaucratic institutions).

Michel Foucault proposed biopolitics to name the ways "[h]umans were governed as individual biological beings who were at the same time members of a larger unit: 'population,' 'nation,' 'species,' or 'race'" (Murphy, 2012: 13). Before the 1700s, European monarchs tended to approach government in terms of territory, taxation, and political sovereignty over their citizenry. Beginning in the eighteenth and nineteenth centuries, however, states invested in a new site of governance: population. "The objects of biopolitics are not singular human beings but their biological features measured and aggregated on the level of populations" (Lemke, 2011: 5). While sovereign power is defined by the king's power to *take away* from his subjects, biopower is necessarily *productive*. Biopower fosters some lives and ways of living and disallows others. If sovereign relied upon repression, theft, and killing, then biopower manifests itself through calculation, measurement, comparison, risk management, appraisal, security, regulation, and control. These biopolitical functions unfold not within the juridical realm of law but more often within, as Mitchell Dean writes,

"the routines of bureaucracy; the technologies of notation, recording, compiling, presenting and transporting of information, the theories, programmes, knowledge and expertise that compose a field to be governed and invest it with purposes and objectives; the ways of

seeing and representing embedded in practices of government; and the different agencies with various capacities that the practices of government require, elicit, form and reform" (2010: 37).

Under biopolitics, individual discipline and good behavior becomes a tool of population management (Spade, 2015). Public health, for example, combines individualized notions of "healthy living" and hygiene with population-level "[p]olicies governing public health, housing, welfare, and reproduction" (Lloyd, 2014: 14).

Sovereign power has not disappeared, but simply been rearticulated toward biopolitical ends. Repressive power has become "merely one element among others, working to incite, reinforce, control, monitor, optimize, and organize" human life and ways of living (Foucault, 1990: 136). The sovereign logic of *make die and let live* has been subsumed under the biopolitical calculus of *make live and let die* (Lemke, 2011). How to reconcile this paradox between life-giving and death-dealing? For Foucault, the two coexist under the modern logic of "state racism" (*ibid*). If the state supports the well-being of the population, "imagined in principle to be a homogenous biological whole" (*ibid*: 41), then state racism marks the "break between what must live and what must die" (Foucault, 2003: 254). In other words, as Michelle Murphy explains:

"as populations were understood to be made up of internal differences, this variation—marked as race, class, pathology, caste, or even sex—could be differentially governed, enhancing some forms of life, neglecting or actively destroying other aspects of life, to bring forth the desired future of that population" (2012: 13).

When the state defines its national body according to fantasies of social superiority and inferiority, then this "dividing line between 'healthy' and 'sick,' 'worthy of living' and 'not worthy of living'" (Lemke, 2011: 42) puts into motion a process "of permanent purification" (Foucault, 2003: 62). "Biopolitics thus also always involved necropolitics—distributions of death effects and

precariousness—at the same time as it could foster life" (Murphy, 2012: 13; see also McIntyre and Nast, 2011).

Debates on incarceration and the prison have largely turned on this bio(necro)political question: is carceral power fundamentally repressive or productive? For Foucault, the modern penitentiary departed from sovereign logics of punishment, which pursued social order via sparse yet spectacular repressive violence (*e.g.*, public execution). By contrast, the penitentiary operates via a diffuse economy of disciplinary mechanisms, including enclosure, panoptic surveillance, policing, individualization, classification, and normalization, that aim to *produce* a docile prisoner (Foucault, 2012). While the sovereign condemns an undifferentiated multitude, known only by its guilt, the prison disciplines the delinquent, whose correction requires intensive knowledge of the individual¹¹ (Shabazz, 2015).

Feminist, postcolonial, and critical race scholars have all challenged this Foucauldian thesis, as well as its “European race-neutral focus” (Shabazz, 2015: 5). Foucault roots his genealogy in European soil and society, internally undifferentiated and divorced from its ‘foreign’ and ‘private’ affairs: empire, slavery, and sexual violence (Davis, 2003). As a result, Foucault universalizes “the body of the white, propertied male” as *the* subject of carceral power (James, 1996: 25). Yet, even in the nineteenth century United States when, per Foucault, corporal punishment supposedly retreated from society, penitentiaries “were largely designed to punish and reform white wage-earning individuals” only (Davis, 2003: 361). Even after a small number of women’s reformatories were built in the 1880s, they were largely reserved for young White women. Designed to deprive individual liberty, the modern prison was “based on a construction of the individual that did not apply to

¹¹ Though for Foucault the penitentiary exemplifies disciplinary power, he is ultimately concerned with the spread of disciplinary techniques and logics across what he calls the “carceral archipelago” of disciplinary society: prisons, schools, the military, hospitals, and women’s reformatories, to name a few. Disciplinary relations across this archipelago can be compact (*e.g.*, incarceration) or diffuse (*e.g.*, abstract, regimented time). While I focus on the prison institution, fellow geographers have examined the continuum of carceral power across institutions (Shabazz, 2015).

people excluded from citizenship by virtue of their race and thus from a recognition of their communities as composed of individuals possessing rights and liberties” (*ibid*).

Post-Foucauldian critical race scholars have thus placed the penitentiary within the wider geography of racial capitalism, wherein “racism enshrines the inequalities that capitalism requires” in order to continually expropriate, exploit, and accumulate (Melamed, 2015: 77). The U.S. penitentiary came to social dominance in the nineteenth-century, when enslaved people, White women, Indigenous peoples, and other Others had no public standing as citizens in U.S. White supremacist, settler colonial society or as ‘free’ laborer in the burgeoning industrial economy. (Indeed, under bourgeois liberal ideology, citizens and workers are largely the same thing [Glenn, 2010]). These groups were therefore denied the penitentiary’s relative privileges. Their bodies remained the locus of punishment. Even as systemic crises have forced racial capitalism to reconfigure itself, punishment has adapted along with it. Following the abolition of slavery, convict leasing recaptured Black life (Childs, 2015); and in the Progressive Era, prison reforms largely benefitted White men and not their Black cellmates (Muhammad, 2011). The prison thus is and always has been one institution in a wider landscape of uneven social and economic (de)valuation and control (Davis, 2003; Hernández, 2017; LeFlouria, 2015; Shabazz, 2015).

Today, U.S. incarceration rates have reached historic highs, disproportionately targeting Black, Brown, Indigenous, and poor people. In 2019, roughly 2,300,000 people are incarcerated in the U.S. (Sawyer and Wagner, 2019). While women’s prisons comprise only 9.5% of this number (Kajstura, 2018), since the 1970s, women’s prisons have ballooned at twice the rate of men’s prisons (Women’s Prison Association, 2009) with impacts similarly disproportionate in terms of race and

class¹². The present realities of mass incarceration¹³ reflect the internal crises, contradictions, and spatial fixes of racial capitalism in the post-war and neoliberal era. In response to the disruptions of insurrectionary Black and Brown life, epitomized in the liberationist and civil rights struggles of the mid-twentieth century, as well as the disruptions of neoliberal restructuring that left poor and racialized communities economically abandoned, prisons became a catchall solution, disappearing those subjects no longer deemed valuable under racial capitalism (Gilmore, 2007). While this has always been true of incarceration as a social project, 'mass incarceration' marks the expansion and intensification of this function under neoliberalism. Carceral power has thus expanded and entangled multiple social institutions within what scholars call the prison-industrial complex (PIC), encompassing an “array of relationships linking corporations, government, correctional communities, and media” that both reproduce racialized economic dispossession and thus vulnerability to criminalization and profit off of prison expansion, thereby grounding carceral systems in “ideologies of racism and the pursuit of profit” (Davis, 2003: 84-85; see also Bonds, 2006; Wacquant, 2009).

As prisons have shifted their function in response to ongoing political economic and social crises, they have also been reconfigured as sites of carceral power. Driven by “a logic of pure confinement” (Martin, 2013: 498), the neoliberal penitentiary today functions more like an idling warehouse than a productive factory. They incapacitate. Rarely do they discipline (Simon, 2010; Wacquant, 2010). In Foucault’s penitentiary, the disciplinary gaze is everywhere. In the neoliberal penitentiary, “all you have to do is count ... to make sure none has escaped” (Alford, 2000: 129).¹⁴

¹² Black women are incarcerated at twice the rate of White women while Latina women are incarcerated at 1.3 times the rate of White women (The Sentencing Project, 2017). Nearly one in six trans people – and half of all Black trans people – have been incarcerated in their lives (LAMBDA Legal, n.d.).

¹³ Another 4,500,000 people are under some form of carceral state supervision – *e.g.*, parole or probation (Jones, 2018). More than 70 million people have some criminal record (Clark, 2017). The age of mass incarceration is also one of mass conviction (Chin, 2012) and mass probation (Phelps, 2017).

¹⁴ At the Washington Corrections Center for Women (WCCW), prisoners are counted twice daily. This can last an hour or longer if guards miscount. Participants often joked that WCCW really stands for ‘women who can’t count women.’

Prisons of the mid-twentieth century were ruled by an ‘old penology’ that sought to discipline the prisoner as an individual ward of the state. Since the rise of neoliberalism and especially since the 2008 financial crash, however, a ‘new penology’ has taken hold that seeks to manage prisoner populations en masse (Aviram, 2015; Gibson-Light, 2018; Wacquant, 2010). The prisoner in the neoliberal penitentiary is no longer an individual ward to be disciplined, but a passive mass consumer, one of many, whose individuality is largely superfluous. This new penal discourse frames prisoners as service users and budgetary drains, not wards and never citizens.

Given this reality, can we really claim that carceral power is productive; that the biopolitics of prison are life-affirming? Black feminist scholar Joy James answers this question when, challenging Foucault’s claim that carceral power “saves everything, including what it punishes” (2012: 301), she writes,

“The U.S. carceral network kills, however, and in its prisons, it kills more blacks than any other ethnic group. American prisons constitute an “outside” in U.S. political life [...] Foucault remains mute about the incarcerated person’s vulnerability to police beatings, rape, shock treatments, and death row. Penal incarceration and executions are the state’s procedures for discarding the unassimilable in an external inferno of non-existence. Not everything, not everyone, is saved” (James, 1996: 34).

James here echoes Giorgio Agamben’s figure *homo sacer*, whose exclusion from political life provides the polity’s very foundation. *Homo sacer* has been reduced to mere existence (*i.e.*, bare life), suspended in a “state of exception” where the rules of law and the rights of citizenship do not apply¹⁵ (Agamben, 1998; see also Moran, 2015). In this formulation, which echoes Foucault’s theory of state racism, sovereign violence provides the conditions of possibility for biopolitics.

¹⁵ While there is fair consensus that ‘supermax’ prisons constitute spaces of exception, existing outside the rules of citizenship (Czajka, 2005; Moran, 2015; Rhodes, 2004), this research joins wider debates about the degree to which ‘normal’ prisons fit Agamben’s rubric.

If the modern prison is better understood as a site of disposability than discipline or rehabilitation, then how might we make sense of Morgan’s story? To be sure, her experience was less than life-affirming. Yet, is prison healthcare the same as police beatings or shock treatments? Does it function the same way? Where might prison healthcare fit in our understanding of carceral power and the prison? To date, critical prison studies have largely overlooked issues of health and healthcare. Scholars may gesture broadly to ‘medical neglect.’ Activists may demand prisoners ‘have healthcare.’ Yet, relatively little time or space has been devoted to understanding what prison healthcare is, how it works, how it relates to prison’s more obviously punitive functions, or how it might be changed. “Carceral institutions are commonly and rightly understood as sites of various forms of violence” (Sufrin, 2017: 5). Yet, if we focus only on familiar sites or forms of penal violence, then we risk overlooking the breadth of our carceral entanglements. How then might we understand the place of healthcare within the biopolitics of prison? What happens when *homo sacer* gets sick?

Biocitizenship and Its Discontents

If biopolitics names the uneven distribution of life chances across an internally cleaved population, then biocitizenship “might be described as the instrumentalization of biopower” (Johnson et al., 2018: 4). If biopolitics idealizes a national body, then biocitizenship entails those “forms of belonging, rights, claims, and demands for access to resources and care” (Mulligan, 2017: 1) that stake their claims to citizenship upon “beliefs about the biological existence of human beings” (Rose, 2007: 132). Adriana Petryna first coined ‘biocitizenship’ to describe post-Chernobyl Ukraine where access to state welfare became discursively tied to “medical, scientific, and legal criteria that both acknowledged biological injury and compensated for it” (2002: 6). A person’s rights, political identity, and social membership as a ‘survivor’ depended on Geiger counts and radiation exposure; and in the process “bodies, populations, and categories of citizenship” were

reordered (Petryna, 2004: 250). Whereas conventional notions of citizenship center a legal rights-bearing subject, biocitizenship “deals with legal subjects that are at the same time living beings” (Lemke, 2011: 4).

For their part, Nikolas Rose and Carlos Novas (2000) argue that biomedicine has radically altered the relationship between biology and politics. Today, individuals and collectives “experience, articulate, judge, and act upon themselves in part in the language of biomedicine,” and make political demands on the state, corporations, and civil society groups based on this biomedicalized sense of self (Johnson et al., 2018: 4). Under this distinctively liberal democratic form of biocitizenship, individuals self-govern through the rubric of *choice*. For Rose and Novas, practices such as BRCA-1 genetic testing or cystic fibrosis Facebook groups reframe biology from a site of passive fate to one of individual autonomy and hope.

Several scholars have critiqued Rose and Novas for reifying liberal teleology whereby the ideal biocitizen is “rational, autonomous, healthy, able-bodied, or *endeavors to be so*” (Johnson et al., 2018: 7). This ideal biocitizen flourishes by invoking the liberal promise of legal rights and the neoliberal promise of consumer freedom. In this line of thinking, individual health eclipses social inequality, legal universality obscures social difference, and individual autonomy opposes collective action (*ibid*). Rose and Novas’s theory of biocitizenship thus “maps closely onto the model liberal subject of classical democratic theory” (*ibid*: 8-9).

Anne Pollock maps biocitizenship theory across two literatures, “one developed for analysis of resource-poor settings and the other for the Global North” (2012: 144). Rose and Novas’s framework, she argues, “paves over heterogeneity both within the Global North and within the United States,” including the U.S. history of racial violence (*ibid*: 145). “[T]he United States was founded on racial genocide and racial slavery as fundamentally as it was founded on notions of liberal democracy” (*ibid*), and racial inequality and White supremacy continue to shape U.S.

healthcare (Roberts, 2010, 2011). As a counter to Rose and Novas, Pollock proposes a distinctly American form of biological citizenship “in which consumer capitalism and racialized deprivation coexist” (*ibid.*: 144). Especially under U.S. neoliberalism, resource hoarding and scarcity sit side by side, each co-constituting the other within an uneven biopolitical landscape.

Pollock thus highlights the *relational* production of multiple, coextensive biocitizenships, dependent less on rights than on the political economy of life. Bruce Braun makes a similar observation when he writes that biocitizenship “defined and experienced primarily as a matter of choice and the individual management of risk” must be seen as specific to “the affluent spaces of the West” (2007: 7, 25). Moreover, the conditions of possibility for *this* biocitizenship may include “the extension of sovereign power” over both internal (*e.g.*, undocumented migrants, the working poor) and external bio(non)citizens (*e.g.*, Chinese pig farmers) (*ibid.*). While Braun merely suggests relational interdependence, Matthew Sparke insists upon it.

“[T]hanks to the exploitative interdependencies of organ and tissue trading, outsourced and offshored drug trials, and health worker brain drain, the biological citizenship of people in more privileged circumstances has become very directly dependent globally on the biological sub-citizenship of others” (2017: 288).

Bio-sub-citizenship as a concept highlights “differential degrees and dynamics of health rights disenfranchisement,” which may unfold through “adverse incorporation as well as exclusion” (*ibid.*: 287). Eschewing the liberal smoothness of Rose and Novas, bio-sub-citizenship traces the messy, nuanced, materially, and discursively relational production of uneven life chances and living conditions that “simple binary accounts of citizenship and its others tend to foreclose” (*ibid.*).

Is the prisoner a biocitizen? Scholars of biocitizenship have to date largely overlooked carceral institutions. We might blame this on insidious carceral thinking, which reifies incarceration as “some building ‘over there’” (Gilmore, 2007: 242; see also Story et al., 2016). Or perhaps the literature’s

analytical preference for high-tech, capital-intensive, market actors (*e.g.*, pharmaceutical corporations) is to blame (Rajan, 2006). Yet, prison healthcare is neither anomalous nor inconsequential. In 2010, 3% of the US population (7,304,910) and 15% of African-American men¹⁶ (2,872,728) were currently or formerly incarcerated (Shannon et al., 2017). Mass incarceration represents one of the most extensive state-building projects in U.S. history (Gilmore, 2007). Prison healthcare is a part of this story.

What then might constitute a *carceral biocitizenship*? Where might prisoners fall along the spectrum “between actual, potential, troublesome and impossible citizens” (Rose and Novas, 2005: 2)? Geographer Nancy Stoller argues that prison healthcare is thwarted by custodial rules and limited prisoner mobility (2003). Nayan Shah places “carceral subjects and stateless persons who are judged to be incapable of following otherwise conventional norms or interaction and whose citizenship status is suspended indefinitely” solidly in the category of impossible (bio)citizenship (2018: 156). Sarah Burgess and Stuart J. Murray (2018) make a similar argument, drawing on the case of Ashley Smith who died by self-inflicted strangulation while on suicide watch in a Canadian federal women’s prison. Burgess and Murray describe the “carceral biocitizen” as “a subject caught between biopolitical practices and scenes of legal sovereignty” (*ibid.*: 53). While carceral institutions “affirm the citizenship rights of those incarcerated” with one hand, they “repudiate the biopolitical operations of law and corrections” and “reinscribe a logic of sovereignty” with the other (*ibid.*). Prisons are duplicitous institutions (Nelson, 2009).

This negation is only possible through the prisoner’s “social death,” which Burgess and Murray define as “a form of necro-citizenship ... neither quite living nor dead, but stripped of her right, a body that belongs to the state” (2018: 56). Social death involves three elements: natal

¹⁶ This study does not calculate how many people in the U.S. have been incarcerated in a women’s prison. In 2018 alone, however, more than 115,000 people were incarcerated in a state or federal women’s prison (Kajstura, 2018).

alienation, gratuitous violence, and general dishonor (Patterson, 1982). Social death marks and mars those subjects seen not to matter: "undocumented immigrants¹⁷, the racialized poor of the global South, and criminalized U.S. residents of color in both inner cities and rural areas" who are deemed "ineligible for personhood" (Cacho, 2012: 6-7). This "killing abstraction" (Holland, 2000) resembles and often overlaps with *civil* death, wherein a subject "though possessing *natural* life has lost all *civil rights*" and legal standing (Dayan, 2011: 44). Social death, however, extends *legal* non-personhood to one's entire social existence, at least as it is made (il)legible within the dominant social order. Ashley Simpson was really "no citizen at all" (*ibid*: 53). She was no biocitizen at all.

Before I move to my conclusion, I offer one final addendum to this discussion of carceral biocitizenship. Burgess and Murray (2018) conceptualize carceral biocitizenship from its limit case (*e.g.*, social and physical death). Yet, as I will demonstrate, the effects of carceral care are not always so spectacular or immediate. As such, I resist a binary account of biopolitical violence that see power-effects as *either* life-affirming *or* death-dealing. Some people and populations do not die but nor do they thrive. They simply live on in a persistent state of precarity, never getting better, often getting worse¹⁸ (Berlant, 2007; Puar, 2012; Shildrick, 2015). This is the difference between death and what Margrit Shildrick calls debility or

"slow death that occurs not as a crisis, still less as a catastrophe, but within 'a zone of temporality ... of ongoingness, getting by, and living on, where the structural inequalities are dispersed, the pacing of their experience intermittent, often in phenomena not prone to capture by a consciousness organized by archives of memorable impact'" (2015: 14; quoting Berlant, 2007: 759).

¹⁷ For a discussion of deservingness, biocitizenship, and undocumented (im)migration, see Willen, 2011, 2012.

¹⁸ Public health uses the similar concept of weathering (Dumont et al., 2012; Massoglia, 2008; Western et al., 2015).

Moreover, we might extend this notion of debility not just to physical death but to the theory of social death. As I will argue, understanding the experience of people inside prisons requires understanding their experience not as a totalizing social death but as one of socially debility. The prisoner has a social being but it is only the one allowed by the prison institution.

Carceral Care

The arguments of Shah, Burgess, and Murray stand in sharp contrast with Carolyn Sufrin's understanding of what she calls *jailcare*. Sufrin uses this neologism to index the "disturbing entanglement of carcerality and care" (2017: 6), which she defines expansively as "the way that someone comes to matter" (*ibid.*: 21; quoting Stevenson, 2012). For my purposes, I extend Sufrin's concept more broadly to a discussion of *carceral care*, or the contingent, often contradictory conjuncture of penal and carceral forms of state violence (*i.e.*, police, punish, contain, control, boundary, coerce) with practices of care (*i.e.*, treat, heal, cure, repair, mend, manage).

Sufrin argues that carceral control does not annul care but actually entangles and even enables it. In the case of jails in particular, neoliberal policies slashing already modest welfare supports have led to an "emerging equivalence between the carceral net and the [social] safety net" as arrest and jail have increasingly become the first point of state contact for poor and drug-addicted people (Sufrin, 2017: 21). Rather, carceral institutions like jail completely erase any possibility for care to occur, this juncture "created opportunities for care and discipline not only to coexist, but to shape each other in unexpected ways" (*ibid.*). Sufrin thus frames people in jail as able to access, albeit with limitations, state resources and interpersonal relations of care (within the jail clinic in particular) precisely because of their criminalization and carceral subjection. Exactly whether or how incarcerated people access healthcare behind bars depends, she argues, upon the ways prisoners and jail healthcare workers navigate the ambiguity that jailcare creates. Jail healthcare employees and whether or not they think a jailed person *deserves* healthcare.

By contrast, I do not always emphasize, as Sufrin does, the interpersonal negotiations of care that unfold in the prison clinic or physical exam. While I do discuss the ways incarcerated women and trans folks experience and navigate the interpersonal (and largely discretionary) relations of carceral care, I also investigate the institutional policies, routinized practices, and bureaucratic rituals that together form the infrastructure for these interactions. This approach expands our attention from the affective negotiations of discretion, which are vital to the personal outcomes of prison life, to examine the administrative structures that condition both care and violence in prison. How do we understand a healthcare system that produces both? Prison healthcare is not, I argue, a mere matter of individual clinical circumstance. Rather, to understand both experiences, we must understand the bureaucratic “structures of violence” (Spade, 2015; Tyner and Rice, 2016) that precondition both life and death in the same space.

So where does Morgan fit into this theory of carceral care? Or the 1,419 people incarcerated in a Washington women’s prison? Or the 17,263 people incarcerated in a Washington men’s prison as of June 2019 for that matter (DOC, 2019a)? According to a recent DOC survey, 72% of prisoners are “satisfied” with medical care in prison and 28% believe it “needs improvement” (DOC, 2019b). Given the survey’s failure to disclose its methodology, however, this knowledge remains vague, even suspect. Indeed, this survey tells us more about what satisfies the carceral imaginary than what satisfies people in prison. Rather than illuminating the world of prison healthcare, this survey shows us exactly what we do *not* know. Most immediately, we do not know how many people they surveyed, who they surveyed, or what questions were asked. More substantially, we do not know *who* accesses prison healthcare, who does *not*, or *why*. We do not know *who* decides or *how*. We do not know *who* benefits from this status quo or what this *means*. Finally, we do not know how it all works. As Sufrin writes, “[w]hat has yet to be examined is how this delivery

of human services actually works” (2017: 9). We do not know, in short, what kinds of biocitizenship(s) people in prison enjoy or how.

For this dissertation, I organize this ignorance into three research questions: 1) How has prison healthcare been defined, imagined, administered, conditioned, and contested in the everyday spaces and practices of prison life – *e.g.*, the courtroom, the cellblock, the bureaucratic office, the prison clinic – and what have been its biopolitical effects? 2) How do the intersecting custodial, clinical, scientific, and bureaucratic regimes of prison healthcare produce particular forms of subjectivity, knowledge, and political authority and agency? 3) How do people in prison, and people in women's prisons in particular, respond to these conditions?

My answers to these questions unfold across three chapters, each with its own empirical terrain and analysis, yet each tied to these questions of health and citizenship. Each of these chapters is driven implicitly by an abolitionist ethos, by a desire to make conceptually possible “[n]ot so much the abolition of prisons but the abolition of a society that could have prisons” (Harney and Moten, 2013: 42). In my conclusion, I turn explicitly to prison abolition to ask what it might draw from my critiques of carceral care and what roles biomedicine, health, and healing might play in such an abolitionist project. I pose the question that so many liberationist struggles have posed: *How is health tied to liberation?* (Murphy, 2012). First, however, I discuss my methodology and its place within the material and intellectual landscape of prison America.

Research and the Politics of Knowledge in Prison America

One of the concerns that I had is how the information would be used, and would it be used for the greater good. There's all these activists and all these people that are speaking for people in prison, and while there may be ... it's just not a large enough voice to really help. So, I wanted to ensure that in some way this information would get out somewhere, where maybe it might open the eyes of someone who can do something.

- Kaitlyn, former Washington state prisoner

To answer my research questions, I conducted an extended case study of carceral care as it has been practiced, structurally produced, meaningfully understood, and experienced within Washington state prisons over the past three decades¹⁹. This extended case method suits my exploratory approach and allows me to use my observations to expand, correct, and improve existing theories for understanding prison, carceral care, and the politics of health (Babbie, 2010; Burawoy, 1991). By taking *carceral care* as my unit of analysis rather than, say, *prisoners* or the *prison clinic*, I am concerned with relationships and processes over things. I study “fields rather than places, boundaries rather than bounded groups, processes rather than processed people, and cultural conflict rather than group culture” (Desmond, 2014: 548). Of course, the abstraction of carceral care can only be encountered in its concrete manifestations. The nurse’s tone of voice. The Health Status Report misplaced. Therefore, I focus my inquiry on more tangible units of observation: individuals. I combine legal, policy, and document analysis with semi-structured qualitative interviews with people formerly incarcerated in Washington state women's prisons, their families and friends, advocates for people in prison, several former prison healthcare providers and former DOC employees, state bureaucrats employed outside DOC, and prison volunteers whose work centers on

¹⁹ Any experience of incarceration in a state prison includes time spent in a county jail. Only one of my participants, however, spent the majority of her incarceration at a county jail as opposed to a women’s state prison.

health and well-being. In keeping with my exploratory aims, my populations have been inductively, iteratively defined; my population sizes are unknown; and I use non-probability-based sampling strategies.

While I interviewed a range of actors, my research begins and ends with formerly incarcerated women and trans folks. I interviewed twenty formerly incarcerated cis women and state-assigned-female trans folks, all of whom spent time in one or more of Washington's women's state prisons. Most were aged between thirty and fifty-five. All lived in the Pacific Northwest. In terms of racial identity, the majority were White (sixteen), while the remainder identified as Latina (two), Arab-American (one), or Asian-American (one). This obviously limits my ability to speak to the experiences of Black and non-Black people of color in prison, a fact which stands in stark contrast to the racialized impacts of mass incarceration. As in other states, Washington's carceral violence has been born unevenly. According to 2010 data, Black Washingtonians are incarcerated at a rate six times that of their White counterparts (see figures 2, 3)²⁰. I attribute the unrepresentative Whiteness of my sample to several factors: the demographic Whiteness of Washington state (*i.e.*, people of color are overrepresented in the state's prison population, yet remain a numerical minority); my small sample size; my use of snowball sampling, which tends towards homogeneity (Heckathorn, 1997); and my own positionality as a White, non-criminalized person.

Of course, racialization, structural White supremacy, and interpersonal racial bias shape the experiences and life chances of all people in prison, conditioning interactions between prisoners, guards, and medical staff, as well as stereotypes that each group holds about the other. When asked

²⁰ This data was gathered by Prison Policy Initiative using Census Data, which excludes Hispanic Whites from the White category. Washington's DOC also compiles its own data, which in 2019 recorded the following: Native Americans and Alaska Natives comprise 5.5% of the prison population and 1.8% of the state population. Asian and Pacific Islander people comprise 4.1% of the prison population and 9% of the state population. Whites (including Hispanic and non-Hispanic Whites) comprise 69.8% of the prison population and 80.4% of the state population. According to DOC, 13.8% of prisoners are Hispanic, compared to 12.4% in the entire state. (DOC, 2019a)

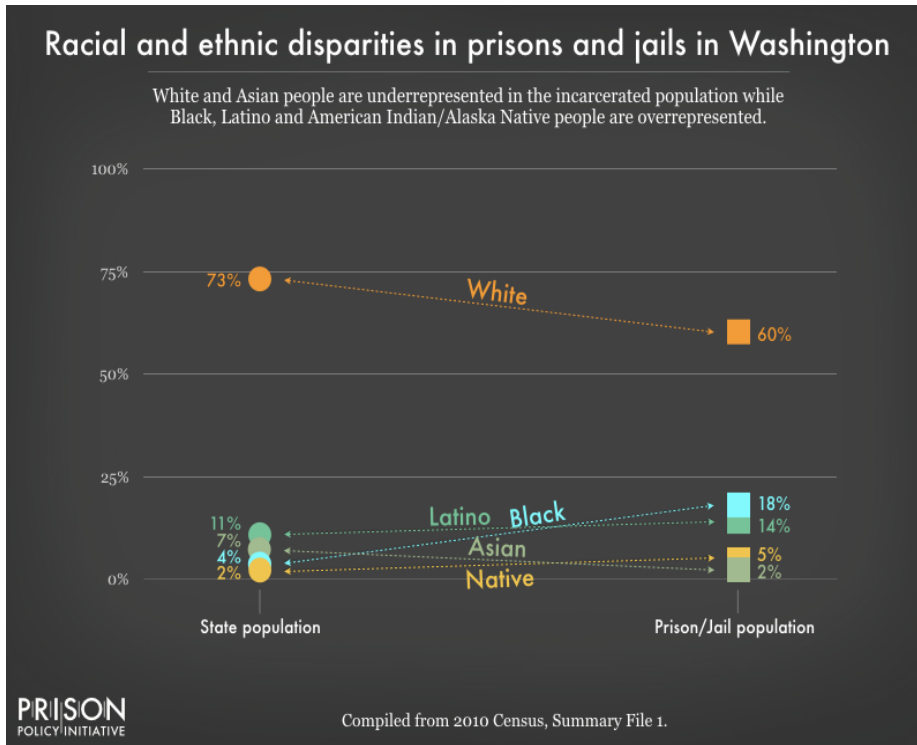


Figure 2. Racial and ethnic disparities in prison and jails in Washington, 2010.
 Source: Prison Policy Initiative
 (<https://www.prisonpolicy.org/profiles/WA.html>) Accessed: May 27, 2019.

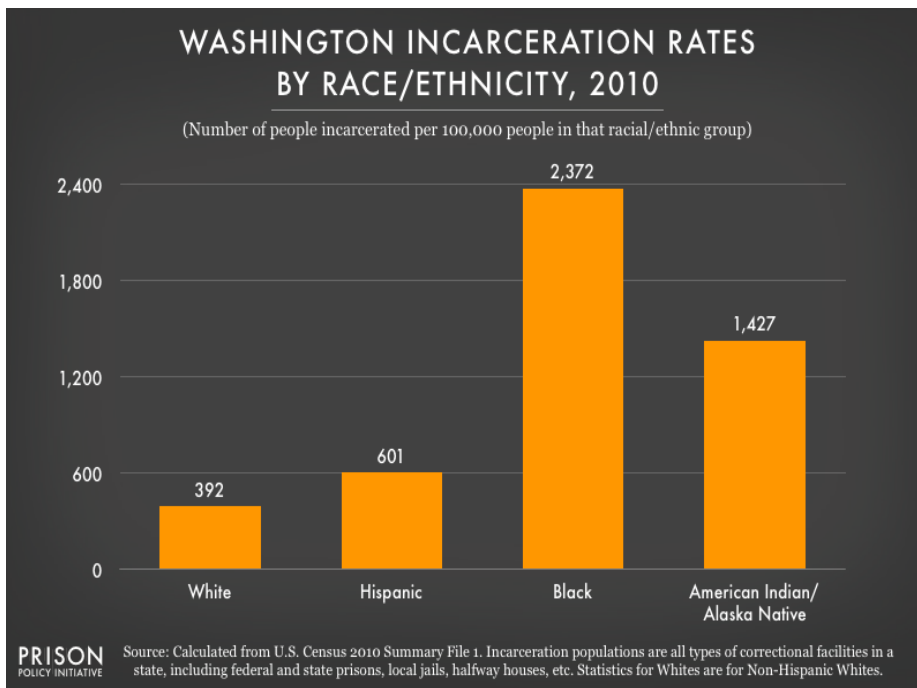


Figure 3. Washington incarceration rates by race/ethnicity in 2010.
 Source: Prison Policy Initiative
 (<https://www.prisonpolicy.org/profiles/WA.html>) Accessed: May 27, 2019.

explicitly about the role that race played in prison life, participants generally noted the absence of open racial animus, prejudice, and strict segregation, attributes they associated with men's prisons²¹. Nonetheless, given the evidence of racial bias in clinical practice *outside* prison (Williams and Wyatt, 2015), it is hard to imagine race was irrelevant to clinical practice and patient experience in prison. Future research should center the experiences of Black and non-Black people of color under carceral care.

For the purposes of this study, however, race steps into and out of focus as a primary category of analysis. Race intersects other forms of difference-making that unfold before, during, and after prison, shaping the institutional contours, everyday practices, and experiences of carceral care. Criminal status, gender, class, paid and unpaid labor, medical history, age, health status, custody status (*e.g.*, minimum, medium, or maximum security; solitary confinement; work release; post-incarceration), sentence length, sexuality, healthcare eligibility status, and cultural discourses of deservingness all articulate alongside and through race. While the majority of my participants were White, they came from diverse class backgrounds. Growing up, some regularly saw a primary care physician, while some had only sporadic encounters with medical professionals. Some had no criminal record prior to their incarceration, while some had moved cyclically from street life to jail to prison and back again. Some had children. Two were incarcerated with their children as part of Purdy's Residential Parenting Program (RPP)²². Some did not have children. Some had higher-paying jobs in prison (*e.g.*, AutoCAD computing) and outside financial support, while some were classed indigent, meaning they never had more than ten dollars in their prison account. The paucity of non-

²¹ This absence may be attributable to the invisibility afforded Whiteness in a White supremacist society, as well as the generally lesser attention White folks pay to racist dynamics and practices (DiAngelo, 2018).

²² DOC allows up to twenty prisoners to raise their children at Purdy. To be eligible, prisoners must have given birth under DOC custody. One participant I interviewed had given birth in county jail just two days before being transferred to Purdy. She was never eligible for RPP. Prisoners must be free of any criminal convictions classed 'violent.' They must be classed for minimum-security housing, have less than three years remaining on their sentence, and meet prison standards for good behavior.

White participants is certainly a limitation of this study. At the same time, in exploring relations of carceral care as they articulate across the above formations of (bio)social difference, I move beyond a singular focus on race and anti-Black carceral violence, while still rejecting colorblind logics.

Following legal scholar Marie Gottschalk, “[t]he intense focus on the racial dimension of the carceral state sometimes obscures the importance of other factors in determining who is punished and for what” (2014: 7; see also Lancaster, 2018).

I met my participants using snowball sampling (Babbie, 2010). I had several friends who had themselves been incarcerated at Purdy, and these women served as gatekeepers and aids. They suggested people to contact and shared my call for participants on Facebook. At the end of every interview, I asked each participant for further contacts, extending my snowball sample. Once each referrer confirmed their contact’s consent to be contacted, I reached out to every referral. A few never responded. A few missed our first interview and were never able to reschedule. Some were eager to take part but were not yet ‘off papers,’ meaning they were out of prison but still on probation and thus subject to DOC rules concerning IRB review and research participation. Towards the end of my research, I was unable to interview a few people due to constraints on my own time, finances, and mobility.

This sampling strategy had both strengths and limitations, which at times proved mutually constitutive. For example, while my decision to use snowball sampling produced a relatively racially homogenous sample, it simultaneously served to honor the personal connections of my formerly incarcerated friends. I followed their recommendations and referrals foremost. I balanced the potential transferability of my findings with my own situated, personal ethical commitments (Baxter and Eyles, 1997; Curtis et al., 2000). My sample *size* reflects this same methodological judgment. I wanted to remain accountable to those I interviewed, especially formerly incarcerated participants. Given issues of feasibility (Curtis et al., 2000) and my own time and financial limitations, this meant

keeping my sample size relatively small. Small enough that I would never fail to return someone's call. Small enough to share my findings personally. This small sample size also allowed me to conduct in-depth interviews that generated rich, detailed stories of prison life and healthcare, producing fleshy accounts of vital matters (Baxter and Eyles, 1997; Curtis et al., 2010). I often felt insecure that my relatively small sample size made my research inadequate, insufficiently rigorous, meritless, and unworthy of attention. This is false, colonial, masculinist, positivist thinking, however, and I reject it. As Margaret Marietta Ramirez argues, saturation and enoughness are not abstract questions of epistemology but lived ethical decisions made as much by participants as by researchers (Ramirez, 2017).

Another tradeoff of snowball sampling was the risk of pre-conditioned responses (Babbie, 2010). Upon speaking with several participants to schedule our interviews, I realized that they assumed I had wanted only to speak with people who had been spectacularly harmed by prison healthcare. They assumed I wanted the horror stories. Of course, I did want to speak with people who had been oppressed, neglected, or harmed by prison healthcare. This was not, however, because of cherry-picking or confirmation bias. Such individuals have experience with the inner workings of prison healthcare, not just its rules but its actual practice, its edges, fractures, contradictions, and failures. As such, they are able to provide information-rich accounts helpful in answering my research questions, thereby increasing the credibility of my final account (Baxter and Eyles, 1997). For the same reasons, however, I wanted to understand the full range of experiences, good, bad, and everything else. I wanted to include negative or conflicting cases. I made sure to explain this to any perspective participants, as well as anyone who might recommend a contact.

A final comment about whom I did *not* speak to and its significance. Though I interviewed people incarcerated as recently as 2017, for reasons I discuss below, I did not interview any people currently in prison. I did not interview anyone who had spent the majority of their sentence in

Purdy's long-term intensive care unit. While everyone I interviewed had some form of direct contact with prison healthcare staff, their stories reflect effects of carceral care both within and beyond the clinic. I also did not interview current or former prison healthcare providers in any systematic way. By chance, I interviewed two former DOC healthcare providers, one of whom worked at Purdy and one of whom worked at a Washington men's prison. I also interviewed several medical residents who have worked with currently and formerly incarcerated folks. While these interviews serve to triangulate and flesh out the stories of formerly incarcerated folks, as well as evidence from document analysis, firsthand accounts of prison healthcare workers are largely absent from these pages. This focus on the voices and subjugated knowledges (Foucault, 1980) of formerly incarcerated folks provides a necessary counterpoint to the privileged expertise of prison officials and medical professionals that not only structures the realities of prison healthcare but also its public narrative. After all, it is "[t]hose who experience the violence of a system ... who know that system most intimately" (Ahmed, 2018: n.p.).

Interviews lasted between forty-five minutes and two-and-a-half hours. I interviewed several participants twice. All participants were compensated with \$40 in the form of a gift card or cash²³. Interviews with formerly incarcerated folks grew out of eighteen questions, iteratively developed over my first few interviews (see appendix of all my interview schedules). These included:

- one question about the participant's path through the criminal punishment system, including jails, prisons, work release, reentry, and potential reincarceration;
- five questions about the phenomenological experience of prison life, including questions about the smells and sounds of prison and the felt experience of health and illness while locked up;
- five questions about experiences with prison healthcare, including visits with DOC Health Services, as well as self-care and communal care practices amongst prisoners;

²³ For me, \$40 reflected a reasonable wage for 30 to 120 minutes of emotional and narrative labor. I also chose \$40 as a token of redistribution in a world where I was being paid to study someone else's oppression. At times, I worried that \$40 might prove coercive to potential participants. One woman who I did end up interviewing spoke plainly beforehand about how she needed to do the interview in order to make rent. She invited a formerly incarcerated friend to join for the extra cash. Such encounters reflect the intimacies of racial capitalism.

- three questions about how people in prison shared information and how they perceived their experiences of health, illness, and healthcare in the prison;
- two questions situating their incarceration within a life history of health and healthcare interactions;
- two questions about the state's 'responsibility' for prisoner healthcare and what the prison could or should do differently.

I also hoped to learn things that I did not know I did not know. Experience manifests in manifold, sometimes aleatory, ways. Different people understand health, illness, and embodied experience differently. As such, I used open-ended questions and conversational prompts and prods to elicit participant responses on topics beyond pre-set themes (Rubin and Rubin, 2005).

During each interview, I used an unobtrusive digital voice recorder, and I took handwritten notes both during and after. I conducted most interviews face-to-face at the person's home, workplace, or a nearby library or café, though I conducted a handful over the phone. I gave everyone the option to meet in a public space of their choosing. Meeting in quiet, relatively private, neutral or familiar locations increased participants' comfort and ease (Elwood and Martin, 2000). Amongst these sites, however, I did not observe a significant difference in responses depending on location²⁴. Privacy is an especially ambivalent and personal phenomenon for formerly incarcerated people. Some participants narrated feeling unfazed about disclosing fleshy personal details to a stranger. After all, prison afforded no privacy in the first place, and they had long since lost what a non-incarcerated person might call body shame. Some participants, on the other hand, had not spoken about prison since their release years or decades prior.

Interviews were transcribed by me or the third-party confidential web service *Rev.com*²⁵.

Handwritten notes from both interviews and document analysis, along with my personal and

²⁴ In some cases, I found over-the-phone interviewees especially forthcoming, perhaps given the lack of any facial cues that might signal judgment. Given my small sample size, I cannot be sure.

²⁵ For details about *Rev.com*'s privacy policies, visit <https://www.rev.com/about/privacy>. The company has also agreed to delete all research records upon my request.

intellectual reflections, were catalogued in a research journal to increase dependability and confirmability (Bailey et al., 1999; Baxter and Eyles, 1997; Emerson et al., 2011). Transcribed interviews, documents, and research notes were then coded and analyzed using the open-access software TAMS Analyzer²⁶. Data was open coded and then axially coded through an iterative process of theoretical refinement: looking for etic codes, developing emic codes, recoding, and so on (Babbie, 2010; Cope, 2010; Strauss and Corbin, 1998). Throughout the processes of analysis and writing, which also unfolded in non-linear ways that often overlapped and informed one another (DeLyser, 2010; MacKian, 2010), I continually triangulated my thinking across interview-based, document-based, and journal-based datasets. In the following chapters, I present this analysis through a balance of theoretical interpretation and rich empirical description. In this way, I hope to offer findings that are both idiographic and potentially transferrable to other contexts (Baxter and Eyles, 1997).

This question of transferability is particularly relevant given the geography of U.S. mass incarceration. At first glance, Washington state may seem a peculiar, provincial choice for a study on U.S. prisons. Prison research and popular attention has largely focused on what Alex Lichtenstein (2015) calls “Flocatex” – the carceral archipelago that spans Florida, California, and Texas, the three largest prison systems in the United States. Over the 70s and 80s, these states manufactured a “sunbelt penology,” a poisonous mixture of ‘tough on crime’ policies and the economic surplussing of poor people and people of color. Despite the national and transnational (albeit uneven) circulation of these Sunbelt policies (Coddington, 2017; De Dardel & Söderström, 2018), Sunbelt exceptionalism persists in popular and professional discourse on prisons. Sunbelt exceptionalism perpetuates a liberal, penal, and moral imaginary which distinguishes mundane carceral violence from extreme carceral violence, thereby diminishing and often dismissing the former. As one

²⁶ Visit <http://tamsys.sourceforge.net/> for details.

Washington prisoner advocate explained, when she tries to address discriminatory policies with DOC administrators, they often rebuff her complaints, saying, “Well, it’s better than Louisiana! What do you want?!”²⁷ This is the self-congratulatory voice of the neoliberal carceral state²⁸.

Regional exceptionalism has also been marked in the study of U.S. prisons. Khalil Gibran Muhammad, for example, argues that “partly out of a long historiographical tradition of Southern exceptionalism, the role of racial criminalization in the making of the urban North remains inadequately researched and theorized” (2011b: 74; see also Thompson, 2010). Muhammad goes on to caution that, though “[n]ew Sunbelt studies on the carceral regimes of California and Texas have shifted some of the focus away from the Southeast and Black Belt ... Southern exceptionalism still shapes the tone and comparative claims of this new body of work. That is to say Alabama was bad, but Texas or California’s ‘Golden Gulag’ is worse” (*ibid.*: 75). Muhammad’s claim is not that Northern prisons were worse. Nor do I claim that Washington prisons are worse. “To be sure, California and Texas are exceptional by many measures of cruelty due to overcrowding, abuse, and exploitation for profit” (*ibid.*: 75-76). Rather, I insist that prison scholars reject regional exceptionalism altogether. Not only does it obscure specificities and generalities within and across prison systems at other scales. It also reduces our understandings of prison to a one-dimensional, uncritical, progress-based, liberal metric: better and worse²⁹. At best, regional exceptionalism provides a tool to shame the state into reform. At worst, it reinforces a race to the carceral bottom³⁰, justifying liberal complacency, depoliticizing prison, evading critique, and shoring up the status quo.

²⁷ For a study on the persistent faith placed in prisons in ‘progressive’ places, see Sundt et al., 2019.

²⁸ Such regional exceptionalism is typical in the Pacific Northwest liberalism, where especially White Washingtonians imagine racism in particular to be much worse elsewhere, usually the South.

²⁹ For a discussion of trans-local prison comparison, see Crewe, 2017.

³⁰ For instance, prison apologists may cite Washington’s incarceration rate of fortieth in the nation, even though this rate would rank fifth in the world were Washington a country. While geographers have critiqued methodological nationalism (Ellis, 2006; England, 2015), in the case of prisons, it is state-level and regional exceptionalism that limit alternative methodological approaches and knowledge production.

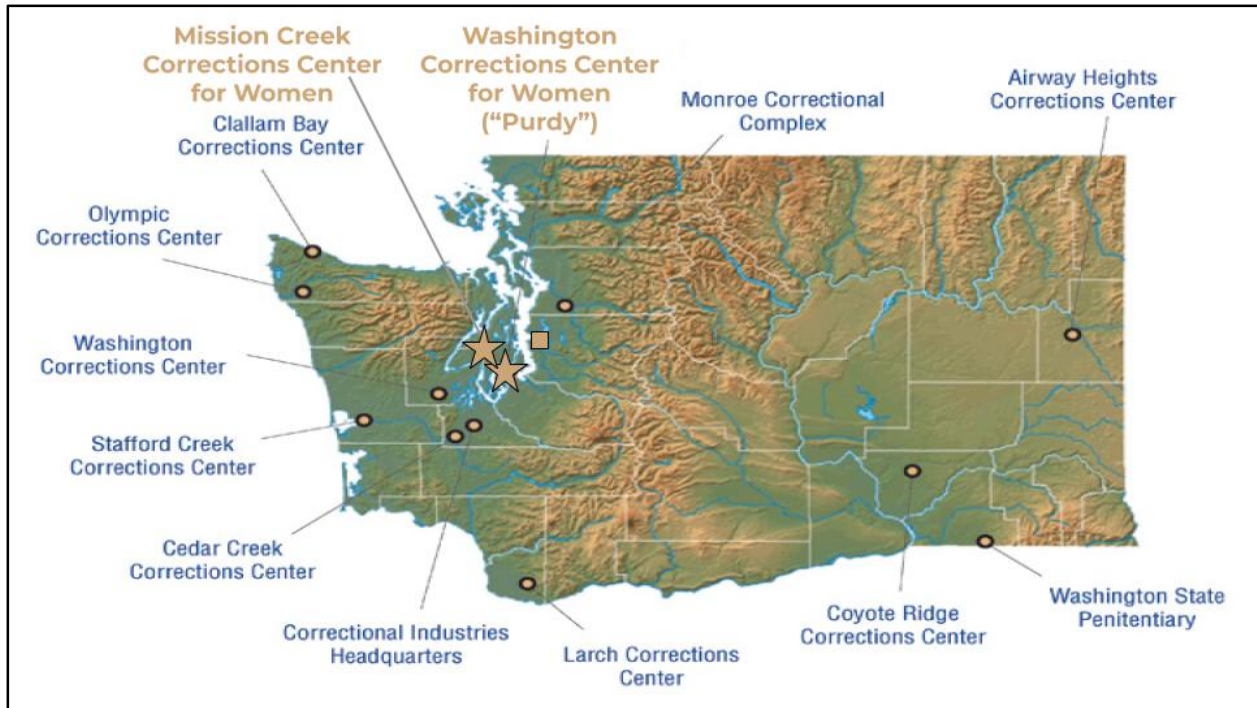


Figure 4. Washington's twelve state prisons.
 Source: Washington Department of Corrections; with corrections by author

Once we move beyond regional exceptionalism, we find other points of comparison: political economy, neoliberal ideology, reformist versus abolitionist commitments. Washington then becomes an instructive, potentially transferrable case study. “[A]ll regions of the country deserve full examination before determining which one is exceptional, and on what basis distinctiveness is to be judged” (Muhammad, 2011b: 76). Washington state prisons in particular offer insight into neoliberal carceral power. Muhammad argues that “it is nearly impossible to fully comprehend the ‘color-blind’ origins of mass incarceration today without examining the ‘liberal’ urban North” (*ibid*). Similarly, Washington state illustrates the neoliberal carceral state in today’s climate of reform. In 2019, we hear growing calls for penal reform. The commonsense of mass incarceration has been questioned, albeit often superficially. Washington state, where persistent racial capitalism combines with depoliticized progressivism and neoliberal technocracy, provides a valuable case study for understanding the ontologies and epistemologies, possibilities and limits of the reformist neoliberal

carceral state. Carceral care in particular puts these tensions and contradictions into relief. How does a prison function as a hospital? How does a person go from prisoner to patient and back again? Do they? Can they? Washington state thus proves a valuable extended case study, offering insight into relations of carceral care not only in Washington state but in other neoliberal carceral contexts.

My methods continue to unfold, particularly as I undertake peer debriefing and member checking of my findings and arguments with my participants (Baxter and Eyles, 1997). Nonetheless, these steps and methodological decisions that I have thus far taken support the ultimate aims of my research: to inductively develop an analysis and a conceptual language sufficient to the task of answering my research questions, of understanding carceral care as not a medical problem but a *bio-political* problem. The extended case method is particularly suited to this aim, allowing me to develop the theoretical arguments, correctives, and provocations I offer in the following chapters (Babbie, 2010; Burawoy, 1991).

Great Expectations

Unsurprisingly, I did not begin my research with this clarity of intent or action. Three years ago, I had no idea I would end up studying prisons. My path, like that of so many others, was a non-linear one (Ramirez, 2017). In the fall of 2016, I had finished my doctoral qualifying exams months earlier, but a concrete research topic remained elusive. I had an inkling of an idea. An exploratory study into the experiences of people living with multiple chemical sensitivity (MCS), a chronic illness rife with diagnostic mystery, debilitating pain, and alienation from both oneself and society. I wanted to understand how MCS sufferers and their communities navigate the dense social and spatial questions that arise from living in an unwelcoming world – questions of health, embodiment, knowledge, uncertainty, medical authority, disability, care, what people need, and what people owe one another. Yet, I remained unsure about my choice of topic and about my ability to say anything new or of value about it.

Clouded in dread, I sought the counsel of a friend. With gentleness, he suggested we take a walk. Autumn leaves crunched underfoot as we ambled, me explaining (or perhaps *jabbering* would be more accurate) about my predicament, my doubts and insecurities, and my idea about research with MCS sufferers. “Well,” my friend offered, “if you want to talk to people who don’t know what’s going on with their body ... why don’t you talk to the women from the kitchen?” My friend worked for a food kitchen in Seattle. Several of his women coworkers had been incarcerated at Purdy. I also volunteered at the kitchen and knew this. We had spent hours together washing produce and packaging meals. To pass the time, our hands busied, we would swap stories. Though their lives obviously extended beyond their time behind bars, stories of prison life were common. Stories of guards particularly cruel, blundering, or caring. Stories of an annual craft fair or family visit. They also recounted the havoc prison wrought upon their minds and bodies, even long after their release. Weight gained. Acne. Dry, itchy skin. Damaged, brittle hair. Headaches. Triggered memories. Stress, anxiety, and depression. Physical and psychic trauma of all kinds. And the noxious blend of confusion and powerlessness that a person in prison experiences when her body is so painfully, so plainly out of her control. I was intrigued by my friend’s suggestion, but I remained doubtful. I decided to raise the prospect with two friends from the kitchen.

Feminist and decolonial scholars have long argued for the necessity of countering social science research’s oppressive legacies and logics, which mask conquest as discovery, domination as expertise, and extraction as knowledge production (Haraway, 1988; Smith, 1999; Tuck and Yang, 2014). Feminist anti-oppression research instead centers relations of mutual vulnerability and unsentimental togetherness “without guarantees” (Nagar, 2019; quoting Hall, 1996: 45; see also Mitchelson, 2017); co-production to blur the categories and hierarchies of researcher and participant (Mullings, 1999; Caretta and Riaño, 2016; England, 1994, 2006; Kristiansen and Bloch-Poulsen, 2014); reciprocal exchange of knowledge and skills (England, 2006; Ramirez, 2017); responsibility to

one's own positionality (England, 2006); intersubjectivity or “strong objectivity” (England, 1994; Harding, 1992); epistemological and interpersonal respect (Ramirez, 2017; Tuck and Yang, 2014); and accountability (England, 2004; Gupta and Kelly, 2014; Perez-Darby and Fujikawa, 2018; Ybarra, 2014).

This is a tall order. Nonetheless, as I set out to speak with my friends at the food kitchen, I was anxious to fulfill it. I was also, of course, destined to fail. Part of me knew this. I often caution my undergraduate students against turning feminist methodologies into a new orthodoxy, against smuggling masculinist ethics of purity, perfection, and self-mastery into feminist principles, and instead encourage them to embody practices of care, curiosity, openness, and humility. But, alas, rarely do we take our own best counsel. So, I fretted. I worried that I would mess it all up. I was afraid of being a *bad researcher*. My most immediate concern was how to raise the topic of my interest. What to call it? How to name it? I worried that my own discursive frames might erase or distort their experience. This is a common conundrum in social science research, and there is no way entirely around it (Domosh, 2003). This familiar fact did little, however, to abate my anxiety. In the end, I decided upon the frame of *health* for its breadth and multiplicity. “What would you think of me doing research on health in prison?” I asked.

My point is not that I got the question right or wrong. On the contrary, I share this story to highlight the ways my moralistic obsession with, rather than reasonable curiosity about, the question distracted me from being present with the people right in front of me. Ethics in the abstract obscured relational ethics in practice (Mitchelson, 2017). Thankfully, my friends in their immediacy quickly drowned out my neuroses. With stories. Too many stories to tell. Stories about visits to the prison clinic. Stories about long wait times. Stories about aging, bone health, calcium, and rationed milk. Stories about test results and medical records never seen. These stories and the conversations from which they emerged formed the foundation of my research. Given my original interests and

the pressures I felt to dissertate 'on time,' however, these stories were, I admit, neither what I expected nor what I hoped to hear. But ego is a bad researcher, and so I listened. I listened to understand what they wanted me to understand and what they wanted me to ask. Over the following months, I learned to follow where they led, slowly reorienting my study until it would produce, ultimately, these pages.

As noted above, feminist and decolonial scholars advocate models and methods of research that redistribute agency between the researcher(s) and research participant(s). (Caretta and Riaño, 2016; England, 2004; Kristiansen and Bloch-Poulsen, 2013). In this way, knowledge production becomes not just co-produced but co-determined. Sara Kindon (2005) develops a typology of participatory-action research (PAR) to further distinguish the manifold relations of co-production and participant participation. On one end of the spectrum, under research-as-co-option, the “researcher designs and carries out research” (Kindon, 2005: 262). However, participants are “largely uninvolved,” and there is “no real power-sharing” (*ibid*). On the other end, under research-as-collective-action, participants “set their own agenda and carr[y] it out with or without the research” (*ibid*). Compliance, consultation, cooperation, and co-learning populate the space between these poles.

I never consciously approached this project as participatory-action research *per se*³¹. Nonetheless, Kindon’s typology helps me to understand the relationships that shaped this project. By and large, I practiced what Kindon calls consultation, a relationship of “limited power-sharing” in which the researcher “seeks [participants’] opinions but then analyzes and decides on [the] best course of action independently” (*ibid*). At times, however, my research relationships with

³¹ In large part because I understood PAR to work best in collaboration with a clearly defined community institution, activist collective, or NGO. Several such groups led by formerly incarcerated folks exist in the Puget Sound area, but none of my friends were members and my commitment was to them first and foremost. I do wonder, however, whether this lack of membership may be racialized, shaped by the relative lack of politicized identity amongst poor White folks as compared to African-Americans, particularly when it comes to oppression by the carceral state.

participants would be better described as ones of cooperation and co-learning. Formerly incarcerated women helped me to set my research questions and priorities (*i.e.*, cooperation). Over the two years that followed, I continued to seek their wisdom and guidance, to share power, however informally, however tenuously, and to decenter my authority over the research.

Yet, at the end of the day, I alone “decide[d] on [the research] agenda and direct[ed] the research,” what Kindon calls research-as-compliance (2005). I did not share material or institutional power with my participants, a reality ultimately unsurprising given our positions within carceral capitalist U.S. society. I was an unseasoned graduate student with few research funds, bills to pay, significant teaching duties, a long-distance boyfriend, and my own mental health to care for. My participants were formerly incarcerated women and trans folks focused more on stitching a life together than collaborating on something as esoteric as research. They were interested. Some were excited that someone was looking into prison healthcare. Most appreciated being listened to about their experience (Bosworth et al., 2005). Some provided feedback when their work schedules permitted. All of them were glad to know someone cared. Yet, they were busy. This is not to say, however, that participants did not exert agency on the research in ways both immediate and eventual. One way they did this was by sharing knowledge (*i.e.*, co-learning). They did this, of course, through the actual interviews, but knowledge need not always be affirmative either. Refusal is also a form of knowledge-sharing. For example, while most people I asked to interview agreed, one close friend from the food kitchen declined. After decades of concrete walls and stifled existence, she had had enough of prison. She preferred not to relive those memories. Similarly, when I interviewed Kari, whom I introduce in Chapter 3, and asked them to explain their treatment by prison healthcare staff, they refused. By refusing a single question or an entire interview, the person “decides what are the limits of the project, what knowledge or experience goes undocumented” (Ramirez, 2017: 37; see also Simpson, 2007). Refusal thus decolonizes the research encounter, “plac[ing] limits on the

conquest and colonization of knowledge by marking what is off limits, what is not up for grabs in discussion and what is not known” (Tuck and Yang, 2014: 225).

Despite its nuance, however, this project ultimately enacts an all-too-familiar dynamic in which a person neither currently nor formerly incarcerated authors research involving criminalized people (Aresti and Darke, 2016; Jones et al., 2009; Newbold et al., 2014; Piché et al., 2014; Richards and Ross, 2001; as a counterpoint, see the Journal of Prisoners on Prison at www.jpp.org). How to reckon with this reality? How might this fact illuminate the conditions of possibility that undergird all knowledge production in our carceral society? Dylan Rodríguez, building on his relationship with the incarcerated Viet Mike Ngo, explores these constitutive contradictions in research involving non-incarcerated researchers and incarcerated participants (2006). Prison research, Rodríguez writes, is "fundamentally structured by an institutional hierarchy of capture and punishment" and "a white-supremacist continuum of freedom and unfreedom" (2006: 32). My (liberal) freedom as a non-incarcerated person depends upon the (liberal) unfreedom of the incarcerated. My research studying violence depends upon violence done to my research participants. Any attempts at collaboration across the hierarchies of criminality and incarceration are thus "radically insufficient ... there can be no authentic relation of integrity or equity between those inhabiting the formal and opposed categories of free and unfree" (*ibid.*: 33). Yet, we must ask: insufficient by which and whose standards? Rodríguez does not condemn research. Rather, he calls for prison scholars to rethink the standards by which we undertake and evaluate research collaboration. To that end, I share a story from my own research that highlights the institutional limits placed on knowledge production within U.S. carceral society and, in turn, the necessity to reframe research in terms of criminality and abolition.

“Notice to stop all work on DOC interviews.”

This was the subject line. The body of the email, sent by the Director of Research and Data Analytics at the Washington Department of Corrections, continued: “I am cc’ing your advisor, the UW IRB, and the Washington State IRB (WSIRB) to ensure all parties are aware you are to *immediately cease all research activities involving DOC*. The WSIRB or DOC will be in contact regarding further action regarding this serious matter.” The email arrived in early March 2018. I was eleven months into data collection and finally building momentum. Upon reading the email, my breath stopped short. My viscera seemed to have disappeared entirely. I flitted from shock to terror to confusion. I wrote only two words in my research journal that day: *Well, fuck*.

The reason behind the email was simple. I had interviewed a DOC employee. This was, unbeknownst to me, against DOC policy. (Ironically, I had interviewed the DOC internal ombudsman, the one person whose very status as a DOC employee was contested³².) I was surprised for two reasons. First, naïvely, I was surprised I would need approval to speak with DOC employees, especially administrative employees located far from any prison. Second, throughout my university IRB’s lengthy approval process, I had not been informed of any special status afforded DOC employees. IRB only instructed me in the protocols for doing research with prisoners³³, deemed a

³² For years, prisoner advocates and family members had lobbied the Washington state legislature to create an independent ombudsperson to oversee the prison system. In 2016, DOC and the state legislature compromised and created an *internal* ombudsperson position. Under this system, prisoners had to pursue any complaints through the DOC’s internal, three-step grievance process before they could appeal to the ombudsman. Family members of prisoners could take complaints directly to the ombudsman, but only if they applied to issues that exclusively affected family members and did not relate to prisoners’ conditions of confinement. Prisoner advocates and family members, however, continued their campaign. In 2018, they succeeded and a new Office of the Corrections Ombuds (OCO) was created under the office of the Governor.

³³ The UW IRB defines a “prisoner” to be “[a]ny individual involuntarily confined or detained in a penal institution. The term includes individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures which provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial or sentencing.” Individuals on probation or wearing monitoring devices, however, “are generally not considered to be prisoners” (2019). These definitions clash with DOC rules requiring approval for any research involving “persons under its legal jurisdiction” (DOC, 2019). For better or for worse, IRB rules do not yet reflect the full reality of our carceral society.

“vulnerable population.”³⁴ Despite DOC’s suggestion to the contrary, I knew that I had caused no harm. I was not trying to interview any employee who was not already public-facing. It took hours on the phone with my very kind and thoughtful university IRB to decipher what rules I had even allegedly broken. After asking multiple times if I had *actually* broken any university or IRB rules, I finally learned that I had not. All this stood in sharp contrast to the email’s tone of alarm, defensiveness, and penal authority, all of which I found especially striking given the passive veneer of politesse and professionalism so often affected by Washington state technocrats. Reflecting upon a similar experience with prison research in the UK, criminologist Matthew Yeager pantomimes this disbelief: “surely a Western liberal government would not wish to destabilize legitimate university research in this era of openness and global information sharing? Think again” (2008: 415).

Prisons and the penal logic they embody have a way of treating everyone like a prisoner, a criminal, and/or a threat. Prisons, as places designed to confine criminals, presume guilt and demand suspicion. Through this email, DOC hailed me not as a criminal but as a subject nonetheless of the carceral state to be governed by its insidious and binary penal logics. If I was not on the side of the punishers and the rule makers, then I belonged, albeit retrievably, among the punished and the punishable. Of course, my socialization under the penal logics of *good|bad, citizen|criminal, human|subhuman* had been underway long before this interaction. Indeed, my response reflected this. Upon receiving this email, I succumbed quickly to DOC’s intimidation. All manner of apocalyptic

³⁴ Like most IRBs, the UW IRB defines former and current prisoners as a “vulnerable population.” Yet, as geographer Matthew Mitchelson argues, this categorization reinforces a logic of categorical and decontextualized vulnerability that misaligns with “actually existing vulnerability” (2017). This reification makes difficult practices of “relational vulnerability” by which both researcher(s) and participant(s) might actually engage and be responsible to “the social and spatial relationships that produce vulnerability, within and beyond the prison” (Mitchelson, 2017: 913; see also Greenhough and Roe, 2010). Indeed, I would argue further that non-incarcerated folks too often assume that all (formerly) incarcerated people are vulnerable such that they make reactionary presumptions of passive victimhood and non-agency. Given my own experience with the DOC gatekeeping and paternalism, I worry that presumptions of categorical vulnerability effectively forfeit material, moral, and epistemic control to the carceral state and thereby compound the categorical denial of individual autonomy and agency to people in prison. This has had a narrowing and quieting effect on the kinds of research relationships and projects that are possible in the prison context.

thinking entered my mind. Would I have to end my research? Would I be kicked out of graduate school?! My susceptibility to penal logic coupled with my unfamiliarity with actual policing, criminalization, and incarceration betrayed my position as a person socialized on the 'right side' of the criminal binary.

This penal logic of suspicion and punishability is amplified by the prison's antipathy to being studied, infiltrated, or known. While every carceral state resists its own critique, the neoliberal carceral state given its pretense of democratic government, uses distinctly duplicitous means "to 'structure' or destabilize critical research" (Yeager, 2008: 423). In a 2008 article, Yeager outlines the range of tools used by the UK government and his own neoliberal university to derail a research project involving incarcerated men. These varied from outright stonewalling by hostile prison administrators to Byzantine bureaucratic quagmires that included "lengthy delays and approval processes ... designed to discourage all but the most hard-headed of researchers" (*ibid.*: 423). Hesitant to explicitly bar or censor, the liberal carceral state instead frustrates, limits, manages, and structures critical prison research. Yeager summarizes the liberal carceral state's epistemological vice thusly: "the state centralizes research, uses secrecy to threaten researchers' autonomy, prefers the standardization of research (highly statistical database work is the norm), obscures decision-making, and then finally will assert that the project is not compatible with the government's research interests" (*ibid.*: 415).

Originally, I had planned to seek DOC approval to interview currently incarcerated people. I quickly abandoned these hopes, however, once I learned of the significant barriers posed by DOC. First, applications for research approval are only accepted for review twice per year. Second, once underway, DOC's review process takes at least six to eight months (DOC, 2019). Third, paralleling Yeager's experience in the UK, DOC prioritizes prospective research according to certain criteria: "Human subjects and data-based research requests will be prioritized based on: Executive

Order and/or legislation, legal mandate, or imminent public safety risk; Alignment with the agency's mission and strategic goals; Partnerships with mutual benefit; Requestor's experience in correctional research and subject-matter expertise in the proposed topic; Available resources to support the requests" (DOC, n.d.). This list makes little room for exploratory research or research that does not already fit within carceral ontologies or comport with the mandates of carceral state-building. DOC's role as the sole and primary review body for outsider research itself presents a conflict of interest³⁵. Under the guise of professional ethics, "the State [can] simply rul[e] that the project is not in the 'public interest' or part of its corporate research policy" (Yeager, 2008: 423). DOC further exacerbates this conflict of interest by requiring researchers provide "deliverables ... for review" (Washington State DOC, 2019). I quickly realized that such strictures doomed any hopes I had for conducting research inside prison. Indeed, such strictures likely doom all but the most secure, resource-rich university faculty.

The carceral state thus has (or acts as if it has) final say over who knows what when it comes to prison³⁶. Indeed, the DOC head of Research and Data Analytics personified this paternalistic control when in a late email she wrote: "My understanding is you have at least two active public disclosure requests related to this unapproved research study. While some or all of the information requested may be covered by the Public Records Act (PRA), the PRA was not established as a method to circumvent research approvals. The approaches you are using make me question the intentions of this study, but I leave that to your advisor and the UWIRB." This administrator had gone out of her way to look up whether I had active Public Records requests, despite their irrelevance to her office and their protection under both state law and DOC policy. I was being

³⁵ My own experience being censured for attempting to interview the ombudsperson, the one person tasked with overseeing DOC, illustrates the essential contradictions and shortcomings of DOC internal oversight.

³⁶ In the end, I did delete all related documents and recordings. When I asked my IRB contact what DOC could do if I refused, however, I was told DOC could hound me throughout my career and threaten to sue should I ever publish my research. In the UK, the state has threatened to sue academic publishers under the Official Secrets Act (Yeager, 2006).

bullied. I was being surveilled. This story lays plain the ways penal logic conditions the ostensibly neutral realms of liberal democracy and scientific research.

The Carceral State, Criminal Methodology, and Abolition as Horizon-Oriented Praxis

I introduced this story by arguing that in order to understand and evaluate research collaboration across the liberal divide of un/freedom we must first understand its carceral context. Rodríguez argues that such collaboration is a "charade" and its vernacular of "coalition, solidarity, partnership ...exaggerates the politics and historical possibilities of these meetings between free and unfree, to the extent that one of the 'collaborators' is categorically immobilized – not at liberty to move, speak, and practice" (2006: 32-33). Again, Rodríguez is not condemning prison research in toto. (After all, he did write a book.) Rather, he insists that the ontological assumptions of dominant methodology cannot account for the un/freedom prison imposes. Carceral society *necessitates* research that is uneven and appropriative. By definition, prison research will be "structurally dominated by free world (professional and nonprofessional) intellectuals and activists," and yet, at the same time, this "necessarily exploitative use of [incarcerated folks] texts (for there is little material benefit and much potential punishment in store for their authors) is often endorsed and encouraged by their imprisoned counterparts" (*ibid.*: 37-38).

My claim here is not that non-incarcerated prison researchers are beyond reproach. My claim is that instead of remaining invested in a methodological framework of collaboration based in a liberal social ontology, we must push collaboration to its most criminal connotations. Co-conspiratorial praxis, rather than liberally-framed collaboration, must be our goal. Rather than collaborators, we must be accomplices. Approaching research praxis from an orientation of co-conspiracy acknowledges from the beginning that the non-incarcerated researcher and the prisoner participant can never meet as equals when the freedom of one depends materially and ontologically upon the other. Collaboration is ruled out *a priori*. Thus, the only good meeting between prisoner

and non-imprisoned researcher "is the one that foments the collapse of its condition, the disarticulation of what has been" (*ibid.*: 32). Feminist and decolonial scholars have long argued for research collaboration that recognizes uneven hierarchies of power and privilege (England, 2006; Smith, 1999). By insisting researchers reorient ourselves from the position of collaborators to that of criminals and co-conspirators, I do not intend to reject these important contributions. Rather, my contention is that our continued investment in collaboration adopts the standpoint of a free world ontology, which must be abandoned if we are to undertake an abolitionist praxis. We must undertake research from the standpoint of criminality. We must become criminal, however limited, however situated. We must practice criminal methodology.

Criminal methodology is not orientalist make-believe. It is not the performative guilt of the non-incarcerated. Nor is it a new orthodoxy by which to judge in the abstract. Rather, it is a praxis of mutual liberation that unfolds through ongoing, uneven, situated struggle towards the horizon of prison abolition. Liat Ben-Moshe conceptualizes prison abolition as a dis-epistemology, "which is about both knowing and unknowing ... giving way to other *ways* of knowing ... letting go of attachment to certain ways of knowing" (2018: 347). Such disorientation, "although often unpleasant and jarring can also be productive" (*ibid.*). Practicing a horizon-oriented politics, however, is not about predicting or guaranteeing the future. "[I]t is about letting go of attachments to forms of knowledge that rely on certainty (what are the definitive consequences of doing or not doing); prescription and professional expertise (tell us what should be done); and specific demands for futurity (clairvoyance – what will happen)" (*ibid.*). Critics may incriminate this (dis)orientation for being unrealistic, abstract, or without concrete solutions, yet these are its strengths. If we are to build something yet unknown, then how can we predict it? Practicing a horizon-oriented politics requires process, not just staying with but amplifying the trouble, and concrete utopianism (Lewis, 2019; Muñoz, 2009).

What might this criminal co-conspiracy look like? How might the mundane tensions, failures, and victories of a horizon-oriented research practice unfold? I recall one exchange with Kaitlyn, who spent much of the past two decades at Purdy and who I interviewed over the phone at her home in Idaho. I had just explained my plans to share the research “with everyone who I spoke with.” I continued, “And strategically, I’ll try and share that with activists, DOC folks as much as I can, legislators, that sort of a thing.” I asked if she had any questions. She replied,

“One of the concerns that I had is how the information would be used, and would it be used for the greater good. There aren’t a lot of people, I think ... there’s all these activists and all these people that are speaking for people in prison, and while there may be ... it’s just not a large enough voice to really help. So, I wanted to ensure that in some way this information would get out somewhere, where maybe it might open the eyes of someone who can do something” (personal interview, 2018).

Kaitlyn knew I was appropriating her stories, *and* she still shared them out of a hope that doing so might in some small way undo our carceral nightmare. I did my best to honor her hopes and her skepticism. I replied, “That’s my hope, for sure. I also want to say I really appreciate that skepticism. There’s plenty of folks who come from universities and ask people to share their stories, and then it doesn’t really go anywhere. I’m still in the middle of this, so I can’t predict the future, but I just want to say that I’m aware of that and really don’t want to recreate that. So, my goal is to be as in touch with folks who are actually affected by this as possible, so that I can share this in the most effective and strategic way possible. That’s not a perfect answer, but I totally respect that skepticism” (*ibid*). Kaitlyn responded simply, “Okay. I appreciate that,” and our interview continued (*ibid*). In quoting Kaitlyn, part of me hesitates to make sense out of her words. Part of me wants to leave them as they are, firm and unsettling. Yet, Kaitlyn’s words illustrate for me the impossibility of collaboration (in a liberal sense) and the necessity of co-conspiracy. To imagine non-incarcerated researchers might

reform our research practices to the point that collaboration becomes possible, this is a cruel optimism (Berlant, 2011). Rather, criminal methodology and horizon-oriented research praxis conspires to undo the liberal bind of un/freedom so that collaboration might then be truly possible. In short, prison researchers should be strategizing our own obsolescence.

How might I do this? First, I take as foundational my conviction that mass human caging is harmful and unethical. My arguments and interpretations reflect, however modestly, this desire to think with and for a world beyond cages; indeed, to think with and for the abolitionist worlds that exist already inchoate within our carceral society. Second, following Ben-Moshe (2018), I seek not only to unlearn carceral logic but also to dwell in the spaces of uncertainty and potentiality that abolitionist thinking requires. Importantly, this does not mean I offer no alternatives to our carceral status quo. "[P]ragmatism and vision for the future of a non-carceral society are not necessarily binary opposites" (*ibid.*: 349), and abolitionist reforms (as distinct from reformist reforms) can be part of this praxis. Thus, in each chapter I suggest alternatives for doing things differently. My suggestions, however, are not fully-realized policy solutions. I offer neither prescription nor guarantee. Rather, I resist the certainties that might be co-opted by a carceral state. In this way, I hope to perform critique that constructs without structuring.

Coda: On Language

I close this chapter with a discussion on terminology. There are many words I might use to refer to people who are incarcerated: *prisoners*, *inmates*, *offenders*, *convicts*, *criminals*, *felons*, or even *clients*. Each term brings its own baggage, communicating assumptions about the people it references and their personal history, social context, and moral value. This conundrum is not confined to the realms of intellectual debate. On November 1, 2016, then DOC Secretary Dick Morgan announced that DOC would cease referring to people in prison as "offenders" and start using "incarcerated individuals" instead (Jenkins, 2016). Many celebrated this name change (*ibid.*). This change in policy,

though still not fully implemented³⁷, reflects the desire of many formerly and currently incarcerated people to be referred to using person-first language (Farkac, 2019). Eddie Ellis, writes that "[w]hen we are not called mad dogs, animals, predators, offenders, and other derogatory terms, we are referred to as inmates, convicts, prisoners and felons—all terms devoid of humanness which identify us as 'things' rather than as people. These terms ... are no longer acceptable for us, and we are asking people to stop using them" (2007: 1). Ellis goes on to offer several person-first alternatives: "People currently or formerly incarcerated, PEOPLE on parole, PEOPLE recently released from prison, PEOPLE in prison, PEOPLE with criminal convictions" (*ibid*; capitalization original).

I am committed to using language that centers the complex humanity of people who are formerly and currently incarcerated. Person-first language is one rhetorical strategy to achieve this end. "Person in prison" or "incarcerated person" describe something *done* to a person rather than something they *are*. At the same time, however, I aim to represent the realities of our carceral society, including its dehumanizing and violent effects. Prison is not a person-first institution. I worry that person-first language risks painting an agreeable veneer onto the violence of prison. Indeed, as Washington's recent policy change illustrates, the neoliberal carceral state is well capable of co-opting person-first language into its carceral machinery.

Arthur Longworth, an author currently serving mandatory life without parole (LWOP) at Washington's Monroe Correctional Complex, rejects the "entire lexicon of false words propagated by those who run the prison" (2004: n.p.). In this "catalog of misnomers," prisons become corrections centers, wardens become superintendents, low-level prison administrators become correctional counselors, prison guards become correctional officers, cellhouses become units, cellblocks become pods, solitary confinement in the hole becomes segregation, and prison factories

³⁷ As of this writing, the term "offender" still appears in the title and body of dozens of DOC policies. Visit <https://www.doc.wa.gov/information/policies/default.aspx>. According to anecdotal evidence, many prison guards continue to use the term "offender."

become correctional industries (*ibid*). Longworth prefers instead the terms *prisoner* and *convict*. He does not resist the term “prisoner” because “[i]t is what I am” (*ibid*). Longworth understands this as resistance. When the state renames your reality, speaking truth to power provides clarity.

This debate is for me about the distinction between a person and their social positions. As a subjectively lived place, prison incarcerates people with complex interior lives, histories, ways of thinking and feeling, and social contexts. But as social institutions, prisons and prison healthcare are organized around social positions—prisoner, guard, doctor, patient, warden, police, nurse, delinquent, citizen, non-citizen—and ontological categories—criminality, gender, class, labor, health, custody, sexuality, and bureaucracy. Therefore, when I discuss people in their lived capacities as complex social actors, I use person-first language³⁸. I also do not disclose formerly incarcerated folks' criminal convictions³⁹. When I am discussing the logics, discourses, and systematic social impacts of prison and prison healthcare, however, I use the term “prisoner.” When discussing other vernaculars of prison life, I strike a balance between, on the one hand, making my language intelligible to incarcerated folks, prison officials, and those unfamiliar with prison, and, on the other hand, using terms that “rob the objects they purport to describe of their true identities” (*ibid*, n.p.). As a result, I have written a story not about *correctional centers* but about *prisons*, high- and low-level *prison administrators*, *prison guards*, *prison factories*, and *prison clinics*.

Finally, a note on gender. In this research, I focus on the experiences of people who spent time in a Washington state women’s prison. I only interviewed people formerly incarcerated in a women’s prison. I did not interview anyone who spent time in a men’s prison. The term “women’s

³⁸ I deliberately do not use the DOC term “incarcerated individual” because of the way it alludes to neoliberal ideologies of the individual floating free from society. Incarceration, in particular, individualizes social disorder into a singular criminal. As Allen Feldman writes, “[a]rrest is the political art of individualizing disorder” (1991: 109).

³⁹ In doing so, I do not mean to facilitate a politics of innocence (Wang, 2018), by which non-incarcerated people find it easier to pity, sympathize, or care about an incarcerated person. My goal is not “to make a case for someone [in prison]” by “characteriz[ing] them as blameless, hardworking and charming, but down on their luck” (Skinner, 2019: n.p.).

prison,” however, is a misnomer. Due to the long-standing practice of sex-segregated incarceration based on state-assigned sex at birth and related state-sponsored cis-normativity and transphobia, Washington state women’s prisons incarcerate cis women, trans men, trans women, and gender-variant folks⁴⁰. Of the people I interviewed, however, almost all identified as cis-women. One person identified as trans-masculine without specifying a binary gender identity. Two others described their experiences explicitly in terms of female masculinity or butchness. As such, I use accurately gendered, trans- and gender-variant inclusive language when referring to research participants. When referring to population-level data, I use the language of “women’s prisons” and “men’s prisons” in an effort to denaturalize the invisibilization of trans and gender-variant folks within the binary-gendered carceral system (Stanley and Smith, 2015).

⁴⁰ In my own experience, though still rare, Washington women’s prisons are more likely than men’s prisons to incarcerate prisoners according to their gender identity/expression rather than their state-assigned sex.

Carceral Care and the Administrative Violence of Carceral Biocitizenship

“We’re moving you to the top bunk,” the prison sergeant⁴¹ announces plainly. It is 2014 and Amy has spent just two months at Purdy. She has thirty-four months to go. “I can’t go to the top bunk,” she protests. “There’s an HSR in place. It has been since the day I got here.” The Health Status Report (HSR) records “any medical, visual, mental health, and/or dental accommodations” deemed “medically necessary” by DOC Health Services⁴². Effectively a prison permit, the HSR allows prisoners to deviate from standard rules and protocols and alerts security staff (*e.g.*, guards) not to hamper a prisoner’s medical accommodation (DOC Health Services Orientation Handbook, 2018: 8). “I needed an HSR,” Amy later explained to me, “for a low bunk because of the fact I have severe nerve damage in my back and in my legs. I fell off a ski lift and had several surgeries and fusions and so forth. It did damage to the nerves in my feet. I can’t climb a ladder at all.”

The sergeant calls up the prison clinic. Amy feels sure they will confirm her HSR status. “I had this HSR. It’s in my records. Everybody knows. I was on a low bunk in receiving. I was on a low bunk in my dorm.” The guard hangs up the phone. “Nope. Nothing there. We need, I need you to move.” Still, Amy refuses. She appeals to the sergeant’s higher-ups, but meets only doubt and indifference. “They all thought I was just being this horrible, emotional...wanting my way.” Here, Amy’s voice paused. Nonetheless, the unspoken accusation of female hysteria, echoing centuries of women’s punishment in asylums and psychiatric institutions (Foucault, 2006; Houston, 2002;

⁴¹ “Sergeant” is shorthand for a mid-level correctional officer.

⁴² DOC Health Services crafts and administers all DOC healthcare policy and clinical practice. The Health Services budget is set by the state legislature and operates independently from each prison facility. Health Services is responsible for the healthcare of all 20,000 people incarcerated by Washington on any given day. On December 31, 2018, the DOC had 17,012 people locked up in state prisons and 644 people under its supervision at its twelve work release programs. In late 2017, DOC Health Services affirmed that it was obliged to provide healthcare for everyone at work release. Prior to this, DOC had remained ambivalent about its obligation. Prisoners going to work release lived in uncertainty, oftentimes hoarding medications before release. As of December 2018, DOC also held 1,713 people at county jails where the state rented bed space. State prisoners locked up in county jails receive healthcare through jail facilities (Washington State DOC, 2019).

Hunter, 1983; Mollow, 2006; Stoller, 2003), rings clear through the void. In the end, Amy is forced to move.

Amy now lives every day in fear. Afraid she might slip and fall, everyday actions like making the bed, sleeping, waking, and getting dressed become ridden with anxiety.

“It’s terrifying because they don’t have rails [on the beds]. So, anybody could roll off, and they do. You have women there suffering from PTSD, obviously, as well as depression, and stress and anxiety just because of where they're living. They don’t have railings on the top bunks because if we were able to get them apart we could use them as weapons. Women fall a lot. I lasted four days.”

It is a Monday morning when Amy falls.

“I was making my bed, which is regulation, before I went to work. I was coming down the ladder. Foot went out. I went down. Jaw hit the metal storage bins, and my cheek and eye socket hit the ground. It was this deafening roar. I knew it was pain. The gals that were still in the dorm yelled to Ms. Jones—she was our regular CO [correctional officer]—to call a medical emergency. Here come the nurses. They put me in their emergency room section. I never once saw the doctor. My doctor was there, but she never set foot in the room. I was telling them that it just really hurts. They took X-rays and they said it was just a bruise. They know my history of blood clots.”

Amy suffers from a congenital blood clotting disorder. For her, nothing is ever just a bruise.

Despite this, the nurses sent Amy back to her dorm with an HSR for ice and one day’s lie-in to miss work. They tell her to take Tylenol and go to bed. “That’s their answer for everything,” she later joked. “Take Tylenol and go to bed. You have a boil on your toe, take Tylenol, drink water, and go to bed.” The nurses deny her request for a soft diet, however, and as a result Amy does not eat

for several days. But Amy refuses to be ignored. She sends kite after kite⁴³ demanding to be seen. She makes numerous visits to the clinic, each time costing her \$4 copay.⁴⁴ She recites her symptoms to the prison's nurses and doctors, who prove to be little help. "I can't hear and all I have is this pounding sensation in the side of my face. But they're telling me it's a bruise. Finally, because I kept bugging them that I was dizzy, [they told me] 'Well, you do have a concussion.'" The nurses had sent Amy to bed with a concussion. "Makes perfect sense, right?!" One particularly brash nurse harasses Amy at each visit. "Every time, she said, 'What are you doing here again? You just want pain meds.' No I don't," Amy objects. "I want to know what's wrong. I want to feel like somebody's paying attention."

Finally, Amy learns the root of her mistreatment.

"They were so sure that I'd been beat up and I wasn't telling them who had done it, so they withheld treatment ... They were so sure that I had been beat up, or I'd done it to myself... The director of the clinic, when he saw me, he said, 'You know, I was going with everybody else that you did it to yourself, you were having a problem, you wanted a low bunk...but no woman would do that to her face intentionally.' Really?! You think?!"

The pounding in her face and her impaired hearing continue. After several days and a call to her husband, her attorney contacts Health Services, demanding they examine her. "That's when it was determined that I had lost the hearing in my ear," Amy explained. "They could have saved it if they would have listened to me in the first three days." This is not the only call her lawyer makes. After her fall, DOC punishes Amy with two major infractions⁴⁵: one for damaging the bedside storage bin

⁴³ "Kite" refers to any written or digital message sent between a prisoner and prison staff.

⁴⁴ Under DOC policy, all Washington state prisoners are charged a \$4 copay for any medical appointment which they initiate. Follow-up appointments initiated by Health Services staff are free.

⁴⁵ Two major infractions would have not only cost Amy her prison job but also made her ineligible for Washington's Community Parenting Program, a diversionary program that allows (state-recognized) parents to spend part of their sentence under electronic surveillance at home.

and one for damaging her own face⁴⁶. Amy's infraction directly contradicted her medical diagnosis, however. Her lawyer makes another call to the prison lieutenant. "Well, if you guys are saying I damaged state property," Amy explained, "it was obviously more than a bruise, wasn't it? [The lieutenant] knew right then they can't say it's a bruise and charge me with damaging something."

It has now been several years since Amy was released from DOC custody. Her jaw is still not fully healed. She is suing DOC for medical neglect. Any payouts from the prison, however, will not go to Amy. She has stipulated that all damages awarded be funneled back to Purdy to improve healthcare for the women still locked up. "Whatever I am awarded will go to them. The money ... is to go straight back into the health clinic and education system at Purdy." DOC has offered to settle the lawsuit out of court if Amy agrees to a gag order. "This is the bottom line of their level of care," Amy explained to me. "We are going to bring you in here. We're going to break you down to the point you're not an *anything* anymore. The more you struggle against us owning you, the worse it's going to be for you." Amy refuses to settle.

Prisoner or Patient?

What does it mean to be both incarcerated *and* sick? How does a person seek care when she is defined by her punishment? What kind of care does she receive? How does an institution based in security, control, and punishment incorporate relations of treatment and care? Can it? When a prisoner goes to sick call or visits the in-patient infirmary, has she exited the prison? Who is she then? A prisoner? A patient? Someone in between or someone else entirely? Is she an actual, troublesome, potential, or impossible biocitizen?

⁴⁶ According to Amy, guards described this infraction as a punishment for her "damaging state property." These infractions are common at Purdy, Amy argued, citing the example of prisoners who receive infractions for sunburns after lying in the summer sun, something other participants corroborated. Though I have been unable to find any policies naming prisoners as property, the suggestion remains telling. Guards often use infractions to coerce information from prisoners they suspect of lying to cover up their own or others' behavior. While technically untrue, the fact that guards claimed Amy's face to be state property and the fact that this was conceivable, even unsurprising, to Amy points to the severity with which prisoners experience their loss of autonomy and lack of agency in the face of carceral power.

In her ethnography of San Francisco's County Jail and its clinic, anthropologist and OB/GYN Carolyn Sufrin traces the ontological choreographies healthcare workers and incarcerated pregnant women perform as they negotiate their everyday clinical routines. When she enters the clinic space, Sufrin asks, is the jailed woman a prisoner or a patient? On the one hand, "[t]he space of the clinic in jail offer[s] the possibility of transforming, albeit temporarily, a prisoner into a patient" (2017: 84). This transformation is aided by the clinic's distinct built environment and physical distance from the rest of the jail, the way jailed women shed their "orange pants and sweatshirt for standard white paper gowns," the absence of guards from the exam room, and the presence of other medical hallmarks (*e.g.*, stethoscopes) that "momentarily mak[e] the space of incarceration look and feel like a clinic in the outside world" (*ibid.*). Healthcare workers also see themselves as separate from the rest of the jail. "[T]hey were there to treat patients, not inmates" (*ibid.*). The jail's orientation for new clinical staff reaffirmed this "distinction between patient and prisoner, healing and custody, us (clinicians) and them (deputies)" (*ibid.*: 85).

Yet, this very affirmation suggests its own contingency and possible reversal. "For this reason," Sufrin argues, "inmates in clinical configurations are better understood as patient-prisoners" (*ibid.*: 84). The patient-prisoner position is thus deeply unstable. At any moment, prison nurses or doctors might slip back into a carceral mindsight in ways that alter whether and how they provide care. Healthcare behind bars thus becomes a constant struggle in which medical providers suss out whether or not prisoners *deserve* care. Deservingness, anthropologist Sarah Willen argues, is the "flip side of rights" (2012; see also Willen, 2011). While the right to healthcare may be universal to all prisoners, individual and group-based deservingness is negotiated relationally based on social and moral constructions of belonging, criminality, and (un)worthiness. Jail clinical staff are thus constantly "sorting the people before them along a continuum of patient and prisoner subject positions" (Sufrin, 2017: 85-86), based on what they know or don't know about a person's criminal

identity and history. These judgments are also inflected by racialized, classed, and gendered perceptions of incarcerated women as more manipulative and deviant but also more vulnerable and marginalized than their male counterparts. For their part, women in jail also "pla[y] with this patient-prisoner continuum ... by manipulating staff, stealing items, or referring to themselves as criminals (*ibid.*: 87).

This question of subjectivity mirrors larger debates about the relation between care and control within carceral or disciplinary institutions (Disney and Schliehe, 2019; Philo and Parr, 2019; Garcia, 2010). Geographer Nancy Stoller sees carceral power as fundamentally opposed to caring relations, as incarcerated women in their attempts to access care are "thwarted by rules, custodial practices, poor health care management, incompetence, and indifference" (2003: 2263). By contrast, in her ethnographic account of a Washington state supermax men's prison, anthropologist Lorna Rhodes writes that "[c]ooperation between custody and treatment is commonplace," as when psychiatric power diagnoses, medicates, and moves an unruly prisoner from the general population (2004: 154). Yet, such complicity is fragile and contentious. For instance, mental health workers may balk at custodial rules but also alter their behavior to avoid any perception by guards that they are "inmate-lovers" (*ibid.*: 152). Similarly, Sufrin sees the controlling and even punitive functions of jail as mutually constituting its spaces and relations of care. Custody and treatment, prisoner and patient intermingle in the jail clinic. This ambiguity itself becomes a conduit for care. Drawing on her own experience covering for a prisoner who had stolen from the jail clinic, Sufrin writes that "[c]are emerges precisely in these moments of ambiguity, when disciplinarity involves human connection, intimate concern, and suspicion" (2017: 88). Rhodes's focus is more biomedical knowledge and practice. Sufrin conceptualizes 'care' in the sense of interpersonal relation and attention paid. Yet, both highlight the ways custody and care enable *and* limit one another. Both see the prisoner as a *potential* biocitizen whose potentiality is actualized through these spaces of encounter.

In many ways, this account of the prisoner-patient reflects Amy's story above. When the guard told her to move (*i.e.*, a custodial procedure), she resisted, saying her HSR guaranteed her protection and medical accommodation. Nurses degraded her as a criminal and an addict faking it to get pain meds. Her medical diagnosis weighed on and ultimately lifted her disciplinary infractions. Yet, while the logics of care and custody frequently clashed in the stories that formerly incarcerated women and trans folks shared with me, interpersonal ambiguity was not the only or even the most salient way in which these clashes occur or find resolution. In every case, the possibilities for care behind bars are always already conditioned both by routinized punitive thinking and institutional policy. Indeed, often the tension between custody and care never appears as such. While Sufrin in particular highlights the negotiations of prisoner-patient subjectivity that occur within the clinical interaction, I highlight here the administrative mechanisms that structure these negotiations, that either condition or preempt the prisoner's entry into the position of patient in the first place. For Amy, her suffering was *administered* slowly and tediously by the mechanisms of bureaucracy.

In this chapter, I argue that the unique contradictions of care and violence that carceral care makes possible, by which some individuals may receive medical treatment, few receive meaningful care, and many merely soldier on in suffering, depend upon a particular formation of carceral biocitizenship. The prisoner under carceral care, I argue, is socially disabled but biologically diagnosable, treatable, and cared for, even if minimally or not at all. Their treatment as biological bodies depends in fact upon their depoliticization as non-citizens. As I demonstrate, the prisoner under carceral care is far from the entitled, individualized, legally defined, rights-bearing citizen. She is de-individualized, subject to not just mass incarceration but mass treatment as well. She may be seen by the clinical gaze but she is rarely heard as anything more than a series of medical symptoms. She is patronized by paternalistic doctors and excluded by sexist policies. The ideal prisoner under carceral care therefore is a passive consumer. She receives what care the prison has decided she

deserves, but she asks no questions. In this way, carceral care reflects the wider logic of neoliberal penology that permeates the rest of the prison, seeing the prisoner not as an individual ward or citizen but as a passive consumer and a drain on state resources.

Prisoners under carceral care, however, are far from singular. They are multiply positioned within the wider landscapes of racial capitalism. As a result, what counts as care and what counts as violence are, at least in experiential terms, deeply shaped by prisoners' subjection both before and during incarceration. Finally, the prisoner under carceral care is one whose suffering is tolerable, calculated, indeed enabled by the prison system. As a result, the prisoner under carceral care is not, I argue, *homo sacer*, the spectacular figure of killability, but rather a far more mundane figure of debility, whom the prison may be required to sustain but who, as a result, can only live on but never get better, never thrive, never live in anything but a biological sense. The prisoner's citizenship in biological terms depends upon her degraded citizenship in political terms.

The Birth of the Prison Clinic

The patient-prisoner as abstract legal subject, both endowed with and denied certain rights, may be defined in the annals of jurisprudence, but the contours and substance of the flesh and blood prisoner, the conditions of their care (or lack thereof), the biopolitical governance of their lives and life chances—these are shaped less by law and more by a penal bureaucracy of rules and routine practices. While the convict of the courtroom may be a legal being, the prisoner in the penitentiary is a thoroughly administrative subject. This reformation of the incarcerated subject is central to the workings of carceral care. Yet, while this transformation may seem automatic and instantaneous, as inevitable and solid as a prison door, in reality, this process takes time and space. It requires rites and rituals. It is prolonged and power-laden, yet it is therefore also necessarily partial and subject to contestation.

For everyone incarcerated in a Washington state women’s prison, this subjection begins at Purdy’s Reception Diagnostic Center (RDC)⁴⁷ (DOC Policy 310.150), commonly known as ‘receiving.’ One former prisoner called this the “in-between place.” New prisoners are transferred from county jail and typically wait six weeks or more while DOC assigns them a security status (*e.g.*, minimum, medium, maximum), housing, programming, and/or work. It is a dull six weeks. It is during this limbo, this banal crucible that newly incarcerated women and trans folks first learn—in visceral, affective, material, and discursive terms—what it means to be a prisoner under carceral care.

This embodied education begins on Chain Day, the day when newly convicted people are moved from county jail to receiving. As Caroline, who was incarcerated for six years in the 2000s, explained:

“Thursday is King County – probably the biggest county in the state for people going to prison. That’s maybe fifteen women that week, right? Pierce County, that’s another big day ‘cause Tacoma’s pretty big. So maybe they’ll send five women on that day. Other days of the week, it’ll be other counties, and they might have one or two each. So you end up developing this cohort, a weekly cohort. It’s like thirty people. So everything that you do, from the clinic to the mental health facilities to everything, you’re herded in your cohort.”

Chain Day is also the first day people in receiving meet DOC healthcare staff. “Your very, very, very first contact with the clinic is literally your first day in,” Caroline went on. “The very first day you come in, the medical staff is actually there when you strip search out of your clothes. They’re documenting all your tattoos, scars, marks, identifying things, if you have a metal hip. They’re categorizing all of the things that could potentially be going on with you there.” What does such an interaction communicate to the new prisoner? Healthcare staff do not formally serve any security or

⁴⁷ Cis men, trans women, and gender variant folks categorized “male” by the state are sent to the RDC at Washington Corrections Center in Shelton, Washington.

custodial function in the prison. This fact is central to many prison healthcare providers' professional identities (Rhodes, 2004; Sufrin, 2017). This fact is also clear to Caroline. The distinction between healthcare staff and guards is clear. Yet, healthcare staff are present, facilitating the custodial process. This encounter illustrates the experiential ambiguity of prisoner and patient identity under carceral care.

Once Chain Day is over, newly incarcerated women and trans folks enter weeks of waiting. This monotony is broken only by the occasional evaluation or orientation from prison staff where new prisoners learn the rules of incarcerated life. Virginia was incarcerated in 1997 when she was twenty-seven years old. She spent the next two decades at Purdy. “When I went to prison,” Virginia recalled, “they did have an orientation. They let us know the sick call rules, basically. Don't go to sick call unless it's something you would go to the emergency room for. Stuff like that.” It is during one such orientation, usually five or six days after arriving at receiving, that the newly incarcerated receive a copy of the Health Services Orientation Handbook. In this slim booklet of just sixteen pages, the prison makes clear what prisoners should expect when it comes to their health behind bars:

“All medical, dental, and mental DOC Health Services will be provided consistent with the DOC Offender Health Plan (OHP). The OHP is available for you to read at all Law Libraries, unit duty and through the KIOSK system, where available. Providers (including nurses) are responsible to deliver all medically necessary care as defined in the OHP⁴⁸. There are various guidelines and DOC Health Services policies established to help them deliver quality care. If you have questions or need any issue explained, please discuss your concerns with the nurse conducting your intake interview or sign up to see a provider” (2017: 3).

⁴⁸ The Offender Health Plan outlines which medical interventions DOC will provide and which it will not. I discuss the OHP in detail later in this chapter. In 2019, the DOC changed the name to “Washington DOC Health Plan.” This reflects a DOC-wide effort to expunge the word “offender” from department policy and vernacular. Officially, DOC has opted for “incarcerated individual.” In this manuscript, I refer to the “Offender Health Plan” or “OHP” because at the time of research it remained in use and today remains a familiar term to most prisoners and DOC staff.

This handbook is more than a mere recitation of prison policies, however; it is a tool of subjection, interpellating the new prisoner into the logic of carceral care.

The prisoner under carceral care is first and foremost dependent on the prison institution. The prison healthcare system will provide for her ... except when it will not. I expand on this administrative conditionality below. Second, this prisoner is depoliticized through her subjection as an *administrative* subject. The handbook never once mentions the law, the prisoner's (albeit minimal) constitutional rights, or the legal onus upon her captors to provide (albeit minimal) care. Outside the “right to refuse examinations, treatments, and procedures in almost all instances” and the “right to confidential mental health care,” the juridical language of rights is entirely absent. Instead, the new prisoner is told which healthcare services cost a \$4 co-pay⁴⁹, which are free, what the penalty for missing an appointment is, when she can refuse a provider's orders, and so on. Nowhere does she learn during the legal foundations of carceral care, why DOC treats some conditions and not others, or who decides. Any language of rights is eclipsed by an administrative discourse of rules, restrictions, allowances, formularies, policies, procedures, and protocols.

In using the procedural language of bureaucracy, DOC elides the context and historical contingency of prison healthcare, thereby reifying present realities as though they were beyond contestation. Prisoners are told how to file a grievance, but not what legal recourse is available should that effort fail. Moreover, prisoners can only file a grievance when a DOC policy has not been followed. They cannot contest DOC policy itself⁵⁰. Prison healthcare is thus portrayed as a purely administrative issue of procedure, from which individual bad actors may stray but whose fundamental nature cannot be questioned or changed. The prisoner under carceral care has no

⁴⁹ A typical hourly wage for non-industry work in a Washington prison is \$0.36 per hour. An individual in a non-industry prison job can make up to \$55 per month. Industry jobs under Correctional Industries are paid between \$0.70 and \$2.70 per hour (Sawyer, 2017).

⁵⁰ That is, unless they have the immense resources necessary to file a lawsuit. As I discussed in my introduction, however, the PLRA requires prisoners exhaust administrative channels before they pursue legal relief.

political agency to contest the way things are with prison healthcare, nor even to contest their apolitical standing. They are at root administrative subjects and, as such, are trapped in the discursive terrain of carceral state bureaucracy. The newly incarcerated are simply told the way it is, as though it has always been and always will be this way. The new prisoner is removed from the juridical realm of rights and placed into a land of rules. The elision of rights for rules reinforces the prisoner's passive position under carceral care. *Them's the rules.*

Mass Treatment

For the women and trans folks in Purdy's receiving unit, this period is marked by experiential opposites: long periods of waiting around interrupted by sudden moments of intense activity. The new prisoner spends hours, even days being seen by no one, only to be suddenly put under the gaze of the prison nurse. While experientially distinct, I argue that both are materially, and indeed symbolically, central to the relations of carceral care. Carceral care, I argue, involves both bureaucratic surveillance and systematic non-knowledge, both mutually enabling the other.

Caroline, incarcerated in the mid-2000s, entered Purdy's receiving unit eager to see a doctor. She had given birth at the county jail just two days prior⁵¹. Purdy staff, however, failed to provide sufficient or timely post-natal care.

“I got to prison two days after I had my baby. And because I didn't have my baby at Purdy, because I had my baby at King County [Jail], Purdy did not acknowledge me as having a baby. Even though I told them I just had a baby, for some reason there seemed to be a really big gap in them understanding that and getting me any of my post-natal care. So, like, my six-week checkup – that I should've had as a woman just to make sure I was okay after having a baby – I didn't end up getting until like three-and-a-half months after I had my

⁵¹ Because she gave birth in jail and not under DOC custody, Caroline was not eligible to benefit from Purdy's Residential Parenting Program.

baby. Just because they just didn't, I don't know, it was like they didn't see it as an event because it didn't happen there.”

Despite communicating her situation during her intake exam, and despite formal policies meant to ensure the transfer of medical records from jail to prison, Caroline did not receive proper care.

Such simultaneous surveillance and neglect may appear merely coincidental. Formal mechanisms of bureaucratic knowledge, however, often actually enable systematic neglect. In the case, whose story opened this chapter, nurses at receiving *did* write her an HSR. Before entering Purdy, Amy had heard stories about a woman with her condition who had died in DOC custody. When it was Amy's turn to see the nurse at receiving, she "needed to make sure they understood why I take an anticoagulant every day ... because the condition I take it for is more rare than the normal one” (personal interview, 2018). Miraculously, Amy's HSR, the one the guard had said was nonexistent, reappeared just days after her fall. Amy wrote kites, made appointments, and paid co-pays. Multiple doctors and nurses saw her at the prison clinic. There was no shortage of paperwork. Yet, neither her HSR nor her kites nor her appointments ensured her any relief. Rather, these bureaucratic tools, while at times ensuring some prisoners access to medical accommodations, also provide a procedural veneer to the brute violence of prison. Indeed, Amy was moved to a top bunk precisely to accommodate another prisoner who, being pregnant, was given an HSR for a low bunk. In the end, it was neither Amy's nor the other woman's HSR that shaped the course of events, however. It was simply and plainly the sovereign authority of the prison guard. In this way, the seemingly individualizing mechanisms of disciplinary power actually produce sovereign effects of non-individuality and impersonal violence. Amy's HSR mattered little to her broken jaw.

It is common in public and academic discourse to refer to these events as evidence of medical *neglect*. But what exactly does neglect mean? Some people in prison avoid the clinic due to costly co-pays, worry over lost wages, or fear of medical maltreatment. Others, as I illustrate below,

struggle to have their symptoms taken seriously. Both Caroline and Amy, however, alerted the prison to their healthcare needs. So, their neglect was not due to *ignorance* on the part of the prison. Rather, this neglect resulted from what anthropologist David Graeber calls “structural stupidity” (2015). “[M]ost acts of extreme violence ... take place in bureaucratic environments,” writes Graeber (*ibid.*: 53). This is not because bureaucracy, be it state or corporate, produces individually stupid behaviors—though it does do this—but rather because bureaucracy emerges as a managerial response to situations that are already inherently stupid because they are based on structures of violence; and brute violence need not be intelligent or well-informed. In the case of prisons, the sovereign violence of incarceration, of putting people in cages, creates a situation of structural stupidity that must be managed, and perhaps ameliorated but never solved by prison healthcare. The frequency with which formerly incarcerated people described ‘falling through the cracks’ or being ‘churned through the mill’ suggests that this is not mere *neglect* but rather a persistent structure of stupidity and uncaring non-attention that carceral institutions like the prison create.

This experience of surveillance and neglect, of being known and not known, of being seen, not seen, and rarely heard, also shapes the prisoner’s experience as a (non)individual under carceral care. At different times and places, carceral care both disciplines the singular individual and abandons the undifferentiated mass. In receiving, prison healthcare staff may examine, diagnose, and classify the new prisoner as an individual patient. During the rest of their time in prison, however, prisoners suffer long wait times, a general lack of attention to individual clinical circumstances, and one-size-fits-all treatments that together render individuality effectively superfluous.

For example, when asked why she had not received timely care, Caroline responded:

“The receiving process is just sort of them checking things off of a list. I think they were listening to me. They may have even been charting it. I feel like the follow-up didn’t happen because nobody ... nobody took the initiative to say ‘Oh! Maybe we should make sure

there's something done about this ... I just don't think that anybody was cognizant enough.

Because when you're going through the receiving process they're just sort of herding you."

Indeed, many participants described receiving as a kind of cattle call. "It's not me going to the clinic and getting seen," Caroline explained. "It's me and thirty of my friends going to the clinic and being seen. It's just too fast." On Chain Day, people are individually catalogued, their bodies charted for tattoos, scars, or injuries. Yet, Caroline continued, "That is done very group-like. Because it's done on the main floor of the [receiving] unit. You're strip searched out in the showers" in full view of other prisoners. Tricia, who was incarcerated from 2006-2008, described a similar experience being required to strip for a medical exam alongside eight others.

This paradox of mass neglect via individual treatment (and vice versa) emerges in the space of the prison clinic, as well. "When you went into medical," Kari explained, "it's this not large but maybe medium room. Not comfortable. By no means. Everybody is shoulder to shoulder, and it's always packed. There is not a time that it's not a packed unit. It's all about let's get them in as fast as we can, in and out, in and out." For Kari, who was incarcerated throughout the 2000s at both Purdy and the now shuttered Pine Lodge, this experience was the same whether at a 6:00 a.m. sick call or at a scheduled appointment, though appointments usually had slightly shorter wait times. This experience of superfluity carried over into clinical interactions, as well. When I asked Kari how they were treated by clinic staff, they responded, "like an inmate ... like an inmate ... kind of like less than a person." When I asked Kari to explain further, they refused. "I don't know the words to describe it," they murmured. "Yeah, I don't want to get...," they trailed off. Thus, as Sufrin (2017) suggests, any status as patient is constantly under threat, even overshadowed, by the prisoner's criminal status.

Diagnosis and treatment prove crucial sites in this negotiation of surveillance and neglect, individuality and sameness. Many women I spoke with described receiving one-size-fits-all

treatment. Jolene was released from Purdy several years ago. Before incarceration, Jolene had been on psychotropic medication for depression and anxiety. While she tried to continue her treatment at Purdy, she was often frustrated by long wait times, rote clinical evaluations, and staff dismissal of clinical symptoms. “Once I had to turn myself into County,” she explained,

“that all stopped abruptly. So I'm going through withdrawals while I'm in there. That's something I didn't even think about before going in. I mean there was just so much on my mind ... that should've been a number one thing for me to figure out or at least give myself time to wean off⁵²” (personal interview, 2018).

It would be two months before Jolene saw a healthcare provider. “I sent a little thing to the [jail] doctors ... [It came] back saying, 'Well you're on your way to [Purdy], so we'll deal with that when you get there.'” Jolene continued, explaining that once in receiving at Purdy, she

“once again sent a kite asking to speak with a medical professional regarding my depression and anxiety. And once again, it was probably at least two weeks later I got something back stating that it will be addressed once I'm where I'm going to be staying ... So once again you're in like this limbo period ... It sucked.”

After six weeks in receiving, Jolene was finally moved to Mission Creek.

“So once again, I filled out my little kite thing and then waited, and so then when I finally [got an appointment] it was ... and I don't blame the doctors and nurses. They're just doing what they can, but there's only a limited amount of time and you're not really getting the medical attention that you need ... You don't really get to go into detail like what your symptoms are, like ‘I have trouble sleeping’ or ‘I'm just feeling very like I'm going to have panic attacks.’ You don't really go into any information like that. It's more just like, ‘Okay,

⁵² I asked Amber if any state officials – judges, public defenders, DOC personnel – had explained to her what would happen when she surrendered herself to the county jail. “No, I didn't have a lot of money at that time and I had a public defender and he really didn't tell me what to expect either,” she replied.

how long have you had this?’ and that was about the extent of it. It's just very in and out ... very, very in and out. Just kind of a general like ... you're just a generic robot-type person.” Even after finally securing a diagnosis for depression, Jolene continued to suffer what she described as “one-size-fits-all” treatment.

“‘Oh, you have depression, okay, we're going to put you on this.’ They didn't ask what I've been on prior. I don't know if that's something they can get in there. I'm just like, okay ... And that's the other thing. They have med times, it's in the morning at probably like 6 a.m., 6 or 7 a.m. and then at night at like probably 6 or 7 p.m. as well, and those are the only times you can get access to your meds. And sometimes with mental health and meds like that, some meds need to be taken with food or in the afternoon rather than first thing in the morning, or at night, because they affect everybody differently and individually, people find the right fit for them. So it's really hard to have to be told this is the only time you can get it. And a lot of times you have jobs that you're assigned to. Like I had [a job] at night, so I'm up all night. But if I want to take my meds, which make me feel sleepy, at night is the only time I can take it. That's my only option. Then of course you're going to sleep the next day, because you work at night, but then you've got to get up and take your med at 7 a.m. So it's really hard. It's very one size fits all. And the meds that they give you, they don't ask you what you were on prior at all. They just give you what they're going to give you and you can take it or leave it.”

For more than two months, Jolene went without her medications. She had no warning or time to reduce her dose. Once she finally saw a prison psychologist, her individual symptoms, medical history, and self-knowledge proved entirely superfluous. Moreover, the strictures of prison custody—the industrial logic of mass confinement upon which the prison is built that shape when

and where a prisoner can eat or work or take their medications—clash with the fleshy, bodily needs of the individual incarcerated patient.

This sense of one-size-fits-all treatment and shared subjection proved common for incarcerated women and trans folks. Generalized treatment became a basis for incarcerated folks recognizing their shared positions and identities as prisoners: equivalent, standardized, dismissed, minimally supported. After receiving her prescription for mild depression, Jolene lamented, “So now here I am in this place surrounded by lots of other females who are probably going through the same thing and trying out this new med.” Several other participants also described learning that their individual diagnosis and treatment plans were strikingly similar to many of their fellow prisoners. This was perhaps most distressingly evident in prison mental healthcare. “Everyone was on the same pills!” exclaimed Mary, who was incarcerated twice in the early 1990s and again in 2000.

“Everyone was on the same friggin' pills! And if there was any mental health thing—I can't remember if they ever tried to push it on me—it seemed like they were on Seroquel or Lamictal. Seroquel and Lamictal, just knowing what I know now, keep you kind of sedated. And it's like they're trying to, I don't know, herd the cattle, or something. Everyone's walking around all stoic ... They almost walk around, not drooling, but everything but. Like zombies ... And it was those two. All the time, you'd hear people were on those, in addition to Celexa or Paxil or something⁵³.”

While I cannot speak to the prevalence of chemical restraint and its use in Washington state prisons, this concern about psychotropic sedation, and Seroquel⁵⁴ in particular, proved common among former prisoners. Moreover, these perceptions echo a deep history in the U.S. of carceral

⁵³ Mary also acknowledged that some women needed psychiatric treatment. “If they didn't [get their pills], like the girls with mental health issues, you'd know it. Oh, so and so didn't take their pills because they were losing it.”

⁵⁴ Seroquel is an atypical antipsychotic drug generically sold as quetiapine and used to treat mood disorders including schizophrenia, bipolar disorder, and depression (Mayo Clinic Staff, n.d.).

institutions, including prisons but also women's reformatories, asylums, and psychiatric hospitals, using chemical restraint to subdue unruly subjects, including prisoners, neurodivergent people, and disobedient women and trans people (Foucault, 2006; Houston, 2002; Hunter, 1983; Mollow, 2006). As Anthony Ryan Hatch argues, psychotropic drugs have been central to enabling mass incarceration and their use in prisons remains largely unaccountable for their use (2019). Whether or not systemic chemical restraint is taking place in Washington, it is clear that generalized treatment, dismissal of individual symptoms, and uniform diagnosis creates the conditions for such abuse to happen. Mass incarceration begets mass treatment. In two chapters, I will return to this mass subjection to illustrate the ways incarcerated women and trans folks play upon this collective biosociality on their own terms

Uneven Carceral Biocitizenships under Racial Capitalism

Not everyone's suffering behind bars, however, is treated or even untreated equally. While many institutional policies and rules, as well as the discretionary powers of guards and administrators are common to all prisoners, these top-down regimes are imposed on women and trans folks unevenly situated within both the prison institution itself and the wider landscape of racial capitalism. People in prison also possess and practice their own unique agencies. While necessarily partial and preliminary, here I draw attention to just a few ways in which multiple biocitizenships articulate along lines of race and class. In the policies and everyday spaces of prison healthcare, the differently positioned inequalities of the free world collide, producing different experiences of healthcare itself within prison walls.

In 1978, reflecting on her and her women comrades' experiences, Black Liberation Army member Assata Shakur wrote:

“For many, prison is not that much different from the street ... For many, cells are not that different from the tenements ... and the welfare hotels they live in on the street ... The

fights are the same except they are less dangerous. The police are the same. The poverty is the same. The alienation is the same. The racism is the same. The sexism is the same. The drugs are the same and the system is the same (quoted in James, 2005: 85).

For Shakur, a growing neoliberal nexus of organized abandonment and carceral control targeted at the racialized urban poor "rendered the free world an extension of the prison" (Dillon, 2012: 113). This reality, in turn, shapes incarcerated women's and trans folks' experiences of carceral care, differentiating their self-conceptions, emotional reactions, and political agency in ways that produce multiple distinct, if related, carceral biocitizenships.

Before incarceration, several participants I interviewed had been living on the street and/or suffering from one or more substance abuse disorders. They often described the visceral and emotional relief they felt upon entering prison, where they had access to regular and reliable food, clothing, shelter, and basic hygiene and medical care. Before her incarceration in the late 1990s, Mary had been on and off the streets and suffering multiple addictions. When she got to Purdy, however, "instead of me having to remember my six month checkup, they would put me on the call out. Things like that were, of course, better taken care of in prison because I wasn't on drugs and because they would schedule it" (personal interview, 2018). Following decades of neoliberal budget cuts, what were already meager welfare state supports have been shredded. As a result, carceral institutions have stepped in to fill this gap, often providing emergency assistance alongside a cage (Sufrin, 2017; Wacquant, 2010). While this is most obvious in county and city jails, where people cycle in and out, prison also serves a similar function. Shirley was incarcerated at Purdy in 2006 for two years. Before that, however, she spent more than 20 years cycling in and out of the King County Maleng Regional Justice Center in Kent, Washington. During her time in jail, she received multiple surgeries for an abdominal hernia related to a stabbing attack she suffered when living on the street. When she was finally sent to Purdy, she gained significant weight. "I just was hungry all the time cuz

I'd been on the streets and not eating for so long," she explained. "So I gained weight, I gained a lot of weight at both Purdy and Kent ... And I was really underweight every time I got locked up. So I gained a lot of weight."

These stories contrast sharply with those of Amy, Jolene, or Morgan, whom had all been stably housed, employed, or financially supported by a spouse, and at least occasionally seeing a personal physician. Such disparate experiences illustrate what Pollock calls a distinctly American form of biological citizenship "in which consumer capitalism and racialized deprivation coexist" (2012: 144). A world of difference exists between losing medications upon incarceration and knowing where your next meal is coming from for the first time in weeks. This is not to say, however, that the politics of carceral biocitizenship can be reduced to one of cultural relativism. We must not base our standards for life-promoting care upon the minimal affordances of a racist, classist carceral welfare system. Mary was well able to appreciate the meager affordances that carceral care allowed her within a larger context of racial capitalism *and* to see the violence of grounding care in an institution driven by criminalization and punishment. "In general, they did something about it when you went in," she told me. "They don't care, though. You know what I mean? Almost like 'If you did this, you wouldn't be here.' What am I trying to say? It wasn't compassionate care" (personal interview, 2018).

Suffering—(Un)Diagnosable and (Un)Deserving

As the above stories illustrate, women and trans people in prison struggle to gain the individualized attention of the clinical gaze, often leading to delayed, incorrect, or unknown diagnoses. In this way, the prison clinic and the clinical interaction become biopolitical spaces, in which nurses and doctors actively and passively judge whether or not prisoners deserve healthcare (Sufrin, 2017). Whether or not a prisoner deserves a diagnosis or treatment is not solely determined

within the clinical setting, however; rather these decisions are preconditioned by formal prison policies and protocols. Deservingness is administered.

Though “not a contract or a guarantee of services,” the Offender Health Plan (OHP) “describes the health and mental healthcare services available to offenders, as well as the services that are limited or not available” (DOC, 2019f). To this end, the OHP divides healthcare services into three levels outlining which diagnoses DOC will treat (and pay for) and which it will not. They include: level one or “medically necessary care” (e.g., cataract excision, moderate or severe depression); level two or “medically necessary care under certain circumstances” (e.g., cystic acne, mild major depression); and level three or “not medically necessary; NOT authorized to be provided” (e.g., acupuncture, genital warts, rosacea) (*ibid*). What then does the state consider ‘medically necessary care’? According to the OHP, a treatment must meet “one or more” eligibility criteria to qualify. These include: preserving life or limb, reducing “intractable pain,” preserving activities of daily living (ADLs), reducing “severe psychiatric symptoms” in a way that serves correctional interests, serving public health interests, or reducing the future risk that a prisoner will face one of the above conditions. While level one treatments are seen to meet this definition, level three interventions “merely speed recovery of minor conditions, give little improvement in quality of life, do not advance correctional interests, offer minimal relief of symptoms, are exclusively for the convenience of the individual,” or only serve a “social function” (*ibid*). Level two interventions, meanwhile, depend upon “clinical circumstances” and must be approved by the Facility Medical Director or Care Review Committee, an administrative process I discuss later in this chapter

While U.S. prisoners have the constitutional right to access care, to receive prescribed treatment, and to receive professional medical judgment (Rold, 2008), the precise substance of constitutionally adequate care remains legally vague and geographically uneven. Indeed, with federal and state courts and legislatures largely silent on the question, what counts as constitutionally

adequate care is largely determined by individual prison administrators and clinicians (Vanheuverzwyn, 2009). In Washington state, the OHP translates this distinction into the difference between care it considers medically necessary and, as the former Health Services Chief Medical Officer put it, "care that may simply be reasonable or appropriate but not necessary" (Hammond, 2017). The OHP thus divides prisoner suffering into three categories of medical (un)deservingness. These eligibility criteria serve as tools of administrative violence, bureaucratically determining which forms of suffering are worthy of receiving care and which are undeserving, or even unintelligible *as* suffering.

Under the OHP, any prescribed treatment qualifies as medically necessary if it preserves a prisoner's activities of daily living (ADLs), defined to include activities "related to personal care and include bathing or showering, dressing, getting in or out of bed or a chair, using the toilet, eating, and walking or assisted mobility sufficient to accomplish these activities" (*ibid*). As a result, ADLs prove a particularly contentious site in the biopolitics of prisoner suffering and carceral care. On its face, this definition values incarcerated people's needs apart from their criminal status. In practice, however, DOC only values ADLs to the extent that they fit within its state-audited correctional goals: work assignments and court-mandated or otherwise required programming. A medical intervention may improve a prisoner's health or well-being, but if the prisoner can still walk to work then the DOC has ruled that person's suffering unworthy of state resources.

One former Purdy psychiatrist explained to me how this biopolitical logic came to shape her clinical interactions with prisoners.

"So there are a lot of restrictions on what you can prescribe. And a lot of restrictions on for whom you can prescribe because of the whole mental illness versus suffering. We were not allowed to treat suffering. That was a really, really hard ... I think for me that was like, I can never work in the prison system because I believe suffering should be treated and just

because it doesn't constitute an illness *per se*, there is certainly relief that could be had, and that was not the philosophy of the head of psychiatry for the prison system” (personal interview, 2018).

The administrative violence of prison healthcare policy thus hinges on the discursive cut between an illness that is medically diagnosed and thus deserving and suffering that is undiagnosable and thus undeserving. This same clinician went on to explain the eligibility criteria along which this cut was made:

"So that's a very fine line. So a lot of times in my practice [outside prison] I will treat somebody's symptoms, whether or not they meet the diagnostic criteria for a certain diagnosis. 'Does this person meet every single criteria required for the DSM-5?' I can put it in the insurance that this is what I'm treating even if they don't really meet those requirements. However, in the prison system, if they didn't meet all of the bullet points, then you weren't treating. So that's kind of where the difference comes in. So let's say someone comes in and they are telling you, 'I am *so* depressed. It is *so* hard to get up every day and go to school and go to my job and I'm crying every night.' The key is they *are* getting up every day and they *are* doing it. It doesn't matter how hard it is for them. It doesn't matter how much they're suffering. They have not gotten a reprimand ... They haven't been written up for not showing up, for not meeting expectations. So therefore they're functioning. It doesn't matter how hard they're working or how much they're suffering in the process. If they're meeting the expectations and not breaking the rules, then in the system's mind they're functioning."

The politics of carceral care reduce the prisoner to a stripped-down understanding of 'daily living' akin to Agamben's conception of bare life, defined as "suffering bodies and biological life devoid of social and political content" (Ticktin, 2006: 35). It does not matter *how* a prisoner gets out of bed as

long as they do it. Yet, the suffering prisoner is not entirely devoid of social or political context. It is simply that their criminal status (and the rehabilitative requirements placed on them as a result) is the only context that matters. In the abstract, ADLs may seem discursively capacious, able to capture the different situated needs of people in prison. In practice, however, the prison only cares about those ADLs deemed necessary according to its own carceral logic of control and discipline.

Indeed, when this clinician raised her concerns with Purdy's head of psychiatry, he made clear the prison's dependence upon a narrow definition of worthy suffering.

“So he did spend some time trying to convince me of like why we treated illness and not suffering. And I think it was kind of like, 'Look, these people are here to be punished.' I'm like, really? I thought they were here to be reformed ... I thought we were here to like offer people more opportunity to get something out of, you know, something that they could learn from this experience. Not just in terms of like paying for their crime, but like maybe they'd have a job skill when they left here so they won't have to be reduced to breaking and entering or prostituting themselves or whatever they had done to get in there ... And he was like, 'That is not what our penal system is about' ... I said, 'I clearly, I have a different interpretation or a different understanding of the penal system.' And he's like, 'Well, you're not ingrained in it.'”

This is the bare-faced, biopolitical logic of carceral care. It does not seek to improve or promote the well-being of prisoners, but only to maintain their minimal survival, their existence as bare life, not as vulnerable people in need of compassionate care, but as bodies, sick or healthy, a collection of medical symptoms, devoid of any social or political context, desire, or agency. The suffering prisoner may live on but may not get better (Shildrick, 2015).

Of course, at some point somewhere, an ontological line must be drawn between suffering that requires medical care and suffering that does not. (Or at least this is true in a context of

commodified medicine.) This clinician recognized as much when she contrasted her clinical practice inside and outside of prison. "You know, I'm a midwife. That's what I do," she explained. "Like I help people with their suffering. Or I help them make the distinction between: Is this acceptable pain versus is this suffering? And like, maybe that's the place where we draw the line." Carceral care relies upon a techno-medical system seated in a standardized, rigid, bureaucratic regime of order, control, scarcity, and commodification. By contrast, this clinician insists upon practicing care as a relational, recursive undertaking in which patient and doctor together navigate the space between suffering and well-being, organizing their response always in terms of need rather than deservingness.

Carceral care, however, cannot abide such social or biological complexity or relationality. With materially limited resources and minimally defined concern for prisoners' daily living, the prison's ability to meet its meager carceral burden while maintaining carceral control necessitates keeping the distinction between deserving illness and undeserving suffering, set and static. Indeed, if the prison were to recognize even a limited set of prisoner suffering as requiring care, this would likely be the end of mass incarceration as we know it. Not only are people entering prison (and especially women's prisons) likely to suffer from stress, depression, anxiety, and a history of trauma (Bronson and Berzofsky, 2017), but incarceration itself causes significant suffering. Given this reality, it is unsurprising that carceral care requires a strictly policed divide between deserving illness and undeserving suffering.

Gendered and Sexualized Vulnerability under Carceral Care

The divide between what and whose suffering is deemed (un)deserving hinges on whether that diagnosis is (un)diagnosable. For incarcerated women and trans people, however, this divide is shaped by paternalistic clinical care and sexist medical policy. For example, Colleen, who was recently released after more than two decades in prison, explained to me how the OHP and DOC

policy normalized inadequate reproductive healthcare. While locked up, Colleen frequently experienced abnormal menstrual and intermenstrual bleeding⁵⁵. "I would wake up in the middle of the night, having started my period. And in the morning, I would have, for lack of a better word, bled to death, and been so weak that I passed out on the toilet. And I had to have a medical emergency called." When asked how Health Services responded, Colleen replied, "Treat the symptoms. They don't, like I said, there's not a lot of women's health there. Or there wasn't when I was there." Colleen suspected she might have endometriosis, an often painful disorder involving abnormal uterine tissue growth⁵⁶. She asked the clinician if the prison treated endometriosis, but "the answer I got was 'We don't diagnose that here.' Fortunately, for me, the provider that I was seeing at the time was actually caring and kind and apologetic that that was something that they don't do" (personal interview, 2018). Since her release, Colleen has started seeing a regular primary care provider who did diagnose her with endometriosis.

This sexist bureaucratic exclusion was paired with more mundane forms of sexist and paternalistic treatment from clinicians. As outlined in earlier comments by Amy, Kari, and others, nurses and doctors at Purdy frequently treated prisoners seeking care and their symptoms with blanket disrespect, disregard, or doubt, believing them to be merely drug-seeking. While this systemic doubt may be a partial response to the rising number of people in prison dealing with substance abuse disorders, it is also rooted in sexist attitudes that see women as more likely to overmedicate and inherently manipulative (Stoller, 2003).

While sexist treatment may manifest in preemptive distrust, it also manifests through demeaning, paternalistic treatment by healthcare staff. Several years into her incarceration, Colleen went to the clinic for what she suspected to be a yeast infection. "The provider that I saw," Colleen

⁵⁵ While they could not explain it, several other interviewees also mentioned seeing surprisingly high numbers of women suffer similar symptoms.

⁵⁶ Endometriosis affects more than seven million women and people with uteruses in the United States.

explained, "was this lady...She puts me up on the table, puts my feet in the stirrups after she gets me naked. She looks at my vagina and proceeds to talk to it like it is a three year old and said, 'Oh, well aren't you an angry little baby?' She talked to my vagina like it was a sad little three year old, in a baby voice" (personal interview, 2018). Following this humiliation, the clinician told Colleen she had trichomoniasis, an STI, even though Colleen professed she had not been sexually active. Two weeks later, Colleen received a kite from Health Services telling her she had, after all, had a yeast infection.

While the risk of sexist treatment that incarcerated women and trans folks face is grounded in the systemic relations of carceral care, this structure of violence does at times personify in the form of particularly harmful individual actors. Multiple participants described experiences of inappropriate treatment or even sexual assault by prison doctors. When Mary was at Purdy in the mid-2000s, "the primary doctor there was kind of like a creeper, super uncomfortable feeling. You know what I mean? It's just like if I had a choice, I wouldn't have him do a pelvic" (personal interview, 2018). Claire was incarcerated from 1997 to 2006, spending four of those years at Purdy and the rest split between Mission Creek, Pine Lodge, and Tacoma Pre-Release⁵⁷. "So, there was a doctor" at Purdy, she recalled.

"He was an old guy who did physicals for us, you know, our yearly exams. And we would go in there and get our whole pelvic exam and all that stuff done. And then at the end, no warning, no nothing, he would just stick his finger in your butt, and pull it out. And that was it. It was all over. And it was like, 'Oh, okay.' You know, and the thought process was, 'Well, was he checking for polyps or whatever?' You know, but ... Like, I have had five children and never, and I'm 40 now, so I've had an annual every year since then, and never had another doctor do that. And he never explained it or anything. There was no warning, there

⁵⁷ No longer open, the Tacoma Pre-Release facility was housed on the campus of the Western State Hospital in Lakewood, Washington. It was designed to house 140 state-assigned female prisoners who had less than 24 months remaining on their sentence. <http://www.prisonstake.com/forums/archive/index.php/t-374827.html>

was no nothing. And that was the other thing, right? So, like I said, I've had multiple encounters with gynecologists. And, every doctor that I've ever seen, you know, you get your feet up in the stirrups and they're, like, 'Okay, you're gonna feel me touching your leg, and then you're gonna feel some pressure as I do your pelvic.' They kind of like talk you through it and warn you so you're ready. This doctor, it was nothing. Put your feet in the stirrups. The nurse would have you get your feet in the stirrups. You'd be sitting there waiting. And the doctor would just come in and like, no warning. Just cram the speculum in, do the exam, and get the hell out of there. Stick his finger in your butt and then get the hell out. He didn't even really talk to you the whole time. He never explained any of this stuff to you. It was more like a veterinary clinic."

Incarcerated women and trans folks are not passive victims to this abuse. When they do speak out against such violence, however, they are often ignored and left with little recourse. In 2006, Charles Momah was sentenced by the King County Superior Court to twenty years in prison for raping and sexually assaulting multiple female patients when he worked as an OB/GYN in the Seattle metropolitan area (Ostrom, 2005; Westside Seattle, 2006). Multiple survivors at the time also accused Charles Momah's identical twin Dennis, who was licensed as a general practitioner, not as an obstetrician or gynecologist, of posing as his brother, performing unnecessary procedures, and sexually assaulting his patients (Schmader, 2005). Claire remembered hearing about this story when it appeared on the news in 2005. "I never saw this doctor," Claire explained,

"but a lot of the other girls there had. His name was Dr. Momah. And there was this whole big thing we saw on the news about a Dr. Momah. And they showed his picture. And it looked identical to the guy that they'd been having come in. He was a gynecologist in the community who was being brought up on charges of sexually assaulting multiple of his

patients. And, girls had been complaining about him for quite some time” (personal interview, 2018).

It remains unclear whether the prison had been contracting with Charles Momah, an OB/GYN later convicted of rape and sexual assault, or Dennis Momah, who is not an OB/GYN and has multiple allegations of sexual assault against him. Notably, however, no news story on the Momahs mentions either brother’s employment with DOC. No story mentions the complaints incarcerated women and trans folks often made about their misogynistic mistreatment. People at Purdy had been speaking out against their abuse, but nothing was ever apparently done about it, nor was it ever publicized. At the time, guards told Claire that it was Dennis Momah. Whether or not this was true, as Claire put it, for people in prison, “we’re inside there, so we couldn’t actually do any research to find out.” Incarcerated women and trans folks are systematically dismissed, gaslighted, and denied the agency necessary to know the truth of their conditions, much less do anything about it.

Much attention has been paid in recent years to the particularly gendered experiences and needs of incarcerated women. While much of this debate has focused on the needs of women in prison to have greater access to women's healthcare, often in the form of so-called 'gender responsive' policies and institutions (Braz, 2006; Wright et al., 2012), far less attention has been paid to what it means to be a person in a women's prison seeking healthcare at all. Personally isolated and politically disenfranchised as prisoners, and thus as not-quite-patients, incarcerated women and trans folks are left vulnerable to abuse by medical professionals. This abuse may come in the form of mundane disregard and disrespect or in the form of intense physical and sexual abuse. This compounds the violence of a carceral context that already institutionalizes gender violence. Sixty percent of people in federal and state women's prisons have a history of sexual abuse (Lapidus et al., 2005). The stories of people formerly incarcerated at Washington women's prisons highlights that both care and violence in prison are deeply gendered and sexualized.

Medical Authority under Carceral Care

The prisoner under carceral care is socially dead but biologically diagnosable, treatable, and cared for, even if minimally or not at all. This distinction in turn depends upon the discursive distinction of medical authority in prison as an apolitical institution separate from the prison's carceral logic and function. As sociologist Paul Starr argues, since at least the end of World War II medical science has been driven by a liberal fiction of "progress without conflict" (2008: 336). Modern medical authority is premised on the ideal of scientific progress and professional expertise serving the public good, even while numerous struggles and people's health projects lay bare "the gap between the promise of better living through medicine and actual conditions of inaccessible, demeaning health care" (Loyd, 2014: 3). In the case of carceral care, this discourse of technocratic magnanimity is maintained through administrative mechanisms that keep prison medical authority as an insular, unaccountable, unmonitored, depoliticized site of biopolitical decision-making.

At the beginning of this chapter, I referenced the Offender Health Plan's three levels of medically (un)necessary care. Level one is medically necessary. Level three is medically unnecessary. Level two is a space of ontological betweenness, encompassing those conditions, ailments, and treatments that *might* be deserving "under certain clinical circumstances" (DOC, 2019f). When proposed care falls into OHP's level two, it may be reviewed and approved or denied by the prison's Facility Medical Director or by the Care Review Committee (CRC⁵⁸), a statewide weekly teleconference where the prisoner's attending physician presents their clinical case to a panel comprised of "available primary care physicians, PA(C)s, and ARNPs" and chaired by DOC's Chief Medical Officer. In making their rulings, CRC members are advised to consider the following factors (in order of importance): medical necessity, medical tests, safety and effectiveness, urgency of

⁵⁸ Most Level Two designations are resolved at the CRC. However, in a small number of time-sensitive cases, the prison's Facility Medical Director or DOC Health Services Chief Medical Officer may decide.

treatment, and "length of the offender's remaining sentenced stay"; "time to release" when "time is not of the essence", community resources for continued care post-release, pre-existing conditions, cost minimization and cost effectiveness, custody, safety, and security (*Haldane v. Hammond*, 2017). Non-DOC consultants and specialists involved in the prisoner's care are "welcome and encouraged" but not required to attend⁵⁹. This creates inconsistencies in prisoner care, as one prisoner advocate described. "The allergist will say they need x, y, z recommendation and then the CRC will say no. 'Well, did you have an allergist on the CRC?' And a general practitioner on the CRC who knows nothing about allergies will say no" (personal interview, 2018). While this inconsistency is worrying, prisoners and their allies have launched a much broader critique of the CRC and its decision-making.

On November 17, 2015, Seattle-based non-profit Columbia Legal Services (Columbia) initiated a class action lawsuit against DOC with the U.S. District Court for Western Washington. First, however, Columbia had to file for class status. To this end, Columbia composed a seventeen-page complaint against DOC asserting that CRC policies violate the Eighth Amendment constitutional rights of "all current and future prisoners" in Washington (*Haldane v. Hammond*, 2017). According to Columbia's suit, the CRC "regularly results in arbitrary and medically unsound decisions" that expose incarcerated people to "a substantial risk of ongoing and unnecessary pain, functional limitations, and other serious harm, in violation of the Eighth Amendment to the United States Constitution" (*ibid*). Specifically, the CRC process "denies medically necessary treatment ... by allowing a committee of clinicians and administrators who have little familiarity with the patient to override the clinical recommendations of the patient's treating DOC practitioner and outside specialists" (*ibid*). Moreover, Columbia argued, CRC members have "inadequate time for informed review, debate, and decision-making," "are not required to examine a prisoner-patient or their

⁵⁹ As of yet, there is no publicly available record that precisely reflects how often specialists are present or absent from CRC decisions.

medical records before voting,” regularly recommend "conservative treatment" even when such treatment has already failed, and regularly disregard prisoner's complaints of "chronic and substantial pain” (*ibid*). Finally, Columbia contended that the CRC lacks "standardized medical criteria or objective clinical protocols" for interpreting the Offender Health Plan, which moreover does not provide an exhaustive list of all diagnosable conditions or possible treatments. Prisoner advocates recently corroborated this, saying that Health Services does not have exhaustive treatment protocols and that they were actually surprised how few they do have (personal interview, 2019). As a result, Columbia argued, CRC decisions prove arbitrary or clinically inconsistent. A month after receiving Columbia’s suit, DOC responded, disputing some allegations (*e.g.*, inadequate time for case review) and refusing to answer others because Columbia was not technically suing DOC, only filing for class status. Notably, responding to critiques of the Offender Health Plan, administrators argued that the OHP “speaks for itself” (*Haldane v. Hammond*, 2017)

This lawsuit is unique for the way it challenges not just harmful prison healthcare conditions or medical maltreatment but more centrally the political legitimacy, medical soundness, and moral authority of administrative decision-making that underlies carceral care. As Columbia argued, the experiences of individual prisoners are "not isolated or uncommon" but "reflect a system-wide problem that results in a substantial and ongoing risk of serious harm” (*ibid*) Columbia’s claims largely centered on the CRC’s internal protocols – who votes, who weighs in, who is present, who is not, who provides expert opinion, who does not, for how long, and what qualifies a member to vote on a clinical case? In short, how does the CRC decide who is deserving and undeserving?

To answer these questions, during discovery for the case, Columbia repeatedly petitioned the court to let a third-party observe the CRC in-person or by video or audio recording. DOC refused, however, arguing that this would violate patient confidentiality and potentially violate CRC members’ Fifth Amendment rights against self-incrimination. Judge Richard A. Jones sided with

DOC, denying Columbia access and arguing that they could learn everything they needed to know about CRC decision-making from what it make publicly available: single-page summaries of each final decision that provide no medical reasoning or concrete detail about the events or debates that led to each decision. Per current DOC policy, the CRC is not required to provide anything more. As a result, Columbia's suit rested largely on the individual cases of its four prisoner litigants.

On September 9, 2017, the Court denied Columbia its petition for class action status. According to Judge Jones' ruling, Columbia ultimately failed to "evidence a common policy or practice by the CRC to systematically and unreasonably deny care" or to identify "common policies and practices to show that [DOC was] deliberately indifferent to inmates' needs" (*ibid*). The judge did find that Washington prison healthcare was "certainly concerning and could evidence poor performance – or even malpractice – on the part of DOC practitioners." The judge continued,

"CRC members explained in depositions that meetings often turned on how the committee could 'justify a no' when considering treatment. Dkt. # 47-5 at 36. Some members strategized ways to obtain necessary care for their patients, sometimes by asking for more care than necessary so that a concession would result in the correct amount of care. Dkt. # 72 at 8. But none of these members admitted that a perceived culture of "no" affected their own behavior or caused them to vote against their judgment. CRC members opined on whether some mid-level medical staff were less 'independent,' but no CRC members affirmatively answered that another member had been swayed by non-medical reasons."

While this evidence may be concerning, the judge did not consider it systematically, unconstitutionally harmful to prisoner health.

It remains unknown what if anything may have changed had Columbia had access to the particulars of CRC's decision-making process. Nonetheless, *Haldane v. Hammond* illustrates several persistent patterns in the politics of prison healthcare. First, in distinguishing between medical

malpractice and unconstitutional harm, the judge reinforces the biopolitical logic of carceral care, wherein prisoners can suffer as long as that suffering is not too ‘serious.’ This distinction fails to account for the persistence of carceral violence, the slow, debilitating harm it exacts on prisoners and their minds, bodies, and spirits. Second, the decision illustrates the difficulty of proving ‘deliberate’ harm or direct, intentional violence within complex impersonal bureaucratic structures. This was the main reasoning for Judge Jones’ denial. Columbia, he ruled, had not proved deliberate indifference resulting in serious harm. As Spade argues, the administrative nature of much state violence often effectively nullifies legal action based in a liberal discourse of individual victims and volitional perpetrators (2015). Finally, I argue that this decision cleaves medical authority under carceral care from its social and political context. The court ruled that CRC decisions were ultimately a matter of clinical judgment. What the court did not consider, however, was the administrative decision-making process that determines what suffering is worthy of state resources. The court did not take up the OHP or Columbia’s criticisms of it, preferring to focus instead on the decision-making of the CRC divorced from the bureaucratically determined rubrics upon which it makes its decisions. As I have argued, this distinction is deeply conditioned by the necessities of a mass incarceration that depends upon its own ability to discipline, to control, and to deny its own violence. *Haldane v. Hammond* thus further alienates questions prisoners’ biological selves, needs, and suffering from the wider biopolitical machinations within which this suffering unfolds.

Afterlife

The carceral imagination depends upon a hard boundary between the prison and everything else, between the ‘inside’ and ‘outside.’ Unsurprisingly, however, this fiction fails in the face of incarcerated people’s actual experience. The effects of incarceration live on long after the prisoner’s release date. The production of prisoner subjectivity under carceral care requires intense effort on the part of the prison. In turn, undoing this subjection requires significant time and labor. No one I

interviewed felt that they ever fully escaped this subjection. Your broken jaw never fully healed. The sound of a clanging door sends you viscerally back to the Hole. Racing to make an appointment with your probation officer after you spent too long at the doctor's office, you suffer an anxiety attack in the middle of the I-5 highway. There are few resources available for formerly incarcerated people as they readjust to life after prison, even fewer that focus on their health or well-being. To conclude this chapter, however, I highlight one small program that seeks to undo the logic of carceral biocitizenship.

“You are valued and not forgotten and like you deserve a excellent medical care as much as the next person” (personal interview, 2019). This is the central message Rachael hoped to communicate to her audience. Rachael is a medical resident with Seattle's Swedish Medical Center where she and two dozen other physicians take part in a two-year residency program centering social justice medicine. As part of this program, every month Rachael and one or two fellow residents visit the Reynolds and Helen B. Ratcliff work release facilities where eligible Washington state prisoners spend up to twelve months under carceral supervision before their formal release date. Every month, the residents facilitate a workshop to answer people's questions about their health and what it looks like to access healthcare outside of prison.

These meetings often begin in much the same way prison life usually unfolds. “So the men's work released is far bigger,” Rachael explained, “so they choose like ten, twelve of the newest people to come to the class. Their names are called and they have like no idea. Pretty usual, right? They show up, they have no idea that this is a thing. It's technically required.” However, Rachael does her best to disrupt this carceral rhythm and dispel inherited assumptions about what it means to see a medical professional under DOC custody. “At the beginning, we say, ‘We're not connected to the DOC. Nobody will know whether ... like, from our perspective, you are not from our perspective required to be here. So if you have other things you need to be doing or would prefer not to be here,

you're welcome to leave” (*ibid*). As the meeting continues, Rachael and her colleagues do their best to undo the subjections of carceral care, to rescript the clinical relationship from one of paternalism, passivity, and neglect to one based in relational care and self-determination.

“The way I have experienced it and I've run it is mainly trying to make it a back and forth. Like, ‘Why would you go to the doctor and like what are the benefits of having a consistent primary care?’ Like, ‘What are things that you could talk to that person about?’ And trying to also have it be like an empowerment thing of, like, ‘Look at all of the stuff that you know.’ And also that you can set the agenda. It's a negotiation. So, you know, maybe your doctor's really concerned about your blood pressure, but you're really concerned about your elbow. So like you can say, ‘Listen doc, like I know you're wanting to care about my blood pressure, but it's all about the elbow today.’ Yeah, and just trying to make that point and then answer questions that come up” (*ibid*).

While Rachael and her colleagues answer personal medical questions, the ultimate message of the workshop for her is to undo the social death that incarceration has wrought. “I think the other tools,” she explained, “is to be, like, here are some doctors who really feel like it's worthwhile to spend our time here talking to you guys. Like, you are valued and not forgotten and you deserve excellent medical care as much as the next person” (*ibid*).

Even from Rachael's limited perspective, these workshops do not always go perfectly. People sometimes leave, preferring to go to work or just to spend their time as they see fit. My argument is not that these workshops are necessarily successful. Rather, what they illustrate is the intense effort required to reconnect people's biological selves and medical needs with their social and political life. In this chapter, I have argued that the prisoner under carceral care is socially disabled but biologically diagnosable, treatable, and cared for, even if minimally or not at all. Their treatment as biological bodies depends in fact upon their depoliticization as non-citizens. These

workshops form just one small space in which physicians and former prisoners reckon with the afterlife of carceral care and attempt to repoliticize health and care.

Walla used to breakfast in the cafeteria. They used to visit with friends (and enemies) over a hot meal. In recent years, however, these simple pleasures have been done away with as DOC phased out communal breakfasts in favor of breakfast boats to cut costs (Schwartz, 2018a). Breakfast boats keep prisoners in their cells, thereby freeing the prison from having to manage thousands of hungry, unruly human beings or pay the guards hired to do so. Breakfast boats are not risky. Breakfast boats discipline and securitize. Breakfast boats are cheap ... or so the carceral logic goes.

It is Easter morning, and 2,540 prisoners pop open the cellophane that wraps their boats. The food is cold, sterile, without much smell. Thousands of hands set to work sorting through their boats, busying themselves in a mundane calculus of hunger, taste, disgust, trust, need, and dignity. Powdered drink packets are thrown in the trash. Breakfast bars and muffins are tucked away for later. While fingers sort and jaws chew, minds race and tempers rise. Breakfasts at Walla Walla have not always been like this. Many remember a time before breakfast boats when mornings included a warm meal, conversation, and a change of scenery. It was still prison, make no mistake, but it had been better than this. They had had enough.

For the next four days, more than half the prisoners at Walla Walla went on hunger strike, refusing or trashing all DOC food (Jenkins, 2018; Porter, 2018; Schwartz, 2018a). A subset of hunger strikers held out for ten days. (Schwartz, 2018b). Such mass prisoner organizing was virtually unheard of at Walla Walla. The racially segregated factions that organize life at Walla Walla worked in common cause toward collective demands, each sending representatives to meet with Walla Walla and DOC administrators.⁶¹ They demanded better and more nutritious food, greater meal variety, less soy, more fish, and more frequent and transparent communication from DOC about the food they eat (DOC, 2018; Schwartz, personal communication, 2018). Hunger strikers also demanded

⁶¹ DOC representatives for these meetings included Assistant Secretary of Prisons Robert Herzog, Assistant Secretary of Reentry Danielle Armbruster, Walla Walla Superintendent Don Holbrook, and Correctional Industries Assistant Director Scott Edwards.

DOC end its use of solitary confinement⁶² as a tool of punishment and retaliation. In short, they demanded a life more livable behind bars.

In the immediate aftermath of the Walla Walla hunger strike, prison administrators agreed to reinstate hot breakfasts, include several menu revisions, distribute nutritional information on mainline meals, and begin monthly meetings with prisoner representatives. However, according to a survey of Walla Walla prisoners published in March 2019, by Washington's Office of Corrections Ombud, prisoners continue to report inadequate portion sizes, poorly prepared food, and other ongoing violations of state law and institutional policy. The Walla Walla hunger strike was also not the last. In November 2018, prisoners at Clallam Bay men's prison threatened a hunger strike in protest of planned policies denying hot meals to people in solitary confinement (Perilous Chronicle, 2019). For four days in early February 2019, more than 1,800 people incarcerated at the Coyote Ridge men's prison refused all DOC meals (O'Sullivan, 2019). On October 7, 2019, prisoners at Clallam Bay went on hunger strike to demand revised prison menus, no more breakfast boats, fresher ingredients, and better prepared food. The strikers also demanded an end to centralized food production, which I discuss in detail below, and that all food be prepared on site. They are also demanding better recreational equipment; an increase in work compensation, which has been stagnant for fifteen years; accountability for third-party contractors (*e.g.*, prison email); and an end to racist, retaliatory policies that primarily punish prisoners of color in the name of decreasing “gang violence” (Perilous Chronicle, 2019).

"The act of a hunger strike is a disavowal of the social viability and sustenance in carceral conditions," writes Nayan Shah (2018: 174). With little to no control over their daily routine, their

⁶² According to an October 2015, Washington had 274 individuals (or 1.7% of its total custodial population) in some form of solitary or paired isolation (*i.e.*, 15 consecutive days or longer, 22 hours or more per day spent alone) on any given day. (Association of State Correctional Administrators and The Arthur Liman Public Interest Program, 2016). Black and Hispanic prisoners are overrepresented in solitary confinement, while White prisoners are underrepresented (*ibid*). This racial disproportionality is more pronounced in women's prisons (*ibid*).

social conditions, or their physical environment, the hunger striker asserts control over what little is left under their control: their body and their consumption. The prisoner hunger strike "is a rebuke to the state's control over a person's life and body" (*ibid*). This refusal, however, is not merely a material challenge to state power. The hunger striker also refuses the carceral logic that makes this control possible. The current state of prison food under mass incarceration in particular depends upon situated, state-sponsored ways of knowing the incarcerated body, food, eating, health, and well-being. Indeed, I argue that no demand for materially better food can be simply divorced from the systems of knowledge that underlie it. 'Healthy' food is ontologically neither stable nor self-evident. Any struggle over food is also a struggle, implicit or explicit, over knowledge and power, over how food, eating, health, and well-being are known and made knowable.

With that in mind, this chapter poses two counterfactual questions. First, would incarceration on the scale practiced in the United States even be possible without systematically malnourished prison food? Second, and more radically, would incarceration on the scale practiced in the United States even be possible without the enabling of state-sponsored ideology of nutrition? Put differently, would mass incarceration be possible if incarcerated people had the agency to grow, cook, eat, and share food that was not only nutritious in terms of calories, vitamins, and micro- and macronutrients but also nourishing in terms of taste, pleasure, and cultural and social significance? The answer to all these questions, I argue, is no.

In asking both these questions together, I caution against a naïve call for better food in prisons, a technocratic demand divorced from its social or political context. We must interrogate not just who gets *good food*, but who decides, by what logic, with what assumptions, and why. What even counts as good food? Which metrics should we use? Calories? Milligrams of sodium? Hours between meals? Meals spent with kith and kin? Feelings of satiation or hunger? Moreover, who gets to decide? Whose knowledge matters? State-licensed dietitians? Budget-obsessed bureaucrats? Or

people in prison, whose own relations to food and eating are shaped by diverse cultural, ethnic, religious, biological, and personal histories unfolding within a hegemonically White supremacist, capitalist culinary landscape? The answers to these questions reflect the machinations of carceral care and biocitizenship, in which some ways of life—ways of knowing and being well—and some lives come to matter more than others.

In this chapter, I focus on how these struggles have unfolded not just within women's prisons but through statewide prison food laws, norms, practices, and policies, as well as wider political economic shifts. These processes, though not spatially or bureaucratically bound to women's prisons, are deeply gendered, as well as classed and racialized. With this scope established, I develop my argument in three stages. First, I review the complex relationship between the carceral state and nutrition science, arguing that nutritionist ideologies have been central in enabling the project of mass incarceration. Second, I trace the ways in which over the past two decades state-level Washington DOC administrators have produced a malnourished prison food system harmful to prisoner health, well-being, political life, and dignity. I offer a history of the slow physical, psychic, social, and epistemic violence the carceral state and mass incarceration have wrought on incarcerated people's food knowledge, eating habits, bodies, and health. Importantly, I argue that prison food and its deterioration is not simply due to shifts in institutional budgets or wider political economy but also due to changes in how state actors know and understand food, eating, and the incarcerated body.

Third, I discuss recent efforts to reform prison food in Washington state and the ways such reforms rework but also recapitulate nutritionist approaches to food and eating behind bars. In asking not just whether prisoners get good food but also how good food is known, defined, measured, by whom, and to whose benefit, I argue that reform efforts that seek to improve prison food, but which do so within state-sponsored frameworks and logics, risk reinforcing the carceral

state and its biopolitical control. What counts as *good food* is neither epistemologically straightforward nor politically neutral. To interrogate the role nutrition has played in carceral biopolitics, however, it is necessary first to understand nutrition as not a neutral science but an ideologically dense, geohistorically consequential, biopolitical formation.

Nutrition and Neoliberal Penology

How people understand and assess their bodies, food, eating, and health has shifted dramatically over the past century-and-a-half thanks in large part to the rise of nutrition science. Though American chemist Wilbur Atwater first penned his theories on metabolism in the late 1800s, nutrition science did not become a professional, institutional science with popular sway until decades later during the Progressive Era when government and philanthropic projects found its tools of rationalization and quantification useful in their mission to uplift and civilize the poor, immigrants, and non-White people, and their eating habits (Guthman, 2014a). Since that time, nutrition science has become a dominant epistemology for understanding bodies, their relation to food and eating, and the connection between food, health, and well-being (*ibid*). Nutrition, however, is “not simply a collection of commonsense facts about the relationship between food and the body” (Biltekoff, 2014: 18). Despite its adherents' claims to the contrary, nutrition is not an apolitical, objective science (Scrinis, 2013). Rather, nutrition's seemingly neutral, universal language – *e.g.*, a calorie is a calorie is a calorie – privileges certain approaches to food, the body, eating, and well-being while making others culturally and morally inferior, unimaginable, and materially impossible. Nutrition has become an ideological order, which science historian Gyorgy Scrinis dubs “nutritionism,” propagating non-obvious, provincial but decontextualized knowledges as universal and morally superior (2008, 2013).

Geographers Jessica and Amy Hayes-Conroy outline three central tenets to what they term “hegemonic nutrition” (2013):

“(1) the food-body relationship can be standardized (as in through the standard of the calorie); (2) nourishment can be reduced to macro- and micro-nutrients (Scrinis, 2008) or ‘charismatic nutrients’ (Kimura, 2013); and (3) nourishment is universally equivalent and thus can be decontextualized from the political-economic, socio-spatial, and cultural location in which it takes place” (Hayes-Conroy, 2014).

Hegemonic nutrition works to regulate human social and biological difference, disciplining diverse bodies with differing metabolisms, needs, physical abilities, desires, constitutions, socio-cultural contexts, and ways of eating into one-size-fits-all norms and prescriptions. With bodies thoroughly standardized, hegemonic nutrition thus “renders technical” (Li, 2007) questions of embodiment, food, eating, and health. Complex sociobiological relations of *nourishment* become scientized, technical, managerial matters of *nutrition*. It is no coincidence then that nutritionist thinking privileges quantified techno-fixes overseen by technical experts and isolated from other social or political interventions (Kimura, 2013; Kimura et al., 2014). Nutrition policymakers and commercial dieticians are more likely to prescribe recommended daily intakes (RDIs), nutrition labels, calorie counting, and Soylent⁶³ rather than communal food gardens, expropriated ex-factory farms, or universal healthcare.

In addition, hegemonic nutrition conflates nourishment with health, defining the latter in narrow biomedical terms. The American Society for Nutrition, for example, defines its mission as "improv[ing] health around the world through high quality science-based nutrition knowledge, engagement, and influence" [n.d.]. Through this epistemic reductionism, hegemonic nutrition makes unthinkable those qualities of embodiment, food, eating, health, and well-being that cannot be quantified or biometrically accounted for. Personal taste and preference, fluctuating affects and appetites, pleasure and disgust, non-biomedical healing, cultural meaning, social context, and,

⁶³ Visit soylent.com.

importantly, political struggle have no place within nutritionist worldviews. Prescribing a low-sugar diet to someone with diabetes, for example, may solve the problem of individual disease, but in epistemological isolation, it simultaneously reinforces an individual, biomedical model of disability and ignores problems of poverty, racial capitalism, and commodified healthcare.

Nutritionist ideologies have proved central to racial capitalist and state-based biopolitical projects to dominate, civilize, and/or eliminate *Other* eaters. By privileging epistemologies of food based in abstraction, quantification, and universality (*e.g.*, the calorie), nutrition "makes dietary needs appear commensurable" across bodies, thereby enabling "regulation and surveillance at the level of the population" (Guthman in Biltekoff et al., 2014: 25; see also Cullather, 2007). Nutrition, for example, has been used as a colonial science to justify European and American discourses of White racial superiority (Carpenter, 1994; Orr and Gilks, 1931; Kimura in Biltekoff et al., 2014). In the U.S., knowledge about nutrition and associated eating habits have been used as markers of class status and superiority, "distinguishing members of the responsible middle class from those in the lower classes who were presumed to have failed to realize the goal of health" (Biltekoff in Kimura et al., 2014: 35-36), and used to mark poor people, immigrants, and non-White people as "unhealthy others" (Crawford, 1994: 1348). Dietary advice has also been heavily gendered, focusing its moralistic discipline on mothers in particular "as the gatekeepers for the nutrition of children, families, and nations" (Kimura et al., 2014: 41; see also Mansfield, 2012). Nutritionist ideologies have thus been central to interlocking life-affirming and death-dealing projects of biopolitical governance.

In the U.S. today, hegemonic nutrition continues to be influential within state biopolitical projects, including school lunches, food assistance programs like Supplemental Nutrition Assistance Program (SNAP), and Food and Drug Administration (FDA) regulations (*e.g.*, food labeling). These increasingly neoliberal programs discipline recipients into an individualized understanding of food and eating, placing responsibility for better nutrition on individual consumer choices and self-

control, while obscuring structures of power, oppression, and political economy that shape food landscapes, access, and knowledge (Biltekoff et al., 2014). These scientized, racialized, gendered, and classed programs thus recapitulate nineteenth-century liberal discourses in which “food choice became a sign of the virtuous – controlled and orderly – exercise of free will” (DuPuis, 2015: 9).

With its focus on expert knowledge and quantified yet intangible nutrients, hegemonic nutrition also reinforces a power imbalance between ‘expert’ nutritionists and dietitians and ‘ignorant’ consumers in need of education or missionary conversion to ‘good,’ ‘right,’ or ‘nutritious’ eating. In the U.S., this expertise is thoroughly commodified. Those who cannot afford to pay a dietitian out of pocket must turn to U.S. Department of Agriculture (USDA) pamphlets or the Internet. Moreover, the market for professional dietary advice remains deeply shaped by nutrition’s biopolitical past and present. According to the Census Bureau's 2016 American Community Survey, professional dietitians and nutritionists were 89% women and 70% White (DATA USA, n.d.).

Nutrition is not a monolith, however.⁶⁴ Nutritionist thinking may originate from professional scientific institutions, but it circulates far beyond institutional sites of knowledge production, morphing into and generating new hybrid knowledges. Nutritionist concepts like the calorie or carbohydrate, for instance, circulate within a historically and geographically uneven discursive field comprised of not just nutrition scientists but also food corporations, diet bloggers, pop experts like Dr. Oz, “field agents” like personal trainers, marketing agencies, and everyday eaters (Guthman, 2014; Kimura et al., 2014; Nestle, 2013; Setälä & VäLiterronen, 2014; Yates-Doerr, 2012).

Corporate actors have played an especially outsized role in shaping nutrition science and thinking, dietary advice, eating habits, and government policy (Nestle, 2013). Since the USDA first issued recommendations in 1917, federal dietary advice has continually subsidized the U.S. food

⁶⁴ Indeed, debate persists within the annals of nutrition science (Brady, 2019; Broad, 2014; Broad and Hite, 2014; Coveny and Booth, 2019; Dietitians of Canada, 2009; Gingras et al., 2014). As one former DOC dietitian told me, “nutrition science is a very young science, so it sort of keeps evolving” (personal interview, 2018).

industry. In the 1910s and 1920s, the USDA promoted vitamin-and-mineral-rich foods, a boon to corporations because "*all* [foods] could be promoted on this basis" (*ibid.*: 34). U.S. corporations have also had a hand in defining USDA food groups and serving sizes (*ibid.*: 34-37). Corporate actors influence nutrition science directly by funding academic research, subsidizing academic journal publication, sponsoring professional conferences, and providing lucrative grants to university departments (*ibid.*).

Research on nutrition science and nutritionist ideologies have to date focused largely on the bodies, food cultures, eating habits, discursive milieux, and well-being of non-incarcerated people. But what about life behind bars? How has nutrition shaped ways of thinking, eating, and being in the carceral setting of the prison? To answer this question, it is first necessary to understand how neoliberal shifts in U.S. penal ideology and policy over the past half-century have reshaped epistemologies of the prisoner, incarceration, and the role of the carceral state.

"Under the 'old penology' of the twentieth century, penal policy and administration regarded offenders as individual wards of the state, emphasizing diagnosis and treatment" (Gibson-Light, 2018: 200-201). However, beginning in the 1980s and consolidated under the Great Recession, a new neoliberal penology has taken hold in which prisoners are no longer seen as individuals with even the potential to possess political rights. Under this new penology, prisoners are seen instead as mass consumers, using up state and privatized services and burdening tightened state budgets (Aviram, 2015, 2016; Feeley and Simon, 1992). This shift in penal worldview echoes neoliberal discourses of personal and fiscal responsibility that have dominated government policy and popular culture for the past four decades (Lawson, 2007; Wacquant, 2010).

This new penology reflects wider shifts in U.S. landscapes of social control under neoliberalism. First, the neoliberal state rolled back Keynesian social supports, further abandoning poor people and people of color whom the welfare state had either heavily policed or outright

excluded (Solinger, 2010). Second, the neoliberal state expanded its capacities to criminalize, police, and incarcerate all, serving to disappear, contain, and manage the crises that result from organized abandonment: rising poverty, homelessness, gang welfare (Gilmore, 2007). As part of this, many states cut their prison budgets, privatized prison services, or entire institutions (Aviram, 2015), and trimmed what few state-provided services remained for people inside prison (Lynch, 2009).

As a result, "despite rising prisoner populations ... spending on prison operations per prisoner (in state and private institutions alike) decreased" (Gibson-Light, 2018: 203; citing Kyckelhahn, 2012). To solve this crisis, the costs of incarceration and survival behind bars have been increasingly "downloaded" onto prisoners themselves (Aviram, 2016). Prisons and jails have expanded 'pay-to-stay' programs,⁶⁵ in which prisoners must pay 'user fees' for electricity, healthcare, room and board, telephone and Internet communication with loved ones, and other 'amenities' (Buchanan 2007; Gibson-Light, 2018; Gipson and Pierce 1996; Gottschalk 2010; Jackson 2007; Levenson and Gordon, 2007; Levingston 2007; Lynch 2009; Von Zielbauer 2007). The prisoner is no longer seen as an individual ward of the state but as a mass consumer and a budgetary drain.

Criminologist Mona Lynch terms this cutback in the breadth and quality of prison services "punitive frugality" (2009). In the state's attempt to continue 'tough on crime' policies *and* cut costs, it has produced a prison system that is "overcrowded, underfunded, and offering fewer and poorer quality services" (Gibson-Light, 2018: 203). These cutbacks have affected everything from medical and mental health services (Clark 1972; Clements 1985; Pogorzeleski et al. 2005) to educational and vocational training (Clements 1985; Gottschalk 2010; Schlanger 2006).

These cutbacks and policy shifts have also profoundly impacted prison food. These changes have included prisons "reducing the amount and quality of food served to people in prison"

⁶⁵ These programs perpetuate the capitalist logic of prisoners 'paying' for their crime by 'spending time' in prison (Davis, 2003). Under neoliberal penology, this logic has been extended to every aspect of prison life.

(Gottschalk, 2006: 244); purchasing of low-quality, cheap produce; serving fewer meals per day; subcontracting food preparation to private corporations (Neate, 2016); and reducing calorie counts and serving sizes (Gibson-Light, 2018; Gottschalk, 2006; Smoyer and Lopes, 2017). Importantly, these institutional and wider political economic shifts, in which prisoners are seen as mass consumers draining smaller and smaller state resources, also shape prisoner resistance. As sociologist Michael Gibson-Light writes, under the new neoliberal penology, people in prison "increasingly express power and autonomy through food activities and consumption practices" (2018: 204; see also Smoyer, 2016). Indeed, under this neoliberal penal logic, refusing to consume can become a salient political act in which prisoners may protest their conditions as human rights violations, as violations of their rights as dependent consumers, or some complex mixture thereof. In this context, it is unsurprising that hunger strikes have become so common in Washington state.

This connection between neoliberal penology and prison food highlights the ways macro-scale political economic forces, via institutional mechanisms such as prison budgets, impact incarcerated people at the most intimate, embodied levels (Hiemstra and Conlon, 2017; Mountz and Hyndman, 2006). Of course, problems with prison food are not new. Several critical food scholars and activists have begun to trace the deep historical and geographic ties between U.S. plantation-style agribusiness, racial capitalism, and the modern-day prison industrial complex (Cooper, 2016; Sbicca, 2016, 2018; Watkins, 2017). As Dara Cooper of the National Black Food and Justice Alliance puts it, "the patterns of domination and exploitation that drive our prison and policing systems are inherently connected with the patterns of domination and exploitation that drive the inequities within our food system" (Cooper, 2016: n.p.). In one clearly geographic example, many prisons are built on rural, formerly agricultural land that was left cheap and fallow following agribusiness consolidation⁶⁶ (Gilmore, 2007; Watkins, 2017).

⁶⁶ In Washington, most prisons are on rural land rented from the Department of Natural Resources for \$1 per year.

Yet, this literature on prisons, food, and neoliberalism, however, has yet to examine the connections between the political economy of prisons and food *knowledge* in particular. As the above reference to reduced calorie counts suggests, nutrition science and nutritionist knowledge both shape and are shaped by the neoliberal turn in penal policy. Indeed, an immense biomedical literature documents the mostly negative effects of prison food on prisoners' health and well-being over this time period (Choudhry et al., 2018; Clarke and Waring, 2012; Collins and Thompson, 2012; Cook et al., 2015; Dong and Tang, 2014; Herbert et al., 2012; Leddy et al., 2009; Nikolas, 2000; Schafheitle et al., 2007; Shaw et al., 1985; Schlafer et al., 2017). Moreover, scholars have examined the role food plays in carceral punishment (Smoyer and Minke, 2015).⁶⁷ Yet, the epistemological effects of neoliberal penology on nutrition, as well as the epistemological role nutrition science plays in political contests over punitive frugality, have remained to date outside the purview of scholarly analysis and theory.

In this chapter, I interrogate these geohistorical relationships between neoliberal political economy, penal policy and practice, carceral biopolitics, biocitizenship, and epistemology, as well as the way they condition on-the-ground and imaginative possibilities for prison reform and prison abolition. I conceptualize these situated entanglements by considering nutrition as a potentially carceral, reformist, and abolitionist science. My claim is not that nutrition in the abstract has any necessary pre-determined effects, but rather that in practice, there exists serious complicity, and perhaps tension, between carceral⁶⁸ projects of mass discipline and disposal through the prison and nutritionist epistemologies of rationalization, quantification, and techno-managerialism through the diet.

⁶⁷ For a full bibliography, visit <http://www.amysmoyer.com/prison-food-biblio>.

⁶⁸ I use the term *carceral* nutrition to suggest the transferability of this concept to other sites within our carceral society, including prisons, jails, migrant and youth detention centers, psychiatric hospitals, schools, military bases, and others (Foucault, 2012). In doing so, we can build solidarity across carceral foodscapes towards an ultimate project of abolitionist ecology (Heynen, 2016).

Eat to Live (On): Nutrition as Carceral Science

Nutrition has been a profoundly ambivalent tool for carceral biopolitics in that nutritionist ways of thinking, feeding, and eating have been both foundational to and absent from penal policy. On the one hand, nutrition science provides the exclusive paradigm for defining the state's carceral burden when it comes to feeding prisoners. On the other hand, however, nutritionist metrics are used as tools to minimize this burden, to ensure that incarcerated life is not supported or made to flourish but merely sustained, liminal, even disposable. Moreover, over recent decades, the meager affordances nutrition once allowed have been further diminished as nutritionist thinking has become conditioned by neoliberal epistemologies of 'fiscal responsibility,' techno-market solutions, and punitive frugality. Thus, prisoner nourishment has been narrowly conceived, stifled, and increasingly abandoned.

When it comes to feeding prisoners, the state's carceral burden has been narrowly defined in nutritionist terms. In addition to guaranteeing prisoners protection from 'deliberate indifference' to their 'serious' medical needs, the Eighth Amendment prohibition against 'cruel and unusual punishment' has also been hailed to guarantee prisoners "the minimal civilized measure of life's necessities" (*Rhodes v. Chapman*, 1981), including "identifiable human need[s] such as food, warmth, and exercise" (*Deshaney v. Winnebago*, 1989; cited in Naim, 2005: 9). The state's carceral burden, however, has again been significantly circumscribed, requiring that prison food meet "contemporary standards of decency" (*Hudson v. McMillan*, 1992; cited in Naim: 2005: 9) only in terms of sanitation and nutrition. As witnessed in the previous chapter on medical care, prisoners do not have an affirmative right to 'good,' 'healthy,' or 'nutritious' food *per se*. The carceral state must provide only minimal nutrition. The state cannot underfeed prisoners such that doing so would be considered an egregious, obvious, and deliberate act of punishment. Incarceration reduces prisoners to a state of

bare life that the state must maintain, at least to the point that doing otherwise would be considered “seriously” punitive.

State-level statutes, regulations, and policies also reflect this narrowly nutritionist discourse. Some state prison systems have extensive regulations concerning food and nutrition. For example, California sets specific nutritional requirements, including minimum daily intake requirements for calories⁶⁹ and saturated fat.

“The minimum diet provided shall be based upon the nutritional and caloric requirements found in the 2011 Dietary Reference Intakes (DRI) of the Food and Nutrition Board, Institute of Medicine of the National Academies, the 2008 California Food Guide, and the 2015-2020 Dietary Guidelines for Americans” (California Code of Regulations, 2019).

California also organizes its requirements into the four food groups dominant since WWII: protein, dairy, vegetable-fruit, and grain. While California adopts a quantified, heavily scientized discourse of nutrition, other states are less exacting. Alabama requires only that “[t]he diet of convicts ... be sound and wholesome” (ALA. CODE 14-3-45; LexisNexis 2011). Alaska requires only that “per capita expenditures for food for prisoners ... [not] exceed 90 percent per capita expenditures for food that is available to enlisted personnel in the United States Army stationed in the state” (Sec. 33.30.015).⁷⁰

Regarding meal frequency, at least nineteen states require three meals per day, and many states require that no more than fourteen hours elapse between meals (Bach, 2013). Many states also require at least one hot meal per day (*ibid*). Many states also require a licensed nutritionist or dietician

⁶⁹ California does not establish different caloric requirements according to sex or gender. Washington does.

⁷⁰ Alaska’s statute is notable for its discursive slippage between two carceral institutions: prisons and the military. Prisons and armies both depend upon heavily regimented food systems. Indeed, recommended dietary allowances (RDAs) for calories and micro- or macronutrients were first developed by the Food and Nutrition Board in 1941 and prescribed to military personnel and civilians alike as a tool for national security during wartime (Nestle, 2013: 35). While soldiers are undeniably subsumed under a calculus of expendability, the demand that prison food costs not exceed 90% of military food costs positions prisoners as comparatively unworthy and disposable.

oversee meal planning. For instance, Oregon requires that meals be “nutritionally adequate ... in accordance with a plan reviewed by a registered dietitian or the Oregon Health Authority” (Bach, 2013). Prison systems vary, however, on the required frequency of such review.

For its part, Washington has set requirements similar to Oregon. Prison menus must be reviewed by a licensed nutritionist. According to DOC policies amended in 2015 and active until early 2019, Washington established recommended, binary sex-differentiated, quantified RDIs for calories, protein, fiber, sodium, saturated fat, cholesterol, calcium, Vitamin C, and other micronutrients (PVW, 2016). DOC based these dietary guidelines on standards from the Food and Nutrition Board of the National Academies’ Institute of Medicine.

These regulations signal the epistemological primacy of nutritionism, and institutional nutrition science more specifically, in defining relations of feeding, eating, embodiment, health, and well-being behind bars. At the same time, however, nutritionist thinking makes possible prisoner’s liminality and disposability through its emphasis on minimal, narrowly defined standards of nourishment. Nutritionist discourse turns the production and maintenance of prisoner bare life into a quantified, technical exercise.

This bind, by which nutrition conceptually dominates *and* stifles incarcerated ways of eating, is glaringly illustrated by *nutraloaf*, the dense food brick served in many jurisdictions to prisoners in solitary confinement. It is also known as food loaf, lockup loaf, seg loaf, grue, or special management meal. Recipes vary by jurisdiction. The Florida Department of Corrections’ recipe includes “carrots, spinach, dried beans, vegetable oil, tomato paste, water, grits and oatmeal, mixed and baked for 30 to 40 minutes” (Zoukis, 2016). While legal challenges over due process have led to its recent decline, its nutritional qualities continue to make it an attractive disciplinary tool (Zoukis, 2016). In a 2009 column for the Association of Correctional Food Service Affiliates (ACFSA) trade publication *Insider*, Donna Rogers lauds the loaf, saying there is “no doubt the recipes meet the

FDA's daily requirements for nutrition" (9). The nutraloaf is "designed to meet basic nutritional guidelines" (Zoukis, 2016: n.p.). In its ruling upholding the use of nutraloaf, the U.S. Ninth Circuit Court of Appeals wrote: "[t]he Eighth Amendment requires only that prisoners receive food that is adequate to maintain health" (*LeMaire v. Maass*, 1992; quoted in Rogers, 2009: 9). The nutraloaf thus illustrates both organizing principles of nutrition as carceral biopolitics, creating the epistemological terrain for creating bare life.

The prisoner's nourishment is conceived and assessed narrowly within the rubric of nutrition. All other ways of being and eating are made illicit, materially difficult or impossible, or wholly unimaginable. This epistemological vice does not serve, however, to support prisoner well-being or flourishing but only their sustained, disposable existence. Prisoners are not spectacularly starved to death. Nor are they nourished. They do not eat to live. Prisoners eat only so that they may live on, but never get better (Berlant, 2007; Shildrick, 2015). Nutrition becomes a carceral science of systemic debility.

Indeed, this logic finds its extreme manifestation in the case of hunger striking. As Nayan Shah argues, the same nutritionist thinking that justifies the nutraloaf also animates the increasingly biomedical response to hunger strikes by people in prisons, (im)migrant detention centers, and other carceral institutions. "[B]y measuring subsistence ... tracking physiological effects of starvation, and calculating the limit of survival," nutrition has become a central tool in the practice of prisoner force-feeding and biopolitical management of carceral populations (2018: 155). While prisoners at Walla Walla were never force-fed, they were refusing the same carceral logic of minimum nutrition that justifies everything from force-feeding to breakfast boats.

Caselaw and state legislation together produce the nutritionist regulatory framework in which prison food is produced. Yet, nutrition as it informs carceral biopolitics is not a pure epistemology. The prison is not run by nutritionists or dieticians. It is run by bureaucrats. Thus, as the above

Alaska statute suggests, nutritionist thinking within the prison is always conditioned by the calculus of state budgets, by economizing practices, and ways of thinking. While this has always been the case to a degree, the concomitant rise of mass incarceration and neoliberal penology has escalated this tension, resulting in a prison food system that increasingly disregards even minimalist nutritional standards for the sake of cutting costs.

This has been the case in Washington state. Just five years ago, many kitchens in Washington state prisons still served meals made from scratch by a crew of prisoners overseen by hired cooks and institution-specific food managers. Some prisons also operated small produce farms or dairies (PVW, 2016). This food system relied upon incarcerated folks' coerced, low-wage labor, reflecting the continuity of racial capitalism from chattel slavery to mass incarceration (Davis, 2003).

Nonetheless, this work allowed incarcerated people to practice marketable job skills and creativity in the kitchen. Today, however, Washington prison food comes exclusively in the form of industrially-processed, pre-packaged meals cooked off-site, frozen, and shipped to prisons around the state where incarcerated folks reheat these meals as de-skilled button-pushers (Jenkins, 2018; PVW, 2016; Schwartz, 2018). Incarcerated for much of the past decade, Sarah worked in the Purdy kitchens for several years. Sarah saw the effects of this shift in production firsthand. Under the old system, "girls would actually be cooking. The hired cooks would just tell you what you were doing or how to do it." However, under the new system:

"women's prisons don't really do any production. They used to send food over [to cook with], and then somewhere in the prison system they were like 'This is costing us too much to do, so we're not going to do this anymore.' Then it came down to these bags ... It's like a bag you boil. It has food in there of some sort, and then the directions on it ... I was like, 'What are we all here working for? We're all just going to watch you put this bag in hot

water?! Then we're going to cut it open and dump it in. It's literally slop.” (personal interview, 2018)

These bags came from Correctional Industries (CI), which since 1995 has slowly monopolized all food production and service in Washington state prisons.

Created in 1983, “Correctional Industries (CI) is a unique blend of business and government, using private industry tools and techniques to provide a public service” (Washington State CI, n.d.). Rather than use unpopular taxes or levies to foot the bill of mass incarceration, DOC created CI to offset costs via direct and sub-contracted sales to prisoners (*e.g.*, email, care packages, and commissary) and low-paid prison labor programs. CI’s takeover in Washington mirrors nationwide trends in prison food under neoliberal penology. Over recent decades, prisons and jails nationwide have moved away from on-site farming and cooking toward highly centralized, industrial-style food production (Neate, 2016; Schwartz, 2018b; Watkins, 2017). Many state prison systems outright privatized prison food, outsourcing production to private corporations like Aramark and Trinity Services Group (Neate, 2016). Washington state has undertaken a different path of neoliberalization. By shifting production to CI, a state-run prison-industrial “blend of business and government,” DOC has marketized its prison food system without outright privatizing it, incorporating market logics and corporate cultural norms into state institutions and public infrastructures (Birch and Siemiatycki, 2016). Yet, prison *marketization* has received little public attention compared to prison privatization. While marketization remains poorly understood, headlines about Aramark abound (Delgadillo, 2018; Fassler & Brown, 2017; Kelkar, 2017; Ludlow, 2017; Lyon, 2018; Neate, 2016; Requarth, 2019; Weiss, 2014). This focus on privatization is curious given that “92 percent of the vast money-sloshing public system is central to how capitalism’s racial inequality works” (Gilmore, 2015, n.p.). Examining mechanisms of state-run marketization like

those in Washington highlights the continued dominance of state actors in ongoing physical, psychic, social, and epistemic carceral violence under neoliberal penology.

As a result of outsourcing and marketizing prison food production, administrators nationwide have turned increasingly to non-state and market actors for nutritionist expertise. This is the prison-industrial complex of dietary advice. As discussed above, those states that *do* establish nutrient RDIs have often borrowed standards from the American Correctional Association (ACA), a private, non-profit trade organization that sets industry standards and offers facility accreditation.⁷¹ The ACFSA hosts multiple conferences every year, providing food companies a chance to peddle their private services and ‘corrections-safe’ food products to prison and jail administrators. The privatization and marketization of prison food has also created a cottage industry of private nutritional consultants who help carceral institutions meet their nutritional burden *and* cut costs. For example, Barbara Wakeen, a registered dietician-nutritionist (RDN) and owner of Correctional Nutrition Consultants who has had an outsized impact on prison food policy, encourages the use of fortified foods and nutrient supplements. “I’d like to see everybody get all of the food groups,” says Wakeen, “but I know that in this environment it’s not always possible. As a result, we have all these wonderful fortified things, we’ve got fortified beverages, there’s fortified cake mixes and baking powders” (Neate, 2016). The dietary consultancy business, however, overlaps closely with the food industry, creating questionable conflicts of interest. In a 2010 article for *Insider*, for example, Wakeen spotlights a “new vitamin fortified milk alternate” manufactured by Good Source Solutions Corporation. Good Source also regularly sponsors ACFSA conferences. This nutrition prison-industrial complex shapes medical prison diets, as well. In 2018, Wakeen served as the chair of National Commission on Correction Healthcare’s board of directors.

⁷¹ Because mainline meal nutrition is not seen as a health-related issue, the National Commission on Correction Healthcare (NCCHC) does not host conferences or publish guidelines related to mainline meals; only medical and therapeutic diets.

In Washington, CI's takeover was gradual. When DOC sought to centralize its food management system in the late 2000s, "Correctional Industries saw an opportunity to get more involved," as one former DOC dietician told me (Harold⁷², personal interview, 2018). First, DOC instituted a policy requiring facility food managers purchase a certain percentage of their raw goods from CI. Over the years, however, this percentage grew until centralized purchasing became centralized production. In a bid to cut state spending, CI standardized all menus and centralized production at its "food factory" at Airway Heights Corrections Center, a men's prison near Spokane, Washington.⁷³ As Harold told me, when he began in 2009, CI was

"producing food at the factory and some of it would be utilized, but a lot of it – when I first got there and then for a couple of years – [CI was] utilizing the food vendor and ordering most of their grocery through the vendors, whether that was Food Service America or whatever produce or dairy account they had" (personal interview, 2018).

Over the next few years, however, CI took over all food production. In the mid-2010s, CI opened a second food factory at the Coyote Ridge Corrections Center, a men's prison in Connell, Washington⁷⁴. Today, over 95% of prison food in Washington is produced at CI's two food factories, purchased by CI from third-party corporate vendors, or sub-contracted by CI to third-party corporate vendors. This includes mainline meals, religious and vegan meals, medical diets, commissary (sometimes called canteen), visiting room vending machines, and quarterly packages purchased by friends and family for their incarcerated loved ones.

⁷² Harold is a middle-aged white cis-man with a long career as a nutrition professional working in state institutions, including state prisons and psychiatric hospitals.

⁷³ According to CI's website, this factory "operates 24 hours a day, five days a week" and "employs 14 civilian staff overseeing 300 prisoners" (CI, n.d.).

⁷⁴ This second food factory "employs 20 staff overseeing 166 prisoner workers" (*ibid*) and produces food for prisons as well as outside purchasers.

CI's takeover met resistance. Soon after CI opened its Airway Heights food factory, prisoner complaints and grievances spiked. Department of Health (DOH) inspectors cited the facility for food handling violations (PVW, 2016). Some facility food managers balked at CI's indiscriminate cost-cutting. John Holeman managed prison food at the Monroe Correctional Complex from 1983 to the early 2010s. In 2004, Holeman expressed concern to DOC that rampant cutbacks in food quality would lead to prisoner resentment and unrest. "Cost is important; keeping conversation lines open with the inmates is also important – 91¢ [per day per inmate] will do me no good if they burn the place down" (Weisberg, 2004: n.p.). CI's monopoly over prison food only grew, however, and Holeman ultimately resigned (PVW, 2016). Holeman's displeasure illustrates the epistemic and material shifts between old and new prison food systems. Under the previous system, nutrition still provided the dominant food ontology. Budget still mattered. Holeman and other facility food managers often sought out wholesale savings. Moreover, as Holeman's reference to prisoner unrest suggests, prisons relied upon quality food as a tool of social control. Under the new system, however, neoliberal logics of punitive frugality have come to dominate, replacing discipline and social control with the sovereign violence of disregard and mass disposability.

CI's policies of punitive frugality have also significantly impacted the production, circulation, and application of health knowledge in prison, hobbling nutrition as the dominant epistemology shaping prison food. Most immediately, CI's centralization of food production has paralleled serious cutbacks in DOC Health Service's staff of dietary professionals. When he first joined DOC in 2009, Harold worked alongside seven fellow clinical dieticians stationed at prisons across the state, including three contract dieticians; three state-employed dieticians working at Walla Walla, Monroe, and Airway Heights; and one diet technician providing counseling and treatment plans at Purdy. The financial crisis hit state budgets soon after, however, and within a year, Health Services had fired, refused to rehire, or refused to replace all of them. For a time, CI retained its own dietician, but

eventually that staff was also fired "because [CI] didn't see the need to have a dietician" (Harold, personal interview, 2018). Only Harold remained.

This rollback severely limited nutrition's discursive and administrative importance in the prison food system. "I wasn't happy about this paradigm shift," Harold explained, "because I was concerned that the quality of the food would not be as nutritious as the foods being prepared fresh in each prison's kitchen" (PVW, 2016: 5). In addition, Harold could not by himself provide the nutritional advice and clinical support previously available to prisoners, however minimal it may have been. "I felt a little limited on what I could do as an individual other than to respond to consultations" from Health Services staff, Harold said. "When they got rid of the dieticians, I just said 'Well, obviously what went on in prisons with the dieticians working there is not going to happen anymore. So, nurses and healthcare providers will have to pick up some of that education component'" (personal interview, 2018). Harold was now the sole advocate for nutrition behind bars. Based at DOC headquarters, however, Harold had sparse resources to monitor or enforce nutritional regulations at CI's two food factories and twelve prisons.

As a result, nutritionist paradigms shrunk in both epistemic and material influence as CI continued to monopolize prison food planning, preparation, and distribution. Importantly, DOC Health Services and CI are separate agencies with distinct management, bureaucracies, and budgets. By marketizing food production under its neoliberal, business-oriented arm, DOC effectively alienated all authoritative agency over prison food based in nutritionist ways of thinking and feeding. *Food* became administratively, budgetarily, and conceptually cleaved from *health*. CI functions to save the carceral state money, not to provide nourishing or even nutritious food. As the sole personification of nutritionist thinking, Harold could make recommendations but could not enforce them. For example, he faced an uphill battle when he tried to include more fruits and vegetables in mainline meals. Harold explained:

“[Before CI] we were providing fresh fruit at every meal and fresh vegetables at lunch and dinner and a hot vegetable at dinner as well. Then with some of the changes, [CI would decide] they don’t need fresh fruit at breakfast. They’ve got it at other meals ... I’m like, well, this is what the lawyer says. So, there was a lot of pushback [from CI] and a lot of it was, I would say, bottom line, because the budget for food is very scrutinized. Almost to the point of being ridiculous ... CI controls the budget ... So that’s always a real struggle because of the real penny pinchers on the professional industry [CI] side ... I was always just upset that we wouldn’t spend a little more, especially since I worked for Health Services, not for CI, so my goal was always to improve the health of our incarcerated” (personal interview, 2018).

Under CI’s control, nutrition became an afterthought. Neoliberal logics of state ‘fiscal responsibility’ and cost-savings came to dominate prison food, all so that the carceral state might offload the costs of mass incarceration onto the bodies of its prisoners.

Nutrition science has always been deeply conditioned and commodified by corporate interests and capitalist state actors (Kimura et al., 2014). With the marketization of prison food under CI, however, nutrition is not so much internally rescripted as wholly diminished and displaced. One prisoner advocate experienced this shift in blunt terms when she raised the issue of commissary ‘junk food’ with a CI purchaser. The man had worked exclusively in the private sector. “Candy bars sell,” he shrugged. Geographer Carly Nichols coins the term “economized nutrition” to conceptualize situations in which food is both narrowly conceived within a nutritionist framework *and* heavily rationed through the crucibles of commodification and differentiated human value (2019). In the context of neoliberal penology, nutrition has been economized to the point of malnutrition. This is economized nutrition as carceral biopolitics. While Nichols examines economized nutrition as part of Global South development, in the prison context, such

economization is justified through distinctly carceral discourses about prisoners' (un)deservingness, need for punishment, disposability, and bare life.

The effects of this new system on prison food, as well as prisoners' eating, embodiment, health, and well-being, have been marked. CI's transition to centralized industrial food production has resulted in the gradual reduction of foods that are varied, fresh, palatable, and nutritious. CI opened its first food factory in 1993. By 2016, mainline meals included less fresh produce, less lean protein, no unprocessed meats, and no whole grains (PVW, 2016). According to public records and interviews with prisoners conducted by the non-profit research and prisoner advocacy organization Prison Voice Washington (PVW), prisoners were receiving inadequate fruits, vegetables, and lean proteins, and they receive more grains than the 2010 Dietary Guidelines for Americans (DGA) recommends (see figures 6, 7). PVW highlights other inadequacies: less fresh produce, less unprocessed meat, scant whole grains, high sodium levels, added sugar, and excessive reliance on processed food products such as refined white flour (2016).⁷⁵ PVW also highlights how incarcerated folks, in an effort to supplement or replace deteriorated mainline meals, increasingly rely on commissary foods or quarterly packages purchased by non-incarcerated loved ones. Of course, these options are only available to those with higher-paid prison jobs or outside support, questions of access likely shaped by class, race, and language.

Ironically, such survival strategies further marketize and privatize prison food. Commissary inventory and quarterly packages are overseen exclusively by Correctional Industries. Health Services does not even have the pretense of input or oversight. Thereby, even as many incarcerated folks turn to these options to find more nutritious foods, nutrition itself becomes further commodified.

⁷⁵ PVW's analysis is based on meals served at men's prisons and sex-differentiated nutritional guidelines. PVW states, however, that "the diet for incarcerated women, it should be noted, suffers from many of the same defects" (2016: 11). The same is true for trans folks incarcerated in women's prisons. Moreover, trans folks' gender identity, gender expression, and metabolic needs may or may not align with DOC's sex-differentiated meals and nutritional standards.

Table 1. Detailed Vegetable Distribution Requirement (measured in cups per 28-day period)

Vegetables by DGA Category	DGA minimum	Adjusted DOH Guideline Minimum ¹	Food Services Menu Provision	Detailed Breakdown
Dark Green Vegetables	10	6	2½	all broccoli
Red & Orange Vegetables	28	22	9¾	carrots: 7¼ tomato salsa: 1½ carrots in "mixed": 1*
Beans & Peas	10	6	5½	all beans
Starchy Vegetables	28	20	25	potato: 19 corn: 1½ green peas: 2½ peas & corn in "mixed": 2*
Other Vegetables	22	16	18½	celery: 8½ onions: ¼ lettuce: 7¼ green beans: 2½
All Vegetables	98	70		61¼
Vegetables per day	3½	2½		2.19

* Since "mixed" vegetables are a relatively equal mixture of corn, green peas, and carrots, for the purposes of this table the 3 cups of mixed vegetables served every 28 days have been allocated into the appropriate categories (1 cup red & orange, 2 cups starchy).
¹DOH will need to update the Healthy Nutrition Guidelines to reflect a 2,800-calorie diet. DOC cannot be counted on to make the calculations by extrapolation.
²A cup of lettuce counts as a half cup of vegetables (DGA 2010, pg. 79)
 Note that green beans are considered "other vegetables" and green peas are considered starchy vegetables (DGA 2010, pg. 35).

Figure 6. The difference between recommended, required, and actual vegetable servings in mainline meals in Washington men’s prisons in 2016.

Source: Prison Voice Washington

Table 2. Protein Distribution Recommendation (measured in ounces per 28-day period)

Lean Protein	DGA minimum	Adjusted DOH Guideline Minimum	Food Services Menu Provision	Detailed Breakdown
Seafood	44	32	0	None
Meat, Poultry, Eggs	136	104	? ¹	? ¹
Nuts, Seeds, Soy Products	20	16	28*	all peanut butter
All Protein Foods	200	152		?¹
Protein Foods Per Day	7	5½		?¹

*Soy products are present in nearly all the processed CI food products, so it is difficult to estimate the total amount being served. This quantity is a minimum.
¹ Because CI recipes instruct factory workers to mix beans, crumbled TVP, and finely chopped processed meat protein into sauces, white pasta, or wraps, there is no accurate way to assess protein content of individual servings.

Figure 7. The difference between recommended, required, and actual protein servings in mainline meals in Washington men’s prisons in 2016.

Source: Prison Voice Washington

Moreover, PVW highlights multiple deficiencies in commissary and quarterly package foods, including high costs (Gibson-Light, 2018), few healthy options, and a glut of non-refrigerated, pre-packaged, shelf-stable “junk food” (2016).

The biopolitical effects of this malnutritious prison food system have been uneven across incarcerated populations. The material biopolitics of nutrition are fundamentally shaped by hegemonic nutrition’s ideological dependence upon a universal metabolic body that fails to account for bodily mutability and biosocial difference, not to mention differential access to nutrition information. Under systems ruled by hegemonic nutrition, non-normative bodies disproportionately face exclusion and harm as food is not made with their nutritional needs in mind. In Washington’s new prison food system, hegemonic nutrition has been simultaneously reinforced by, displaced by, and combined with policies of punitive frugality, all with ageist, ableist, time-sensitive, and anti-Black biopolitical effects. To be sure, Washington prison food fails to nourish *all* prisoners, including Latinx, Asian and Pacific Islander (API) American, and Indigenous and Native people. Moreover, it is important to remember that, even if poor nutrition *were* evenly distributed across the prison population, under our present nightmare of mass incarceration, the poorly nourished prisoner is more likely to be Black, Brown, and poor. I focus here on the effects that malnutritious prison food has had on older prisoners, prisoners with decades-long sentences, and African-American prisoners not because they are the only groups negatively affected but because they demonstrate the failure of prison nutrition even on its own terms.

By 2016, the average daily sodium intake for someone in a Washington men’s prison eating CI’s mainline meal was 3,600mg. Washington’s DOH recommended a maximum of 2,300mg and the American Heart Association (AHA) encourages "moving toward an ideal limit of no more than 1,500mg per day for most adults" (n.d.a). Even after reforms undertaken by DOC’s lone dietician in 2017, the daily average was still 3,000mg – 30% above the DOH ceiling. While PVW blames this

excess on CI's industrial-style production, DOC staff laud the benefits of industrial uniformity for prisoner diet and health. For Harold, centralization and standardization allowed him "to decrease the sodium content of the diet," which prison cooks had been adding to improve flavor and taste (personal interview, 2018). This faith in standardization recites hegemonic nutrition's repertoire of rationalization and the universal metabolic body. Praising sodium levels that are uniform (as well as excessive) neglects the needs of divergent bodies. An incarcerated person may be able to avoid this mainline diet by invoking a religious need or securing a vegan diet, though PVW suggests that kosher diets in particular may over-rely on soy products. Alternatively, people in prison may pay for a medical appointment, hopefully secure a diagnosis, and acquire a Health Status Report for a therapeutic diet.⁷⁶ As far as prison nutrition is concerned, the only conceivable non-normative body is the one that is already ill, already pathological.

As a result, prison food and the political economies and compromised state science that enable it become tools of carceral biopolitics, norming incarcerated eating bodies and unevenly distributing risk, debilitation, and reduced life chances. Specifically, the CI mainline diet cannot account for the bodies and needs of prisoners whose health is most threatened by excessive sodium intake: older prisoners, prisoners with decades-long sentences, and African-American prisoners.

First, older prisoners' life chances are disproportionately worsened by CI meals with excessive sodium. Excess sodium intake increases a person's risk of developing high blood pressure, also known as hypertension. Hypertension in turn increases a person's risk for cardiovascular disease events including heart attacks, strokes, heart disease or failure, and/or peripheral artery disease, as well as kidney disease or failure, vision loss, erectile dysfunction, and lowered libido (AHA, n.d.b). In addition, people over forty-five are more likely to develop salt-sensitivity, a condition affecting

⁷⁶ "For the most part," PVW writes, "this is a 'lighter fare' diet that increases some of the vegetables, while decreasing the amount of main course entrées and eliminating potatoes and wheat rolls" (2016: 7).

people with and without hypertension and in which excess sodium consumption causes moderate to drastic spikes in blood pressure. Salt-sensitivity can be nearly as strong a cardiovascular risk factor as hypertension (Choi et al., 2015; Frisoli et al., 2012), and the risk of becoming salt-sensitive only increases with age. CI's standardized manufacture of meals with excess sodium thus disproportionately puts older prisoners at risk of disease, debilitation, and death, all of which may occur during incarceration or after release when the carceral state has released all formal responsibility for care. Given the graying prison population both in Washington and nationwide, itself a result of 'tough on crime' mandatory minimums and punitive sentencing reforms (Chen, 2017; Skarupski et al., 2018), the biopolitical toll of this food system is only growing.

Second, prisoners with decades-long sentences are also put at higher risk by CI meals with excessive sodium. Incarcerated people with long sentences, including people with life sentences or de facto life sentences, will eat CI meals and only CI meals for decades or their entire lives. As PVW argues, these prisoners experience the "deleterious effect on human health of exclusively consuming processed food containing added sugar, sodium, and soy every single day for many years" (2016: 4). This is especially true for those lacking the funds from prison labor or outside support to purchase foods from the commissary. Prolonged high sodium consumption puts these prisoners at higher risk of disease, debilitation, and death. Nutrition has thus been used as a tool of carceral anti-future biopolitics, denying the futures of prisoners with long sentences in both imaginative and material terms.

Finally, CI's diet of systematically excessive sodium puts African-American prisoners at higher risk of ill-health, debilitation, and death. Rates of both hypertension and salt-sensitivity are higher among African-Americans than other ethnic and racial groups (Fryar et al., 2017; Peters and Flack, 2000). The AHA and DGA both recommend lower sodium intake for African-Americans in particular, no more than 1,500mg for both hypertensive and normotensive adults. Excessive sodium

levels in CI's meals thus have a disproportionately negative impact on African-American prisoners. Even after 2017 reforms reduced the daily average intake of sodium to 3,000mg, this intake remains above levels recommended for all adults and double to triple the levels recommended for African-Americans (PVW, 2016; Peters and Flack, 2000; see also the 2010 Dietary Guidelines for Americans⁷⁷).

Hegemonic and colorblind nutritionist thinking has thus become an epistemological tool in the continuation of a racist biopolitics of bodies, food, eating, health, and well-being. Geographer Julie Guthman argues, however, that epistemology and cultural imperialism (Young, 1990) have been largely overlooked by social movements challenging food injustice (2014a). For example, popular anxieties about the U.S. 'obesity crisis' often target Black bodies. Obesity rates, however, are based on the Body Mass Index (BMI), a metric developed using European bodies as the norm (Evans and Colls, 2009). While activists and scholars have long documented the systematic deprivation and denial Black communities and individuals face when it comes to quality, varied, affordable, desired, nutritious, nourishing, and democratically-governed food (Guthman, 2014b; Heynen et al., 2012; Ramirez, 2015; Sbicca, 2018), the epistemic violence of dominant food knowledge and nutrition science and nutritionist thinking in particular is only just beginning to garner attention (Guthman, 2014b). Here, I illustrate the implications of Guthman's critique in the carceral context of the prison where nutrition has been enlisted as a tool of carceral biopolitics that renders both material and epistemic violence upon the bodies of incarcerated folks, especially African-American folks who are already disproportionately targeted by mass criminalization and incarceration. Reflecting the larger

⁷⁷ One of the key recommendations of the DGA 2010 is to "Reduce daily sodium intake to less than 2,300 milligrams (mg) and further reduce intake to 1,500mg among persons who are 51 and older and those of any age who are African American or have hypertension, diabetes, or chronic kidney disease. The 1,500mg recommendation applies to about half of the U.S. population, including children, and the majority of adults" (pg. 21).

institutions of both nutrition science and mass incarceration, prison food today is not a system that centers or even considers the bodies and needs of Black folks.

Importantly, race here is not a biological or cultural *cause* of poor diet and health to be reified, essentialized, and then secured as *the problem*. Rather, race signals the somatized *effects* of intersecting racist social formations (Gravlee, 2009; Guthman, 2014b), including dominant ‘free world’ food systems, mass incarceration, and, I add here, prison food itself.⁷⁸ Racialist frameworks, “which draw attention to how harmful physical and psychosocial exposures due to racism adversely affect our biology” (Krieger, 2003: 195), have also been used to understand hypertension itself, which is “more correlated with an individual’s racial category than it is with ancestry-informative genetic markers” (Pollock, 2012: 98). Epidemiologist Camara Jones attributes higher rates of hypertension amongst African-American to “institutional racism (e.g., lack of access to medical care), personally mediated racism (e.g., racism of medical providers), and internalized racism (e.g., accepting stereotypes as true)” (2012: 98). For example, treating physicians are less likely to prescribe Black patients aggressive treatment for cardiovascular disease than they are White patients (Pollock, 2012; see also Din-Dzietham et al., 2004; Fedigan and Hartgrove, 2017; Smedley et al., 2003; Watson and Fonarow, 2007). Ann Fausto-Sterling connects hypertension to stress experienced by African-Americans living in a racist society.

“Hypertension is an orchestrated response to a predicted need to remain vigilant to a variety of insults and danger—be they racial hostility, enraging acts of discrimination, or living in the shadow of violence. Over time, all of the components that regulate blood pressure adapt to life under stress” (2004: 26-28).

⁷⁸ Drawing the distinction between racialist methodology and racist ideology is especially salient in this case given the long history in the U.S. of conflating ‘the Negro race’ or ‘Black culture’ with criminality (Muhammad, 2011a, 2011b).

Higher rates of hypertension amongst African-Americans embody “the ‘accumulated insults’ of living in a racist society” (Pollock, 2012: 102). Indeed, criminalization and incarceration burden incarcerated bodies with multiple hypertension and cardiovascular disease risk factors, including excessive alcohol consumption,⁷⁹ lack of physical activity,⁸⁰ aging and stress⁸¹, and, as I have highlighted, high sodium consumption. While exact numbers of individuals incarcerated by DOC who are diagnosed with hypertension or related cardiovascular diseases are not available, hypertension is one of DOC’s top five chronic care areas according to its own reporting (Warner and Lucas, 2012).

In highlighting the role nutrition has played in the ageist, anti-future, racist project of carceral biopolitics, I hope to expand dialogue between conversations on food justice, prisons, and science and technology studies. Prison food both reproduces and is reproduced by the epistemic violence and cultural imperialism of hegemonic nutrition. While mass incarceration, anti-Black violence has been highlighted in material and cultural terms, I highlight here the role hegemonic knowledge about bodies, food, eating, and well-being plays in perpetuating this violence.

Nutrition as Reformist Science

The biopolitical violence of CI's prison food system, however, has not gone unchallenged. On October 30, 2013, Washington Governor Jay Inslee issued executive order 13-06 titled "Improving the Health and Productivity of State Employees and Access to Healthy Foods in State Facilities." Though the order focuses on ensuring state employees access to “healthful food and beverages” at work, parroting neoliberal discourses of workforce productivity and health-as-human-

⁷⁹ While alcohol consumption is obviously banned in prisons, the War on Drugs has produced a prison population with rates of substance abuse disorder higher than the non-incarcerated population.

⁸⁰ Incarceration puts prisoners at risk of reduced physical activity (Sufrin, 2017).

⁸¹ Prisons are experiencing a rapidly graying population. While debate persists, there is growing evidence that incarceration also leads to earlier onset and more rapid progression of many chronic health conditions (Chammah, 2015; Leob et al., 2008; Skarupski et al., 2018). Moreover, much of this aging is due to the stress and weathering that incarceration and everyday prison life produce (Dumont et al., 2012; Massoglia, 2008a, 2008b; Western et al., 2015).

resource (Inslee, 2013), the order also technically applies to “state agency services including ... custodial populations,” like prisoners (*ibid*)⁸². The order requires all executive state agencies adhere to newly minted Washington State Healthy Nutrition Guidelines (HNGs), a trove of DOH documents that use DGA⁸³ recommendations to model healthier food and beverage policy⁸⁴. The HNGs were developed by a State Employee Health and Wellness Steering Committee comprised of representatives from DOH, county-level public health departments, and DOC. Harold, then DOC’s lone dietician, sat on the committee. Despite its early involvement, however, a year and a half after Governor Inslee issued EO 13-06, DOC had improved food and beverage services for employees, but food served and sold to prisoners remained noncompliant (PVW, 2016). Neither nutritional content nor quality had changed (*ibid*).

In October of 2016, two months before EO 13-06’s deadline for full compliance, Prison Voice Washington (PVW) published its report “Correcting Food Policy in Washington Prisons: How the DOC Makes Healthy Food Choices Impossible for Incarcerated People & What Can Be Done.” PVW is a small, volunteer-run collective of prisoners and non-incarcerated family members, friends, former DOC employees, and prisoner advocates. According to its website, PVW “exists to help redesign and update Washington’s broken prison system by introducing common sense, humanity, and the latest scientific research into policy discussions. Our goal is to improve both the lives of our prisoners and the safety of our communities” (n.d.). PVW fights to improve prison conditions by lobbying state legislators and DOC administrators. PVW’s report outlines in detail the legal and moral failures of prison food under DOC and CI. “The food served and sold to the 18,000 people incarcerated in Washington state prisons is now unhealthier than it has ever been” (2016: 2). DOC and CI, the report goes on, have “turned Washington prisons into state-sponsored food

⁸² Federally-mandated programs like public school meals, as well as DOC’s religious and medical diets are exempt.

⁸³ While the original EO 13-06 was based on the 2010-2015 DGA, the policy has since been updated.

⁸⁴ Visit: <https://www.doh.wa.gov/CommunityandEnvironment/WorksiteWellness/HealthyNutritionGuidelines>

deserts” filled with “industrialized, plastic-wrapped, sugar-filled” food (*ibid*). Meanwhile, change under the new executive order, they argue, has been grindingly slow. PVW bases its claims explicitly on the state’s carceral burden and legal obligations as defined under EO 13-06 and HNGs (*ibid*).

What kind of opposition is this, what are the terms of its contestation, and what role does nutritionist thinking play in this resistance? In this section, I turn from the biopolitical effects wrought directly by the carceral state and its neoliberal, prison-industrial apparatus to examine recent efforts led by PVW to challenge these effects, to reform Washington’s prison food system, and to end nutritionally inadequate prison food. I focus on PVW for the central role it has played and still plays in statewide advocacy on prison food in particular. Its report has been widely circulated, and its members regularly meet with DOC administrators and state legislators in Olympia. In examining the advocacy of PVW, I argue that prison food reform in Washington state strategically engages the language of nutrition in order to challenge the ways it has been conditioned, demoted, and displaced by neoliberal penal policy. Yet, at the same time, PVW in its efforts to improve prison food has done so within state-sponsored frameworks and logics, ultimately reinforcing the carceral state and its biopolitical control. Here, nutrition becomes a tool of reformist reform.

In its report, PVW contests hegemonic nutrition’s most extreme quantified, scientized aspects. PVW criticizes CI for its reliance on vitamin-fortified supplements and drink powders, which prisoners often trash anyway. Under EO 13-06, PVW argues, state agencies are "meant to meet nutritional requirements without supplementation" and doing so is "contrary to the spirit" of the HNGs⁸⁵ (2016: 17). PVW also criticizes CI meals for being heavily “industrialized, plastic-wrapped, sugar-filled” (*ibid*: 2) and “processed ... eliminat[ing] all freshly prepared, natural food” (*ibid*: 8). Drawing on the HNGs, as well as language popular in mainstream food advocacy, PVW

⁸⁵ Supplements sold in DOC commissaries are also inadequate, PVW argues, given the lack of regulation or quality control in the nutritional supplement industry (*ibid*: 19)

advocates for more “whole” and “locally prepared healthy food” in prison meals (*ibid.*: 2). Finally, PVW insists policymakers reckon with the realities of prison food in its particularity, rather than rely on assumptions based on eating outside prison. When discussing HNG fruit serving sizes, for example, PVW clarifies that “apples served to incarcerated people are of markedly smaller sizes than apples the public sees in grocery stores” (*ibid.*: 25).⁸⁶

At the same time, however, PVW relies rhetorically upon several tenets of nutritionist commonsense. For example, PVW criticizes the culture of indiscriminate cost-cutting that has proliferated under CI. PVW writes in their concluding recommendations that “Correctional Industries revenue priorities are at odds with nutritional goals” (2016: 24). In criticizing CI’s bottom-line thinking, however, PVW reproduces equally economistic arguments that align comfortably with nutritionist ideals of quantification and equivalence. For example, PVW highlights how shortsighted cost-cutting on prison food creates greater downstream costs in the form of increased healthcare costs. “[T]he unhealthy food served and sold to people incarcerated in state prisons ... will lead to costly health care expenditures on preventable diseases” (*ibid.*: title page). In particular, PVW highlights “preventable dietary diseases” like hypertension, cardiovascular disease, obesity, and diabetes. According to its report, healthcare constitutes 19% of DOC costs and “diabetes and hypertension are among the top five chronic care areas for incarcerated people” (*ibid.*: 4).

In focusing on budgetary costs, PVW challenges CI’s state-sponsored marketization and business-minded cost-cutting, yet simultaneously reproduces the basic epistemological paradigm of neoliberal penology. Prisoners are treated not as individual wards for whom the state is legally and morally responsible. Rather, prisoners are still framed as mass consumers and budgetary burdens. In the process, it becomes harder to imagine treating incarcerated people as citizens worthy of rehabilitative care, for which nourishing food would be necessary, or even less thinkable, as

⁸⁶ Several of my interviewees also brought up the meager size of prison apples.

criminalized, complex, non-innocent, imperfect people with the capacity to define and govern their own ways of eating.

This is not for lack of moral imagination or political savvy, however. PVW knows well the discursive and moral terrain it has forfeited and why. One organizer explained how she reckoned with such compromises:

“When I go try to talk about this food issue with legislators who are liberal but uneducated about the prison system, I can’t really get their sympathy until I start talking about the fiscal aspects of it. So, I’m really trying to learn as much as I possibly can about the fiscal side of it. Because even if that’s not the side I give a shit about, that’s how I have to frame it to get these legislators to care about it. So, it’s really, I feel shallow [having] to talk about it in those terms but it’s what I always have to come back to in order to get them to listen to me.

Because they will ask, 'When my constituents email me because they're angry with something I did that sounds like it's soft on criminals, how do I justify it?' Well, I tell them ‘taxpayers shouldn't have to pay for diabetes care for prisoners.’ That’s a pretty compelling thing to tell your constituents when they're pissed off at you for voting for prisoners.”

These comments highlight the discursive bind of institutional reform that relies upon the goodwill of those already in power under the status quo.

PVW also heavily couches its criticism in the language of what Aya Kimura calls "charismatic nutrients," those micro- and macronutrients "that capture the attention of experts and the public" (Kimura in Biltekoff et al., 2014: 22). PVW’s report repeatedly highlights the ways CI’s mainline meals fail to meet the nutritional standards required by EO 13-06, focusing in particular on the ways CI provides inadequate or excess saturated fats, sugar, cholesterol, calcium, omega-3 fatty acids⁸⁷, vitamins A and D, and especially calories, protein, and sodium. It is meticulous in its

⁸⁷ PVW argue for more fish, nuts, and seeds in the prison diet. In a move illustrative of the bind of carceral nutritionism,

accounting. Of course, as I illustrated in the previous section, malnutrition is a serious injustice with very real health effects. Yet, the outsized focus that charismatic nutrients receive in food activism and policy “cannot be fully explained by [their] physiological potency” (Kimura, 2013: 19) alone or by a progressive government finally catching up with ‘good’ food science. Excess sodium is a problem, but it is only part of the problem. More precisely, it is one part of a problem that has been conceived and made knowable in a specific, provincial, non-inevitable way. The tendency for food activism and policy to focus on charismatic nutrients reflects the specific, historically, and geographically situated “sociopolitical networks built around them” (*ibid*). For example, when claiming the inferiority of the Kikuyu people of East Africa, British imperialists cited their plant-based diet and lack of protein. Protein was not an obvious or inevitable criterion of comparison. It was used in ways reflecting its sociopolitical context. In the case of prison food in Washington, PVW’s focus on charismatic nutrients like sodium, saturated fats, or Vitamin D reflects the wider discursive terrain of prison food, which, as outlined above, has been narrowly and thoroughly defined by the hegemonic nutritionist imagination. This terrain includes laws, administrative policies, neoliberal government’s reliance on expert knowledge, and techno-managerial solutions.

Kimura argues that charismatic nutrients dominate expert and lay imaginations because “[t]hey serve as emblems of both the food and nutrition problem and its solution” (Kimura in Biltkoff et al., 2014: 22). Focusing one’s critique of prison food in the terms of hegemonic nutrition, therefore, not only defines the problem of prison food in a narrow sense but also limits the menu of potential solutions to only those already thinkable within a nutritionist imagination. As I have argued, nutritionist thinking is based in logics of bodily equivalence, discrete ontology, universality, standardization, and quantification. Moreover, nutrition renders food, eating, and well-

PVW justifies this by citing news reports on the connection between omega-3 fatty acid consumption and violent behavior.

being into technical and managerial matters, best solved under the expert rule of nutritionist and technocrats. These epistemic tenets, I argue, ultimately make nutrition an appealing technology for a carceral institution like the prison.

Nutrition may not always conform conveniently to the imperatives of prison rule. As the case of Washington illustrates, nutritionist thinking can end up enabling its own disavowal. Yet, can nutritionist thinking really work to limit or undo carceral state power? It is telling that California, reputed for its liberal, progressive approach to governance, also has the most explicit, stringent, and scientized nutritional standards. It also has the largest state prison population in the country. Indeed, in the neoliberal era, when the scaling back of state resources is combined with pernicious audit culture, nutrition may serve to *reinforce* carceral state power. As Kimura writes, "quantification has gained even more currency during the neoliberal era, given the heightened urgency of accountability politics and evidence-based programming" (Biltekoff et al., 2014: 22). As prisons seek to operate more and more using "evidence-based programming," nutrition is a logical discourse to which they might turn. Micronutrient and calorie counts "enable experts to state that they produced a tangible output" (*ibid*). This may be especially appealing when there is only one nutritionist for an entire state.

Nutrition in PVW's critique thus serves, I argue, as a reformist science, not an abolitionist one. PVW's calls for more nutritious, less industrially-produced prison food may increase the cost of maintaining mass incarceration at current levels. It may therefore incentivize decarceration. It would certainly improve the health and living conditions for currently incarcerated prisoners. Yet, by failing to question the epistemic dominance of hegemonic nutrition writ large, PVW situates its demands for reform "in the discursive formation of the system as is, so that any changes are made within or against this existing framework" (Ben-Moshe, 2013: 87). In this way, nutrition becomes a reformist science, turning prison food simply into a matter of "how *best* to run prisons ... rather than question

why these measures are used in the first place” (Garland, 2012: 3-4; quoted in Murakawa, 2014). The carceral machinery just needs fine-tuning.

This is about more than just forfeiting a veneer of legitimacy to the liberal, reformist carceral state. Again, PVW is well aware of this concession. Rather, my concern is that the current reliance on nutritionist thinking makes it more difficult to “imagine a different horizon ... not limited by a discussion of what is possible at present” (Ben-Moshe, 2013: 87) and that nutritionist reforms will ultimately make abolition more difficult in the long run. To be clear, my critique of nutrition as a reformist science does not discount my or PVW’s critiques of nutrition as carceral biopolitics or the impacts of CI’s food system on incarcerated people. The status quo cannot and should not stand. Rather, I offer this critique as an intersecting and coalitional call to consider the limits of dominant epistemology for radical and necessary change and to imagine what other tools might work better to build the futures we desire.

Taking Care: Carceral Expropriation and Incarcerated Women and Trans Folks' Everyday Acts of Commoning

"[P]atriarchy is ... a repeated action of draining our energies through separation and expropriation of our creations. Patriarchy ... is the everyday and reiterated manner of producing and fomenting separation between women, again and again establishing some type of masculine mediation between one woman and another and, thus, between each woman and the world."

- Raquel Gutiérrez Aguilar and Liz Mason-Deese, 2018: 676

"We are seen as nagging bitches, not workers in struggle."

- Sylvia Federici, 1975: 3

Carceral care frames prison healthcare as a scarce resource and incarcerated people as criminal mass consumers. The result, as I have documented, is a crisis of care behind bars, in which incarcerated people's well-being is systematically devalued and debilitated. Yet, this biopolitical logic does not exhaust incarcerated women and trans people's experiences of health, care, or life behind bars. The people I spoke with developed alternative individual and collective care-taking practices that responded to this crisis, and in the process, resisted, exceeded, and escaped, albeit partially, the prison's biopolitical vice. Through messy, conflictual, uneven, everyday practices of getting on together, incarcerated women and trans folks crafted a care commons, sharing resources necessary for their own and each other's ongoing biological and social reproduction. To illustrate this point, I open with three vignettes.

In addition to fighting her own medical maltreatment, Amy also worked as part of a group at Purdy called "seizure watch." "We have women at Purdy that have seizures," Amy explained to me. "So, if all of a sudden one of the alarms went off ... and the lights start blinking off and on, it puts people, who have ... any stimulus induced ... they start dropping like flies." According to Amy, it

was common for people at Purdy to suffer seizures. "So, there was myself and a couple of others who were essentially responsible for making sure ... that everybody got out if they had a seizure, and to make sure that every member of our dorm got out the door" (personal interview, 2018).

While Amy shared her labor, Sarah shared her food. During her eight years at Purdy, Sarah witnessed the slow decline in prison food quality and variety. Eventually, the food became so unappetizing, so enervating, Sarah started buying her meals almost exclusively from the prison's commissary. But "commissary was expensive." She and her cellmates had to get creative. "Once you got your packages or things, you would buy a sausage and somebody else would buy rice or a thing like that. That's kind of how we built community ... because you wouldn't be able to buy all that [by yourself]" (personal interview, 2018).

For Jolene, Purdy's worsening food took a toll on her body, giving her bowel pain for weeks on end. Desperate for relief, Jolene finally gave in and paid the \$4 to go to sick call. After a perfunctory exchange with the prison nurse, Jolene received a prescription for fiber capsules. After more than a month on the medicine, however, nothing had changed. Still in pain and now doubly frustrated, Jolene turned to her cellmates. "I saw that every other girl in there had the exact same medicine as me ... So, I'd ask around, 'Is this helping you? What's going on with your stomach? How are you feeling?' Just trying to gauge and see if we're all on the same thing, are we having different symptoms? Has anyone else got something different?" Jolene, like Sarah, like Amy, was not alone.

One prison. Three stories. Seizing bodies attended and cared for. Meager wages pooled for a potluck. Symptoms and stories shared. At first blush, these stories may seem unrelated, occupying ontologically distinct realms of prison life. What does prison medicine have to do with the commissary? Such neat conceptual separations, however, only make sense from the top-down perspective of carceral care. They do not capture the realities of incarcerated life.

Writing about feminist political economy's (FPE) customary separation of care labor into distinct "modalities and trajectories" (2012: 145), Eleanor Kofman makes a similar argument. In conceptualizing care relations as necessarily disconnected, as either 'social' or 'economic' but never both, "we seem to be hanging onto traditional gendered knowledge" (*ibid*). To correct this masculinist compartmentalization, Kofman suggests FPE scholars take social reproduction (rather than care *per se*) as our primary site of inquiry. Care refers to "a range of activities and relationships that promote the physical and emotional well-being of people 'who cannot or who are not inclined to perform these activities themselves'" (Kofman, 2012: 143; quoting Yeates, 2004). By contrast, social reproduction refers more broadly to the "fleshy, messy, and indeterminate stuff of everyday life" (Katz, 2001: 711). Social reproduction may include "provisioning and caring needs," but also the daily and intergenerational biological reproduction of individuals and communities and "the reproduction of the laboring population" (Strauss, 2013: 182; see also Andrucki et al., 2017; Glenn, 1985; Mitchell et al., 2004; Pratt, 2012). By thinking through systemic social reproduction rather than singular care circuits, we are able to ask deeper questions about the biopolitical structures that value and devalue different people's lives and whole ways of life.

In this chapter, following Kofman, I approach incarcerated women and trans folks' myriad care practices as part of a larger reproductive struggle over whether and how the prison institution and possibilities for living beyond its carceral relations will or will not survive into tomorrow. Criminalization and incarceration dispossess incarcerated people of needed care and support. Moreover, the prison institution continually seeks to disallow any efforts by incarcerated people to care for themselves outside its own carceral imperatives. To compensate for this crisis of care behind bars, the prison then coerces and expropriates incarcerated people's unpaid care labor as stopgap.

It is against this backdrop that practices as seemingly mundane and unrelated as Amy's seizure watch, Sarah's cellhouse potlucks, and Jolene's citizen science become legible as allied practices of counter-conduct against an uncaring prison system. Each responds to, resists, and escapes, albeit partially, this common context of carceral isolation, expropriation, and organized abandonment. Each shares common goals and tactics: survival, autonomy, and the pursuit of "a good life in a bad life" (Butler, 2015: 193). Each seeks to solve the care crisis that prison, including prison healthcare, creates. Incarcerated women's and trans folks' care practices may be individual. They may rely upon state or market infrastructures. At other times, however, incarcerated women and trans folks craft a reproductive commons that lives, at least partially, outside the logics of state, market, or private property. What, I ask in the conclusion to this chapter, might be the political possibilities and limitations of a care commons within the total institution of the neoliberal prison?

In this way, I engage the concept of social reproduction as more than just a diagnostic tool, "simply naming various things and phenomena as 'part of social reproduction'" (Lewis, 2018: 305). Rather, by "engag[ing] with social reproduction's normative stakes," by arguing that some people's social reproduction is being conditioned, debilitated, and even denied and that *the world should be different*, I insist that we imagine other ways to make our worlds. How might we, following Sophie Lewis, learn "to remake life in a livable mold"? (*ibid*). To begin this task, however, we must first understand the historical and geographic relation between political economy and punishment, between labor, care, and coercion.

Carceral Expropriation and Coerced Care

Multiple scholars have demonstrated the central role human caging plays in the history of North American and transnational racial capitalism (Hernández, 2017; LeBaron and Roberts, 2010; Melamed, 2015; Shabazz, 2015; Smallwood, 2008). Within this literature, punishment,

criminalization, and incarceration have been theorized along two axes: first, as (re)producing racial capitalism; second, as resolving and relocating its internal crises via the spatial fix (Gilmore, 2007).

In the first case, policing, criminalization, incarceration, and confinement more broadly (*e.g.*, Indian residential schools) produce and reproduce racial capitalism via processes of racialized accumulation by dispossession (Byrd et al., 2018; Collard and Dempsey, 2017; Coulthard, 2014; Dawson, 2016; Dawson and Francis, 2016; Day, 2015; Fraser, 2016; Hernández, 2017; McIntyre, 2011; McIntyre and Nast, 2011; Pulido, 2016; Tuck and Yang, 2012). Karl Marx used the term “primitive accumulation” to describe capitalism’s pre-conditions: “those moments when great masses of men are suddenly and forcibly torn from their means of subsistence, and hurled onto the labour-market as free, unprotected, and rightless proletarians” (1990: 876). Updating Marx, David Harvey (2003) coined the term “accumulation by dispossession” to capture the ongoing nature of this dispossession, in which “conquest, enslavement, robbery, murder, in short, force, play the greatest part” (Marx, 1990: 875-6), and which arises “whenever workers find ways to overcome their separation from the means of production or to set limits on their own exploitation” (Collins, 2012: 7). This may manifest, for instance, in union busting that seeks to keep labor cheap by keeping workers alienated from the means of production. In the U.S., this expropriation has often had a racial(izing) dimension in the historical and ongoing theft of Black, Brown, and Indigenous people’s land, labor, lives, and life-ways (Day, 2015; Melamed, 2015; Pulido, 2015). Racialized expropriation “manifest[s] in the division between full humans who possess the right to sell their labor and compete within markets, and those that are disposable, discriminated against, and ultimately either eliminated or superexploited” (Dawson, 2016: 147-148).

Before the twentieth century, prisons were largely reserved to reform “white wage-earning individuals who violated the social contract of the new industrial capitalist order” (Davis, 2003a: 361). As a result, criminal penitentiaries have played a relatively minor role in the long history of

racial expropriation compared to other forms of state and extra-legal violence (e.g., policing; see Arnold and Pickles, 2011; Cowen and Siciliano, 2011; Gidwani and Reddy, 2011; McIntyre and Nast, 2011; Merrill, 2011; Yates, 2011). Today, however, prisons dispossess poor people and people of color every day, incorporating them into capital circuits as ‘captive laborers’ for private corporations (a minuscule proportion of prisoners; see LeBaron, 2008), as ‘captive consumers’ in the Prison-Industrial Complex (Delia Deckard, 2016; Hiemstra and Conlon, 2017), or as targets for “fee farming” by financialized police departments⁸⁸ (Wang, 2018). As figure 8 illustrates, incarceration significantly worsens already racially uneven wealth accumulation (Prison Policy Initiative, 2016). Prisons as tools of racialized accumulation by dispossession have today become central to (re)producing racial capitalism.

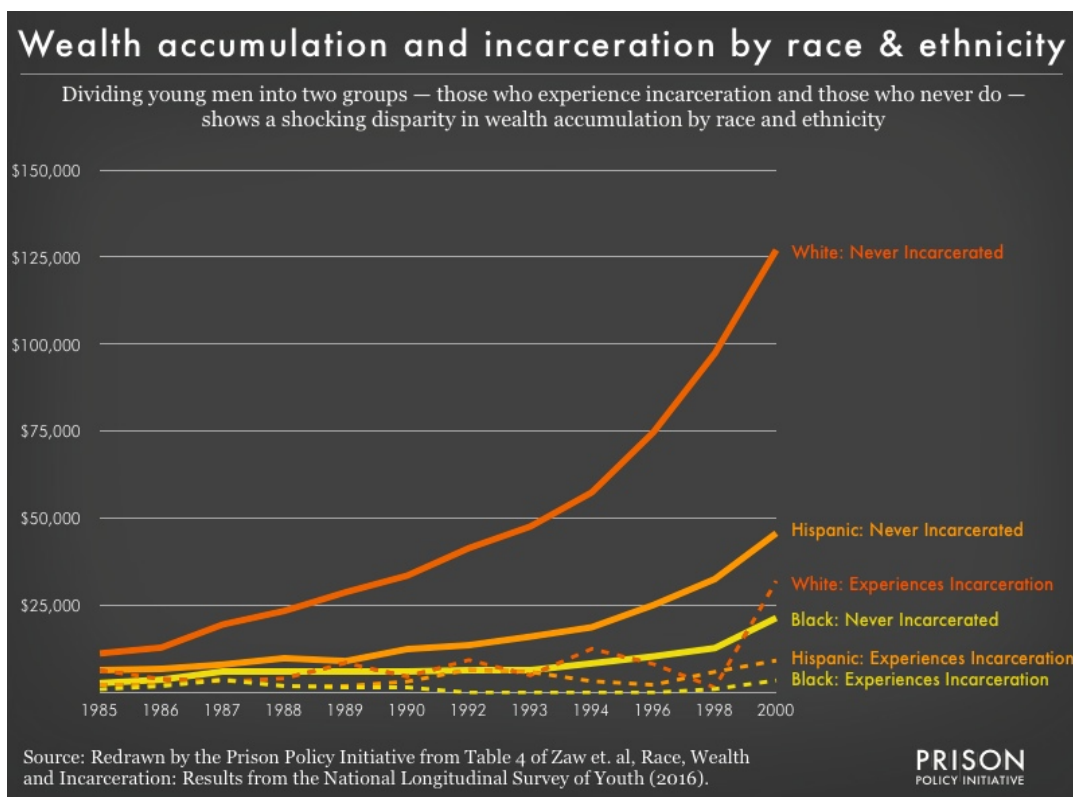


Figure 8. The racially uneven effects of incarceration on wealth accumulation. Source: Prison Policy Initiative

⁸⁸ In Ferguson, Missouri, the police have relied heavily on petty arrests, fines, and legal fees to fund their operations. On August 9th, 2014, in this same town, the young Black man Michael Brown was shot by a White police officer. Racialized expropriability bleeds into racialized disposability.

In the second case, prisons, rather than (re)producing racial capitalism's necessary conditions, solve its internal contradictions by warehousing the predominantly poor, Black, Brown, and Indigenous folks who have been made surplus "based on both their blackness and their surplus status ... [as] incapable of contributing to accumulation" (Pulido, 2016: 1-2; see also McIntyre and Nast, 2011; Robinson, 2000).⁸⁹ "[A]s a class, convicts are the working or workless poor" (Gilmore, 1998: 172), and in the U.S., the working and workless poor are disproportionately people of color. Prisons disappear subjects no longer deemed valuable under racial capitalism. This was the case in post-1980 California when neoliberal restructuring left entire communities economically abandoned (Gilmore, 2007). Incarceration, however, has served as a spatial fix for the social and political economic crises of surplus and rebellious Black, Brown, and poor life since at least 1865 and the legal emancipation of slavery (Childs, 2015). 'Mass incarceration' simply marks the expansion of the prison's political economic function under neoliberal racial capitalism (see Byrd et al., 2018 on the mutation and continuity of racial capitalism under neoliberal restructuring).

Taken together, this literature has mostly analyzed labor and its relation to incarceration and racial capitalism at the levels of social structure and (trans)national economy (Armstrong, 2011; Chase, 2015; Davis, 2000, 2003a, 2003b; DuVernay, 2016; Hernández, 2017; Lichtenstein, 1996; Smith and Hattery, 2008; van Zyl Smit and Dünkel, 2018). However, we can also understand labor at the level of the prison institution. For example, despite a disproportionate focus on prison labor contracted for private industry (Aman Jr. and Greenhouse, 2014; Davis, 2003a; Fenwick, 2005;

⁸⁹ The character of a prisoner's disposability may vary, however, according to hierarchies of class, race, gender, sexuality, indigeneity, residency or (im)migration status, custody level, or sentence. Within racial capitalism, prisoners may function as a reserve army of labor (*i.e.*, competitively cheap prison or ex-con labor; see Weiss, 2001 and Western and Beckett, 1999), as superfluous outcasts (*i.e.*, lifers in state-run prisons), or as threats to capital accumulation and White supremacy (*i.e.*, rioting and political organizing) (Collard and Dempsey, 2017; Pulido, 2016). Under the conditions of what Jackie Wang calls "carceral capitalism," however, these positions can prove messy. For example, even lifers in state-run prisons can be made to serve capital accumulation by subsidizing companies that sell goods and services to the carceral state as part of the prison-industrial complex (*e.g.*, JPAY prison email) and investment firms collecting interest on prison bonds (Bonds, 2006, 2012; Gilmore, 2007; Gilmore and Pyle, 2008; Pulido, 2016; Requarth, 2019).

LeBaron, 2008; Weiss, 2001), most labor inside prisons primarily functions to reduce the institutional costs of incarceration⁹⁰ (Gilmore, 2015). Prison labor has more to do with making prisons cheap for the state than profitable for corporations.

Yet still, these two functions – institutional and structural – are not disconnected. Rather, each ideologically and materially depends upon and reinforces the other. On the one hand, cheap prison and ex-con labor reinforces class inequality and racially stratified labor markets (Gibson-Light, 2017; LeBaron, 2012, 2015; Peck and Theodore, 2008; Smith and Hattery, 2008; Western and Beckett, 1999). On the other, as I will highlight in this chapter, even when prison labor does not directly spur capital accumulation, cheap prison labor is much easier for the prison to extract when incarcerated people have already been socialized and disciplined under racial capitalism.

This literature on prisons, racial capitalism, and prison labor, however, reproduces a patriarchal distinction between what does and does not count as 'labor.' Almost exclusively, it privileges activities that, if performed outside of prison, would be waged. These include prison manufacturing jobs, food preparation, cleaning and janitorial work, welding, carpentry, and agricultural work (Bair, 2007; Haney, 2010; LeBaron, 2008; Mountz et al., 2013; Pryor, 2005; Zatz, 2009). By contrast, critical prison studies have paid scant attention to care labor or its devaluation, (non)compensation, or political significance. Few articles discuss incarcerated women's labor at all, be it 'productive' or 'reproductive.' Those that do discuss incarcerated women's labor focus on low-paid non-care work (Haney, 2010; Pramaggiore, 2016). For its part, Oxford's Bibliography on Prison Labor offers only one article discussing prison care labor ... and it is paid labor performed by men (Taylor, 2016).

⁹⁰ Yet, again, in a world in which municipal and state budgets are increasingly financialized, requiring states to pay back privately-held debt, the cheap prison can itself become a tool for profits in the financial sector.

This oversight is unsurprising given the gendered nature of incarceration, which has served largely (or at least most obviously) to discipline waged labor. Roughly 90% of people in prison are poor and working-class men. It is hard to imagine a world in which 90% of all prisoners were women. Indeed, it is unlikely that our system of white supremacist cis-hetero-patriarchal capitalism could survive such a massive loss of free and cheap care labor⁹¹. Nonetheless, women and trans people are incarcerated and, as Amy's, Sarah's, and Jolene's stories illustrate, they do perform significant unpaid care labor in prison. How then might we understand these myriad practices as each tied to a larger reproductive struggle over an uncaring prison system?

Evelyn Nakano Glenn writes that the United States is facing a care crisis, a "large and growing gap between demand and supply in caregiving" (2010: 1). Following Cazdyn's (2012) comments on crisis, however, Glenn situates the current care crisis within a systemic analysis of political economy of care, by which (paid and unpaid) caring labor and the responsibility to provide it are socially and spatially organized across the state, the market, community associations, households, and individuals (2010). In the U.S., the sociospatial organization of care has been deeply classed, racialized, and gendered, "rooted in diverse forms of coercion ... [that] have served to constrain and direct women's choices," especially those of poor, racial minority, and immigrant women, all with the goal "to keep caring labor 'cheap,' that is free (in the case of family care labor) or low waged (in the case of paid care labor)" (*ibid.*: 5).

Glenn continues a long tradition within feminist political economy (FPE) of making visible how "women's and other subaltern bodies' unpaid caring and affective labor inputs subtend capitalist production" and how "paid forms of caring labor are integrated into circuits of transnational, often precarious, non-market life" (Andrucki et al., 2017: n.p.; see also Dalla Costa &

⁹¹ Though given that it would likely involve the disproportionate incarceration of women of color, the actual effects and import are hard to divine.

James, 1972; Davis, 1993; Enloe, 2014; Fredericks, 2015; Gidwani and Ramamurthy, 2018; McDowell, 1983; McKeithen and Naslund, 2017; Meehan & Strauss, 2015; Wright, 2006). While Marxist feminists in the 1970s excavated capitalism's conditions of possibility within the "hidden abode" of women's unpaid domestic labor (*e.g.*, cleaning, cooking, childcare) (Federici, 1975, 2012; Fraser, 2014; Mies, 2014), narrowly conceiving capitalism in terms of gender and class, subsequent debates have understood the political economy of care as central to not only gender inequality but also issues of social and economic justice, citizenship and statecraft, and racial capitalism (Davis, 1993; Glenn, 1985, 1992, 2010; Fraser, 2016; Wang, 2018).

How is this sociospatial organization of care produced and reproduced? How does capitalism manage to procure so much feminized, free, and low-paid care work, a process we might call gendered expropriation, gendered accumulation by dispossession, or more bluntly, "the extraction of care labor, emotional labor, as well as domestic and reproductive labor" (Wang, 2018: 119)? In her book *Caliban and the Witch* (2004), Sylvia Federici, correcting conventional gender-blind Marxist narratives, argues that capitalism's inauguration in post-feudal Europe required dispossessing peasants from not only their means of production (*e.g.*, land seizure and privatization) but from their means of social and biological reproduction as well. Capitalism could not abide a commons of care. Thus followed the sixteenth and seventeenth-century witch hunts of Europe, during which thousands of peasant women were murdered and many more terrorized. This campaign divided proto-proletarians along lines of binary gender, thereby raising the cost of solidarity; divested women of their bodily and reproductive autonomy; and privatized care within the nuclear family. With workers now alienated from their collective means of life, it became much easier for the capitalist class to instantiate a system of gendered expropriation and exploitation, wherein "[w]oman' is reproduced as inferior through the unwaged theft of her labor, while the esteem of the category of 'man' is propped up by the valorization of his labor" (Wang, 2018: 118).

This patriarchal capitalist division of labor was first exported to North America via colonization and subsequently deepened through U.S. industrialization (Glenn, 2010). While a nuanced history of its development is beyond my scope here, this system has generally demonstrated key features. First, it reinforces a binary divide between men's and women's economic activities, entrenched through the separation and gendering of public and private spheres, with feminized spaces of *home, family, love, and altruism* cleaved from masculinized spaces of *work, money, and self-interest* (Bondi, 1998; England, 2003). This system emerged within the logics of liberalism and market capitalism, wherein the political rights of citizenship and freedom have been ideologically tied to (white men's) ownership of their own labor (Glenn, 2010). As a result, White women, slaves, indentured servants, Black and Brown folks, Indigenous people, and (im)migrants have been excluded from citizenship. Indeed, "race, gender, and class have remained organizing principles of care labor" across both "free-labor" and unfree-labor systems (*ibid.*: 10). Within the "free-labor" system, women's unpaid caring has been morally valued but economically and politically devalued, "simultaneously priceless and worthless" (*ibid.*: 35). Within the unfree-labor system, enslaved, indentured, poor, (im)migrant, Black and Brown, and Indigenous women have been coerced into doing caring labor (especially its messier, fleshier aspects) for more privileged households (*ibid.*; Glenn, 1992; Pratt, 2012).

Given capitalism's persistent need for free and cheap care labor, gendered accumulation by dispossession is also necessarily ongoing. As Raquel Gutiérrez Aguilar and Liz Mason-Deese write, "patriarchy is ... a repeated action of draining our energies through separation and expropriation of our creations" (2018: 676). The reproduction of gendered expropriation (and expropriability) occurs all around us, not only in the everyday labors of (mostly women) homemakers and caretakers but also in the workplace when anyone (usually a woman/femme) smooths over a conflict or washes the office dishes when it is not her job. In the 1970s, the Wages for Housework Campaign called out

this everyday reproduction of gendered expropriability (Federici, 1975). “[T]he unwaged condition of housework has been the most powerful weapon in reinforcing the common assumption that housework is not work” (Federici, 2012: 16). Theories of gendered expropriation and coerced care illuminate the insidious violence that makes capitalist ongoingness possible. Every day, intimate sites of love and care become visible as battlegrounds of differentiated oppression, solidarity, and liberation. Yet, despite Federici’s infamous condemnation of patriarchal housewifery as a fate “worse than death” (1975), Marxist feminists have paid less attention to the experiences of predominantly poor women, undocumented (im)migrant women, women of color, and trans folks trapped within our society’s more compact sites of carceral power – namely, the prison.

Indeed, while a spate of feminist literature has highlighted the ongoing and heightened crisis of caregiving in the U.S. today (Bookman and Harrington, 2007; England, 1996; Gallagher, 2018; Harrington, 2000; Staeheli and Brown, 2003), few explore in any depth its connection to processes of mass criminalization and incarceration. Some may acknowledge the systemic relation between neoliberal rollbacks in welfare and the concomitant rollout in state policing, criminalization, and caging (Iraola, 2018; Katz, 2001, 2008). Yet, research has tended more often to focus on increasingly disciplinary and punitive welfare programs (Willse, 2015), rather than prisons themselves. A few exceptional scholars have in recent years highlighted the unpaid (indeed, costly) work predominantly women of color do to support incarcerated loved ones. In her book *Doing Time Together*, Megan Comfort (2008) documents the exorbitant costs women pay to support husbands, sons, fathers, fiancés, and boyfriends in California’s San Quentin State Prison. Similarly, Brenda Parker documents how Black women living in Milwaukee, where half of all middle-aged Black men have been incarcerated, do the reproductive labor of “temporarily ‘housing’ prison returnees: providing bail or financial support or otherwise negotiating the criminal justice system” (2015: 126). This work underlines the toll mass incarceration takes on social reproduction.

Yet still, FPE scholars rarely look *inside* the prison to understand its institutional practices of gendered expropriation or the work that incarcerated people's care labor does. This is not simply a matter of theoretical oversight. It is a question of politics and strategy. As Victoria Law (2009) argues, representations of prisoners tend to center ostensibly 'masculine' and 'public' acts of resistance (*e.g.*, prison riots) and overlook less spectacular 'private' forms of feminist resistance.⁹² These same masculinist paradigms limit our ability to understand, appreciate, or materially support the work that incarcerated people's care labor does in reproducing one another, the prison institution, or possibilities for living beyond its carceral relations.⁹³

So, what role do prisons play in gendered expropriation? Here, I return to Glenn's work on coerced care (2010). Glenn identifies two forms of coercion central to the systematic (re)production of cheap and free care labor. First, status obligations of kinship (*i.e.*, motherhood), gender (*i.e.*, femininity, womanhood), and race, class, and residency or (im)migrant status mark some people's care labor as a 'duty' (rather than 'work') and therefore as free or cheap. Second, under white supremacist, cis-hetero-patriarchal capitalism, some people are empowered to command the services of other people, whether by law (*e.g.*, slavery, indentured servitude, convict labor) or as a result of inequality (*e.g.*, undocumented migrant labor).

Notably, Glenn briefly highlights how both forms of coercion converge in the history of women's incarceration. In the late 1800s, prisoner reformers in multiple states established women's reformatories "that combined moral uplift and training in domestic skills with the aim of remaking the lives of incarcerated women" (*ibid.*: 58). Given the exclusion of women of color from White middle-class ideals of feminine morality, reformatories disproportionately confined poor White

⁹² They also tend not to notice when incarcerated women *do* riot.

⁹³ Importantly, a few exceptions exist. Haney (2013) and Sufrin (2013) examine the care burdens faced by incarcerated mothers, while Hiemstra and Conlon (2016) explore the "intimate economies" of care inside migrant detention centers in the UK. I hope to build on this work by examining the significance of care labor *between* prisoners, its manifestation inside prisons, and its ties to carceral care.

women. These institutions sought to remove ‘fallen women’ from the corrupting influences of the industrial city, relocating them to rural estates hundreds of miles away. (Ironically, this same geographic separation today limits many incarcerated women’s abilities to care for or be cared for by loved ones outside prison.) With their emphasis on domestic training, women’s reformatories worked to reintegrate women post-release into the economy as effective wives, mothers, and domestic servants. Despite their decline in the 1930s, women’s reformatories represent “one of the clearest examples of how force and coercion were used to track women into caring work” (*ibid.*: 69). Prisons facilitated the social and spatial organization of care under racial capitalism, satiating its need for ongoing gendered expropriation.

In her analysis, Glenn echoes the aforementioned tendency to conceptualize prison labor in terms of its systemic political economic function. Yet, again, incarcerated people’s care labor also has institutional effects. Indeed, many male wardens resisted the creation of women’s reformatories on the grounds that incarcerated women’s free labor (*e.g.*, laundry, cleaning, sewing) was necessary for prison upkeep (*ibid.*). This same gendered expropriation, however, was recreated inside women’s reformatories where women’s vocational training largely involved institutional chores. In this way, women’s reformatories not only served to reinsert women’s cheap labor into the wider economy, but these prisons also benefitted institutionally from incarcerated women’s unpaid reproductive labor, which importantly would not have been so easily expropriable if these women had not been socialized and disciplined under white supremacist, cis-hetero-patriarchal capitalism. This is, in sum, the insight I explore in the remainder of this chapter. While incarcerated women’s care labor may not directly prop up capital accumulation, it nonetheless props up the prison institution in ways that would only be possible under our current economic system.

In the pages that follow, I trace the myriad “circuits and trajectories of care” (Kofman, 2012) that together comprise a reproductive struggle over whether and how the prison institution and

possibilities for living beyond its carceral relations will or will not survive into tomorrow. On the one hand, the prison institution dispossesses incarcerated women and trans folks of their support systems *and* expropriates their own caring labor to serve carceral ends. On the other, incarcerated women and trans folks myriad care practices form a kind of counter-conduct against an uncaring prison system. This resistance reflects the nature of gendered expropriation. As Federici writes, “the body has been for women in capitalist society what the factory has been for male waged workers: the primary ground of their exploitation and resistance” (Federici, 2004: 16). By caring for their own and each other's bodies, minds, autonomy, and being, incarcerated women and trans folks create individual and collective conditions necessary to their getting on together. I close this chapter by considering the political possibilities and limits of this incarcerated commoning.

Everyday Dispossession and the Crisis of Care Behind Bars

The crack of a judge's gavel. The imprint of inky fingerprints across paper. The clatter of a cellblock door ominously closed. These scenes of civil and social debility, common across TV's countless crime procedurals, mark the incarcerated person's dispossession. In the eyes of liberalism and the law, she has lost herself, her property, her rights, her liberties. What these scenes do not show, however, is what the incarcerated person loses as a *social* being, as a person who cares and is cared for by others. Incarceration dispossesses women and trans people of their free-world means of social reproduction, their networks of care, kinship, and social support.

These scenes are also insufficient in that they portray dispossession as spectacular, as a singular originating moment. Following Federici, however, I argue that dispossession is ongoing and repetitive across the life (and afterlife) of incarceration. The carceral expropriation of women's and trans people's collective reproductive means and individual care labor is a daily occurrence. Settler Colonial Studies scholar Patrick Wolfe argues that “invasion is a structure, not an event” (2006: 388; see also Day, 2015; Stasiulis and Yuval-Davis, 1995). Similarly, we can see incarceration as not merely

an event or even just an institution, but rather as a structure, as a persistent relation of state violence and carceral expropriability enabled by White supremacist, cis-hetero-patriarchal capitalism.

Moreover, this expropriation unfolds as part of the bureaucratic policies and protocols of administrative violence (Spade, 2015). Prison policies, guards, administrators, and at times, fellow prisoners daily work to disallow any non-sanctioned practice of incarcerated women's and trans folks' social reproduction that does not serve the carceral logic of security or the disciplinary logic of rehabilitation, reinforces the prisoner as pacified mass consumer, or individualizes survival.

"Almost by definition, incarceration separates individuals from their families," friends, and communities (Rabuy and Kopf, 2015: n.p.). Incarceration dispossesses incarcerated women and trans folks of their kinship and care networks, including those who care for them and those they care for. Teresa described the first months of her daughter Morgan's incarceration at Purdy:

"We just cried a lot on the phone. I'd accept the calls and, you know, the ... it was a funny little recording voice and then you'd have to do one and then you had to do another one.

'Yes, you are receiving this call and will accept the charges.' We had to fill out lots of papers, *lots* of papers, applications, in order to be accepted to go visit. So, I did that and then I had to get [Morgan's] kids' birth certificates to take them. And it was just a long process. So, it was a few months before I got to see her" (personal interview, 2017).

Every time a family member or friend has to take off work and drive hours to visit their incarcerated loved one or every time they are unable to do so, something has been taken from the incarcerated person and their loved one. Even with her well-paying nursing job, Teresa struggled to keep up with phone calls and visits.

Most prisoners and their loved ones are not so lucky, however. According to a 2004 survey, while 70% of U.S. state prisoners had weekly contact with someone outside of prison other than a lawyer, this number dropped to 31% for in-person contact (Rabuy and Kopf, 2015). In Florida, the

average state prisoner receives 2.13 visits over a twenty-three-month sentence, roughly once per year (Cochran et al., 2017). Younger people tend to have more visits than older people; White folks slightly more than Latinx folks, and twice as many as Black folks; people in women's prisons slightly more than people in men's prisons.⁹⁴ This separation likely has even worse consequences for people in women's prisons, where 60% of people have a child under 18 (Glaze and Maruschak, 2008); and while the number of people in women's prisons who care(d) for other family members (*e.g.*, parents) is unknown, given the class composition of prisoners, it is likely they too have experienced a growing elder care burden (Glenn, 2010; Pierret, 2006).

For those who do receive visitors, even these cherished visits can become sites of dispossession in ways that are subtle and visceral. In Purdy's and Mission Creek's visiting rooms, prisoners are allowed "[a] brief hug and kiss (*e.g.*, up to a 5 second kiss followed by a 10 second hug in length) ... at the beginning and conclusion of visits" (DOC Policy 450.300,⁹⁵ Visitor Guidelines),⁹⁶ and they may hold their visitor's hand throughout. All other touch is prohibited. Certain expressions of emotion are also off limits. "Conversations should remain quiet, without harsh language or swearing, encouraging pleasant and family interaction. Visitors and incarcerated individuals will avoid loud, excessively emotional, or disruptive behavior" (Visitor Guidelines). As Rabuy and Kopf point out, these vague rules "leav[e] families' visiting experience to the whims of individual officers" (2015: n.p.). Touch amongst prisoners is also forbidden. They cannot hug one another, hold hands, or notably, have any consensual sexual contact.

⁹⁴ Distance from home is also "a strong predictor for whether a person in a state prison will receive a visit in a given month" (Rabuy and Kopf, 2015: n.p.). While some reformers have called for building more, smaller, and more geographically dispersed prisons, crude proximity alone is unlikely to solve the care crisis created by incarceration and more prisons. Indeed, more prisons are likely only to worsen this systemic crisis.

⁹⁵ Visit: <https://www.doc.wa.gov/information/policies/files/450300.pdf> (Accessed July 3, 2019).

⁹⁶ Visit: <https://www.doc.wa.gov/information/policies/files/450300a2.pdf> (Accessed July 3, 2019).

Economic exchange also becomes a site and conduit of prisoners' reproductive dispossession. While the free-world person has the 'freedom' to commodify her own labor as a wage worker (Strauss, 2012), the incarcerated person cannot. Not only is she paid as little as \$0.36 per hour in Washington, but her work is also *not* contract-based in the free market sense. She has a significantly limited choice in her work, and if she does not show up for work, not only does she lose wages but she is also punished. Similarly, she has lost the class-differentiated 'freedom' of the free world to meet her needs through commodity consumption.⁹⁷ Prison guards daily reinforce this dispossession by disciplining prisoners into a prison economy wherein prisoners are only meant to meet their needs via state-sanctioned provision (*e.g.*, mainline meals) or purchase (*e.g.*, commissary⁹⁸; see figure 9). Prison policy strictly forbids lending and borrowing.

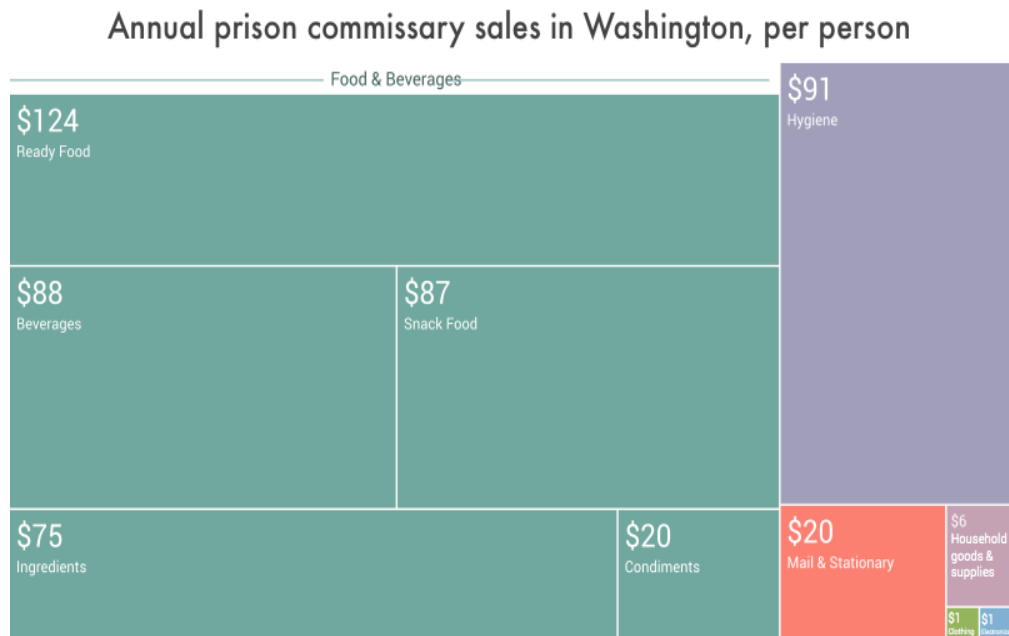


Figure 9. Average commissary spending per category per person in Washington state prisons.

Source: Prison Voice Washington

⁹⁷ For instance, people in prison in Washington state used to be able to order food from outside grocery stores. While prison wages were still meager, prisoners were able (at least in theory) to purchase options they considered healthier, tastier, and culturally desirable.

⁹⁸ Items from the commissary must be purchased with money from a prison job or outside family supports. Even seemingly non-marketized reproductive supports like shelter, electricity, meals, bedding, and medical care, however, have been increasingly marketized through policies of “punitive frugality” (Lynch, 2009) that saddle prisoners with the cost of their incarceration. All prisoners are thus pressured to work so that they might afford their incarceration.

While this policy is ostensibly intended to prevent economic coercion and abuse between prisoners, in effect it limits incarcerated women's and trans folks' abilities to meet their physical, psychic, and social needs. "The big problem that I see, because it causes more of a problem when you're in the dining hall, [is that] if I don't want to eat my bread, or my roll, or whatever, I can't give it to you. That's lending and borrowing," Amy explained. "What that does is leads to women hoarding" (personal interview, 2018). Guards may also search prisoners' cells at whim. "Oh yeah, it happened many times," said Kari. "They confiscate the things [food]" (personal interview, 2018). Rules against non-sanctioned trading thus work to continually undermine any effort by incarcerated women and trans folks to share the burden of social reproduction or, more simply, to exercise their agency outside the desired prison prescriptions.

The result of these policies is a crisis of care for incarcerated women and trans folks. In the case of food and eating, this care crisis is felt viscerally in sensations of illness and hunger. "If I consumed my entire tray," Jolene told me, "it made me feel really bad ... It was like either starve or eat some of this and deal with your stomach being upset later" (personal interview, 2018). Similarly, Maria, who was classed indigent for her entire incarceration, described the hunger she felt in prison. "It doesn't stay long, I guess, true and genuine hunger. But it's pretty pathetic because when you're in a situation like that, food is all you have to comfort you when you're starving" (personal interview, 2018). Samira, who worked in the Purdy kitchens, described the perverse pressures that create this care crisis while, at the same time, criminalizing people's efforts to resolve this crisis and survive through illicit trade.

"So, the food used to be better ... The food was edible ... Over time, that's completely changed. They've taken a lot of that away ... They've cut down. I notice like you used to get full portions. Then they're like, 'No, you guys are all overweight. So, we're going to cut it down.' I'm pretty sure the food wasn't the issue with all of this, but okay. So yeah, over the

years I saw them scale back on the quality of food and the quantity of food. Then, at the very end [of her sentence], now you're scared to go in the kitchen to eat. I wouldn't really eat in the kitchen. You'd eat off of store or packages that you were able to get. So, I've seen that scale back a lot, which also at that same time leads the women to steal more from the kitchen. Because you're taking away. You're just taking a lot away from the women in terms of food. Where everyone should have something" (personal interview, 2018).

This everyday dispossession also manifests in the policies and mundane practices of prison healthcare. As documented in chapter three, new prisoners lose access to free-world healthcare markets, including any culturally competent healthcare providers, public clinics, or previously prescribed medications or therapies they may or may not have accessed before incarceration. While Amy lost her medications for alopecia and nerve pain, Liza was denied her depression and anxiety medications for two months. Multiple formerly incarcerated women and trans folks shared experiences of visiting the prison clinic only to have staff downplay, dismiss, or doubt their symptoms. Jolene explained:

“If you *did* get an appointment with them, they, in a roundabout way, you could tell that they were treating you as *criminal*. Almost like you're trying to make up a medical issue or make it sound worse than it is type of thing. In the way that, it felt like I'd try to mention something or go into details but they'd counteract it with, ‘Oh, well, your vitals seem just fine.’ Or ‘Well, you haven't lost any weight so you're fine.’ Or, you know, just kind of make you feel guilty for coming to them with your medical concerns ... it just really, it sucks if you kind of get that cold shoulder when you really do need help” (personal interview, 2018).

Madison described clinic staff as...

“not unfriendly, but just like talking to a wall. I wouldn't want to ask them questions. Like you didn't get much help from them. They're standoffish, I guess, is a way to put it ... [A]t

night they're especially rude. They don't believe anything. Like if you hurt yourself, they think you're trying to hurt yourself to not go to Mission Creek or not go to work release⁹⁹. But what if you really did do something wrong? The physicians don't believe you. And even just the nurses. They're just rude. I went down there with pains after I had, I don't know what it was, maybe a gall bladder attack or something. I was puking, and it was a horrible pain. They were like, 'Oh you're fine. Just drink this GI cocktail, you'll be all right.' And then they sent me on my way. I'm like, 'Oh my god.' Then later I ended up having stupid appendicitis (personal interview, 2018).

The carceral context of the prison necessarily limits even the most principled, well-meaning medical professionals. One former DOC nurse who worked at a Washington men's prison described feeling hindered in her ability to care for patients:

So, it was a conflict between, I mean, especially as a nurse and as a caretaker ... I think really what made it difficult is we'd have correctional officers at or right close to our nurses' station. And so, I always kind of felt like, 'Could I be nice? How nice could I be to my patient? How like caring and compassionate and interested in them and their story and health could I be?' So, it was really hard to feel like you were doing a good job of taking care of your patient who happened to be an inmate (personal interview, 2019).

Mary, who was incarcerated at Purdy twice in the 1990s and 2000s, echoed this experience. "It wasn't compassionate care," she told me (personal interview, 2018).

The normalcy and systemic nature of this care crisis becomes most noticeable when compared to the rare but real experiences of care that did occur. Later in her sentence, Madison was

⁹⁹ Madison here references the fear many incarcerated folks feel at being transferred to Mission Creek and severed from their prison networks. Other interviewees said they were aware of some women injuring themselves in order to avoid being transferred, which has fewer ADA-compliant entrances and minimal on-site healthcare.

switched to another clinician. This doctor, to Madison's surprise, remembered her from an earlier interaction.

“That's when she was like, ‘Hey, I remember treating you. How are you?’ So, dealing with her was okay ... She just talked to you like a person. You know what I mean? It wasn't like, ‘Oh, I get to go home at night, and I come here at work, and you're beneath me,’ which was kind of the feeling you get a lot from some of those people” (personal interview, 2018).

Incarceration also dispossesses prisoners of significant epistemic resources. Prisoners do not have Internet access. While lower-security prisoners may have a cellblock TV or, if they can afford it, a personal TV, media content is severely restricted. Prison libraries are not mandated to have health resources¹⁰⁰. This epistemic paucity fundamentally alters the way incarcerated women and trans folks understand and act upon their bodies and their health. As Andrea Pitts writes, “[w]ith no access to online health information sites and limited television and print information, prison populations may be at a considerable disadvantage in assessing their own healthcare needs and the quality of care that they receive” (2014: 8).

Everyday clinical interactions with nurses and doctors rehearsed this epistemic dispossession. Prisoners were regularly denied epistemic legitimacy as holders of valid knowledge, including about their own bodies. As one formerly incarcerated woman put it, “they think we don't know our own body” (personal interview, 2017). Of course, the experience of embodied living-being, whether healthy or ill, often evokes feelings of confusion, ignorance, and self-alienation. Nonetheless, incarcerated women and trans folks often experienced incarceration as systematically exacerbating this existential epistemological condition. Morgan was unable to secure an X-ray of her jaw. When the CRC denied Madison surgery for her tendon, “they never gave me paperwork to say why they

¹⁰⁰ In March 2019, DOC issued a new policy banning the receipt of donated books not sent from a third-party retailer like Amazon. After outcry from local non-profits, DOC reversed the ban a month later (O’Sullivan, 2019)

denied it" (personal interview, 2018). As for individual prison nurses and doctors, Kari explained, "depending on who you're with, some were forthcoming; some were just dismissive" (personal interview, 2018). Several people described not having or not knowing they had access to their medical records. Moreover, several folks described learning information about a medical procedure (e.g., a surgical versus a non-invasive procedure) that had they known about in prison would have informed their healthcare choices, or at least how they understood their *lack* of choices, differently. Finally, prisoners can never get a second medical opinion (Holbrook, 2017).

This epistemological dispossession accompanies a loss of bodily autonomy, as evidenced by Amy's description of Purdy and its carceral logic: "We are going to bring you in here, we're going to break you down to the point you're not an anything anymore. The more you struggle against us owning you, the worst it's going to be for you. That is the bottom line of their level of care" (personal interview, 2018). Jolene experienced similar feelings of losing bodily autonomy. Unable to access effective medications for her depression and anxiety, Jolene turned to exercise, meditation, and diet.

"I was just trying to make healthy food choices. A lot of the food just had so much sodium and stuff like that in there. That's just, makes you feel really icky and bad. So that really plays ... bad food in your body really plays a huge role in your mental and emotional health. So, I was just constantly trying to counteract everything in there" (personal interview, 2018).

Jolene's Sisyphean struggle to retain some semblance of bodily autonomy¹⁰¹ and provide for her own social reproduction signals the persistence of dispossession across incarceration.

¹⁰¹ Following her injury, Amy told me, she was infracted for two counts of damaging state property - one for damaging a metal locker and another for her injured face. She went on to tell me: "I can guarantee, this last weekend, it's been very nice outside. I can guarantee if you drove by the grounds, you've got women out there laying in the sun. They use lotion and Vaseline to try and get tan, which also burns. If you get sunburned, they can charge you with damaging state property" (personal interview, 2018).

Incarceration thus reconfigures the social and spatial organization of care for incarcerated women and trans people, as well as their loved ones on the outside. Incarceration severs women and trans folks from their pre-existing reproductive relations, whether these involved state agencies, the marketplace, community organizations, kinship networks,¹⁰² or individuals. Prisoners are then re-oriented towards an outsized, if not totalizing, dependence on the prison's insufficient, institutional supports, or lack thereof (Dolovich, 2009). This alienation, however, extends beyond the prisoner's entry into prison. Incarceration as a structure of carceral expropriability is reproduced through everyday administrative violence of institutional policies and practices that advance dispossession.

Of course, not everyone experiences this dispossession in the same way. Exactly what a person loses materially upon incarceration depends upon their position under racial capitalism. People who had been living on the street and/or living with substance abuse disorder(s), for example, were more likely to experience their incarceration as a kind of salvation, providing them regular meals, a place to sleep, and at least formal access to healthcare (see also Sufrin, 2017). I do not claim incarceration to be a complete or uniform loss of reproductive supports *tout court*. But even these prisoners who described the relative benefits of incarceration as compared to street life also acknowledged the absolute insufficiencies of carceral care. Thus, I argue that all prisoners unevenly bear the effects of mass incarceration's care crisis.

Taking Care: Survival, Reproductive Autonomy, and the Prison Commons

Incarcerated women and trans folks respond to this daily dispossession and the resultant care crisis it creates using a range of everyday individual and collective practices. These practices share common goals: survival, reproductive and bodily autonomy,¹⁰³ and the pursuit of “a good life

¹⁰² We may also think about these as being more-than-human, as in the case of neighborhood air quality.

¹⁰³ This term might evoke classical notions of control over one's biological reproduction (*e.g.*, abortion access, reproductive rights). While incarcerated, people's reproduction is heavily circumscribed by the carceral state (Sufrin, 2017). Here, I build on the work of Black feminist advocates who integrate biological *and* social reproduction in their call for reproductive justice. For example, while there is growing attention being afforded the cruel practice of shackling

in a bad life” (Butler, 2015: 193). Each represents a form of counter-conduct (Cadman, 2010) against the biopolitical logics of carceral care and a generally uncaring prison system. Incarcerated women's and trans folks' practices of care, survival, and autonomy could be individual or collective. Yet, the divide between the two is blurry, each intertwined with the other. Madison captures this complexity when she insists that in prison “you're kind of stuck to your ... You have to survive with other people. If you went to sick call or whatever, I don't know, it's just not good. They don't care. You pretty much have to take care of yourself” (personal interview, 2018).

Many people practiced self-reliance by avoiding the prison clinic altogether. A \$4 co-pay and meager wages surely played a part, but participants also attributed their avoidance to negative past experience. After Jolene's prescription fiber failed to soothe her weeks-long stomach pains, she gave up going to the clinic.

“I ended up just not going to the med line and just letting that [prescription] expire. I just kind of gave up on it and I didn't ... It just felt like I'm not really going to get what I need or get where I need to get and I'm just going to have to be on my own and deal with this type of thing. I just gave up. I didn't feel like going through the process again, writing another kite, waiting, just to have a three-minute in-and-out experience of not even knowing what my symptoms are. I mean, them not asking, not trying to plan a better fit for me. So, I really just threw in the towel.”

After so many failed attempts to be seen by the clinical gaze of prison healthcare, Jolene ultimately decided to live in its shadows.

Regina described a similar attitude of self-reliance, driven in their case by a sense of paranoia and fear about what might happen if they did seek institutional care:

pregnant prisoners during birth, we are far from a conversation about incarcerated people's reproductive needs beyond their procreative roles.

“Like if you’re in the kitchen and something cuts you or burns you, you just have to wash it and clean it and patch it yourself. If you’re in pain, you just lay there in pain. Like you get stomach ache, maybe food poisoning even, you just go through it ... If you do go to the clinic, sometimes you lie and say you’re there for something else so you don’t get stuck there for a long time ... so that you can see someone faster or so that they don’t try to keep you and create more issues or force you to take some kind of pills” (personal interview, 2018).

This distrust and fear was common among many of the people I interviewed. Regina's attitude of self-reliance was more extreme than most, however. As a self-identified neurodivergent trans person in a women’s prison, Regina spent much of their life in prison alone, finding solace in solitude.

People in women's prisons also meet their needs and achieve personal autonomy through sites of collective exchange, such as the prison black market. After Health Services refused Morgan pain medication for her broken jaw, she found other ways to soothe her pain.

“I actually had to get medicine on the black market because [the prison] wouldn’t help me. I know that I was really sick one time. My head was horrible, and it was after my jaw was broken. Someone had a migraine pill, and I was like ‘Give it to me.’ So, if you find something that you can get better with, then you *keep* that. Because you know you’re not getting anything from [the prison]” (personal interview, 2017).

These chemical economies carry serious risks. These included possible penal sanction. Morgan often had to weigh the benefits of pain relief against the risk of being caught by guards. Chemical addiction and its negative health effects were another risk. Regina saw several cellmates appeal to both Health Services and the black market for prescription drugs “cuz it's all they can get their hands on and they just wanna stay high. Just a way for people to cope with being in there for such a long time” (personal interview, 2018). Notably, DOC does not provide methadone or buprenorphine

medically-assisted treatment for substance abuse disorders, except in some cases for pregnant prisoners.

Prisoners also trade commissary to supplement their meager, enervating, or dispiriting prison meals. Mary was classed indigent for both her stints at Purdy, meaning she never had more than \$10 to her name. “I remember if you were indigent,” Mary explained, “they would give you laundry soap or different things that were valuable on the prison market¹⁰⁴. And I remember trading one time my laundry soap for brownies and soup, so I'd have ... whatever you can do, whatever you can do” (personal interview, 2018). By contrast, Jessica, who was recently released after more than three decades at Purdy, “had a lot more money than a lot of the other inmates ... because I had a prison job there that paid pretty well as for prison jobs,” allowing her far more agency to meet her needs on the black market.

"I did a lot of things that I could've probably gotten in trouble for there to get better food. On canteen [commissary], I would order a whole lot of Little Debbie's and stuff like that. And what I would do is everybody would go up to the kitchen. They'd bring their food back. I would tell certain inmates that I knew didn't have a lot, I would say, 'Hey bring me your eggs and often fruit.' And I would trade them ... And the raw vegetables. Cause they'd get us a full bag of raw vegetables. Bags of raw vegetables. And I would trade them for Little Debbie snack cakes. That's one thing I would do. And some girls that would work in the kitchen. I would make a deal with them for them to hide stuff from the kitchen, healthier foods" (personal interview, 2018).

As Jessica's comments about kitchen staff suggest, some people in prison, rather than trade for food, reappropriated or, put simply, stole to meet their needs. This often required stealth, as Amy explained.

¹⁰⁴ The cost is added to a prisoner's post-release debt, which they must pay back.

"They have to offer you fresh one carton of milk a day, and most gals drink coffee, and they want to take it back to the unit. It's been given to you, on your tray. You can't leave the dining hall with it. You can't give it to anybody else. Even though, [the prison] gave it to you, because technically unless you drink it, it belongs to the prison. That's state property. Women would get milk in the morning. Breakfast was the only time they served milk ... Women would sneak milk any which way to get it home. Then you'd have guards that come in and go through the cubes looking for milk cartons. Even if you get it, you're probably going to lose it there" (personal interview, 2018).

Incarcerated women and trans folks work to solve their personal care crises through the mundane politics of refusing insufficient institutional supports, illicit trading, and outright theft. These efforts aim not only to (re)secure their own reproduction but also to (re)gain some level of personal bodily and reproductive autonomy. Within the neoliberal penitentiary, which increasingly treats prisoners as mass consumers, this autonomy manifests through the idiom of consumer choice (see also Gibson-Light, 2018). For the consumer, the most salient mode of counter-conduct is not to consume. Last chapter, we saw this in the case of hunger strikers, who refuse to consume when that consumption has been calculated through the biopolitical logic of minimum nutrition and bare life. Though less spectacular or seemingly newsworthy, incarcerated women and trans folks also refuse to be the prison's captive consumers. Amy used to go to the mainline meals, but she eventually...

"stopped doing that, because I knew that for every time they scanned my badge for a meal, they get money ... They don't care if you ate it or not, but they get money for all of that. If I was not hungry, I did not go to that damn dining hall, because I was not going to let them have whatever that amount was" (personal interview, 2018).

Prisoners refuse the prison's limited, coerced options and seek instead to expand their choices whether through the state-sanctioned commissary purchases, the black market, theft, or other forms of self-reliance. In each case, prisoners sought to regain personal autonomy over their bodies and selves. As the contrasting cases of Mary and Jessica illustrate, however, not everyone is able to meet their individual needs by themselves.

To share this burden, incarcerated women and trans folks also find collective means of autonomy, survival, and counter-conduct. Through messy, conflictual, uneven, everyday practices of getting on together, incarcerated women and trans folks craft care commons, sharing resources necessary for each other's ongoing biological and social reproduction. These reproductive commons live, at least partially, outside the logics of "both State and Private Property, the State and the Market" (Federici, 2012: 139). Sylvia Federici defines commoning as the practice of (re)creating shared means to collectively produce and reproduce life and living-being "in a noncommercial way" through "an economy based on solidarity and the refusal of competition" (*ibid.*: 132, 135). Commoning thus shifts the social and spatial organization of care labor (amongst other things) in ways that counter White supremacist, cis-hetero-patriarchal capitalist logics that coerce, privatize, and devalue paid and unpaid care labor according to lines of class, race, gender, (im)migrant and residency status, indigeneity, and importantly in this case, criminality. By reorganizing care labor, commoning also reshapes the subjectivity of both care-receivers and caregivers. "Indeed if 'commoning' has any meaning," Federici writes...

"it must be the production of ourselves as a common subject. This is how we must understand the slogan 'no commons without community.' But 'community' not intended as a gated reality, a grouping of people joined by exclusive interests separating them from others, as with community formed on the basis of religion or ethnicity. Community as a quality of relations, a principle of cooperation and responsibility" (*ibid.*: 145).

Drawing on the history of European witch hunts and the women-led communal movements that they sought to quell, Federici argues that women in patriarchal societies have often collectivized their productive labor to resist market encroachment (*e.g.*, peasant women's subsistence farming) and also collectivized their reproductive labor "both as a means to economize on the cost of reproduction, and protect each other from poverty, state violence, and the violence of individual men" (*ibid.*: 143). Feminist and anti-racist liberationist social movements such as women's health collectives (Murphy, 2012), the Young Lords (Enck-Wanzer, 2010), and the Black Panther Party (Nelson, 2011) have all sought to collectivize the reproductive labor of childcare, healthcare, and member well-being. Though with less formal organization, incarcerated women and trans folks toil in this same spirit to create the collective conditions of their own survival, their own care, their own ongoingness.

By pooling resources and energies, incarcerated women and trans folks find creative ways to reduce their reliance upon insufficient institutional supports, including commissary, and solve their collective care crisis. In the case of food and nourishment, people in prison often find ways to cook and eat together outside state-sanctioned circuits. Mary describes one such prison potluck.

"Occasionally, if we had friends, especially when some of my friends were having to work to make money, we'd get together, and we'd each like ... One person would do the beans. One person would do the rice. One person would do the tortillas. And we'd make burritos. Like six or seven of us. I worked in the kitchen. So, that would be my addition because I didn't have money. I'd bring the cheese or something" (personal interview, 2018).

Though Mary no doubt faced greater penalties stealing her ingredients instead of buying them, such underground commoning became a means to share the burden of social reproduction without reproducing the classist hierarchies of prison life.

Sarah spent eight years in the 2000s at Purdy. Despite the fact that she worked the entire time and had some outside financial support from family, Sarah still struggled to afford both food and toiletries from commissary. She compensated by swapping and sharing with cellmates.

"It was always one or the other. So, you'd buy your hygiene for one month and then the next month you wouldn't have to buy so much and then you'd be able to buy more food. Then you'd kind of work that out with your roommates or your friends to figure out how you guys would eat throughout the week. Yeah, that's kind of ... everybody does that."

These swaps often became ways to build friendships or even simple camaraderie.

Such communal cooking often required navigating prison rules and guards. "Yeah, you know, you're not supposed to share food," Amy said. "Even the stuff that you've bought from canteen, technically it's yours, but yet you still can't share it with anybody. They can't stop *you* from eating it. But yet we sit there, and we make nachos, and this and that, and there's eight of us at a table." Some days, some guards would allow these potlucks to take place. Other days, other guards would not. Incarcerated women and trans folks had to practice constant vigilance – another form of care labor – to navigate guard discretion. "There's always that feeling," Amy explained, "I know you see me doing this, and I know you're not going to say anything about it, so I'm going to keep doing it." Eventually, however, "one person will do something, and the guard will be like, 'You guys aren't supposed to do this, you know? I can write you up.'" Sometimes everyone would disperse. At others, Amy might jokingly reply, "Here. Have a cupcake" (personal interview, 2018). Sarah had a similar experience. While sharing food beyond one's cellmates required smuggling, "it was easy to do with your roommates 'cause you guys were all going into the same room. So, then they couldn't tell you what you could and couldn't do as much." By the time she left Purdy, however, Sarah noticed a change in institutional practice. "Down there in MSU [medium-security], they didn't care if you were

eating together or not. Well, not at the time. What I've noticed is it's gotten stricter and stricter and stricter over time” (personal interview, 2018).

I asked Amy how these meals made her feel, what they meant to her. "It's something we made," she replied...

"and we made it with seasoning, because you can buy seasonings on canteen. It was something that we made and we knew what was going into it, and even if it wasn't the healthiest stuff, anything is better than what you always have. You were sharing a meal with people that you actually enjoyed their company versus having to sit wherever you can with people that may not talk to you. It was that camaraderie type thing" (personal interview, 2018).

Sarah echoed similar sentiments.

"That's kind of how we built community. You hear that a lot about how people really build a community over eating or birthdays or making cakes or doing those things. That's really sweet and considerate ... that people care. Food was the thing that brought others together in that way. Because you wouldn't be able to buy all that [by yourself]" (personal interview, 2018).

Communal cooking was thus about more than survival, more than bare life. It pushed beyond the carceral biopolitics and slow violence of mere sustenance. It was about reclaiming collective autonomy over their bodies, diets, and self-knowledge. It was also about friendship, support, and pleasure.

Incarcerated women and trans folks not only shared material resources; they also shared epistemic resources, collectivizing their knowledge, experiences, savvy, and know-how through regular story-sharing. After receiving an ultimately ineffective fiber medication for her stomach pains, Jolene shared her frustration with friends and cellmates. She quickly learned that “a ton of

girls in there” with the similar symptoms had been given the same remedy with the same results. “I came to realize that that was just their fix for the upset stomach,” Jolene explained.

“So, I’d ask around, ‘Is this helping you? What’s going on with your stomach? How are you feeling?’ Just trying to gauge and see if we’re all on the same thing, are we having different symptoms? Has anyone else got something different? Just to compare medication and see kind of where things were on the spectrum. Are we all kind of mainly getting the same thing? Is somebody on something that I used to take when I was out? If so, maybe I just need to speak up and maybe I can get that. But no, for the most part, it really was like everybody was on the same thing. Some people had sleep issues, so they got *this*. People that had anxiety, they got *this*. People who had depression, they got *this*. It’s just very cut and dry. Everyone in there is really nice and forthcoming about, ‘Yeah, I know this is not working. I don’t know why, they just give this to everybody.’ Everybody kind of was frustrated. But also, we know, hey, we’re just ... it’s *criminals* in here. Nobody is going to take us seriously. Nobody *really* wants to get to the nitty-gritty of each individual person’s issue” (personal interview, 2018).

This epistemic network was not uniform, Jolene explained, but rather clustered around friends, prison elders, or people with medical experience.

“Girls that were in there a lot longer, I mean, they were kind of your go-to like, ‘Now, this is about as far as it goes. You’re not going to get any more help.’ You know, they know ... because they’ve been trying for years, and they just kind of know the drill. ‘Yeah, it sucks but it’s all, that’s all you get, that’s as far as it goes.’ Mission Creek is a lot smaller, and there you literally know every single person. But you kinda know who you can be comfortable going up to and just having a conversation. ‘Hey, I’ve been struggling with this. I can’t seem to get

to where I need to be with the doctors. Do you know if they deal with this? What else can I do?"

This knowledge proved limited, however. While women might suggest ways to see a different doctor or file a kite, “they don't have the means to really go any deeper” (Jolene, personal interview, 2018). As a supplement, people in prison might turn to other informal authorities. When Madison left Purdy, for example, she left her cellmates a book on home remedies, hoping it might help those she had to leave behind.

Finally, incarcerated women and trans folks shared the physical and emotional labor of caring for one another. While I focus on the messy, bodily labor of caring for sick friends and cellmates, care labor also took the form of friendship, romantic relationships, and sex. Though sexuality was not an explicit part of my interview schedule, many participants described being in or having friends who were in short-term or long-term couples at Purdy. Many of my participants also identified as gay or lesbian or, as Mary put it, “I was gay for the stay. That's what we called it” (personal interview, 2018). Amy described one week when she and her cellmates were quarantined in their cellblock to stop the spread of norovirus through the prison. They did not eat a hot meal for seven days. “The amount of sex I saw in that seven days was more than I ever need to know about,” Amy laughed. “They would position things just right so they couldn't get it on the tape, and whatever” (personal interview, 2018). In a prison environment where people are denied physical touch, where hugging is prohibited, sex becomes a vital caring labor, a form of commoning that’s outside the expectations of cis-hetero-patriarchy or scarcity logics of capitalism.

Incarcerated women and trans folks also stepped in to care for sick friends and cellmates when the prison, whether or not it had met its constitutional or policy mandate, failed to meet their needs. In this way, they struggled to solve the prison's care crisis.

"There's people that'll ask you do you want ice, hot water, whatever. Do you want me to make you some food? Even if it was like, if I was on The Hill [minimum security], they'd send stuff up with my other friends that could get it to me or whatever. So, everybody's pretty caring. That's just what you do ... I don't know. Just anybody, if they're sick, you make sure they have what they need" (Morgan, personal interview, 2018).

Kari spent six years in prison between Purdy and Pine Lodge, the women's prison near Medical Lake, Washington, that closed in 2010. During their sentence, Kari's close friend was diagnosed with Hepatitis C and approved for interferon¹⁰⁵ therapy, a then months-long treatment process involving, as Kari explained "a series of shots, makes you really sick, it's kind of like chemo." But Health Services "ended up stopping mid-treatment because the prison said there's not more funding. That was a pretty bad situation. She had to sit and wait sick and in a lot of pain due to all that." The effects of this start-and-stop treatment were "deteriorating," Kari said. Her friend "needed help just in day-to-day life with that treatment. We would help with that. We would just make sure she was comfortable, does she need anything. Constantly, somebody was always with her. Nobody left her alone just because of the pain that she was in." Such caretaking¹⁰⁶ was technically against prison rules, but, as Kari put it, "You kind of do what you do. You're supposed to be a roommate to go into the cell, but officers kind of overlooked a lot of stuff when it came to her situation. It was pretty bad."

Notably, when participants described guards turning a blind eye or even providing comfort in times of distress, the guard was almost always a woman or a male guard who had worked at Purdy for many years.

¹⁰⁵ For more on Interferon treatment for Hepatitis C, visit: <https://www.webmd.com/hepatitis/understanding-hepatitis-c-treatment#1>.

¹⁰⁶ This care extended to non-humans, as well. Kari's friend "was part of the dog program. She had a dog. People had to take the dog out for her. She was really sick."

Several former prisoners described providing similar care for neglected older women held in the Residential Treatment and Evaluation Unit, known as TEC, the prison's long-stay infirmary, likely a growing population situation given the graying of prisons nationwide (Skarupski et al., 2018). Amber recalled visiting and caring for one older woman in particular.

“There was a mother and her daughter team there. They had done a murder for an insurance thing, and the mother was older. She was an older lady. She was light-haired and frail, probably in her 70s, but she had dementia. Once she started getting older and kinda diminished, they moved her into, they used to call it SNU, Special Needs Unit, now they call it TEC. So, we would go, I don't even know how I got to ... you could just talk to the guards like, ‘Look, I'm gonna go get her.’ So, you would go in and get the old lady. Well, every time I would go in there, she'd be sitting in her own piss and sitting in her own shit. And nobody would change her. Nobody would do anything. So, I would shower her. Well, I wasn't the only one showering her. There was other inmates in TEC that would also give her showers” (personal interview, 2018).

Christina was incarcerated at Purdy for five years in the 2010s. During that time, her friend Felice developed Lou Gehrig's Disease. By the time she was diagnosed by the prison, however, her right limb had become fully paralyzed and her ability to walk was significantly impaired. One day, Felice fell while trying to use the bathroom. Christina happened to be in the same bathroom and, after much embarrassment, Felice let Christina help her use the bathroom. Christina not only performed the dirty labor of carrying and cleaning Felice; she also put her at ease. “Hey, we're all in prison together. At least we're not drunk!” Christina joked (personal interview, 2018). Though Felice secured an HSR for a wheelchair, it took months before DOC found her a wheelchair pusher, a paid position worth \$1.00 per hour. During that interim, however, no prisoner was allowed to help her around. Despite this, Christina and other friends would break the rules to help Felice with her daily

needs. Had they not, Felice feared, the prison might move her to TEC or the infirmary where prisoners are held in sparse maximum-security-level rooms (Christina, personal interview, 2018).

In some cases, incarcerated women's and trans folks' collectivized care labor was semi-formalized. During her time at Purdy, Amy served on her cellblock's so-called seizure watch. Amy “and a couple of others were essentially responsible for making sure if there was a fire alarm or something that everybody got out if they had a seizure and to make sure that every member of our dorm got out the door.” These people “had had the training. It goes a little bit above the normal CPR, First Aid, Health classes.” Amy had worked as a special education teacher before her incarceration so “I know what to do for somebody who is having a seizure.” Seizure watch was both common and entirely informal. “It's a known thing,” Amy explained. “All of the units have it.”

As a member of seizure watch, Amy was on-call at all times.

“If somebody had a seizure during the middle of the night, or during the day – some people have them all the time – daytime officers would call myself and another gal ... I could be in the day room and they'd say [so-and-so] is having a seizure, Amy. We would go and take care of them. The officers wouldn't step in and help her. They've been trained to. But those ones never threatened to write us up ... The daytime guards were very cool with that. One of them, she said, ‘I don't want to hurt anybody.’ She was pretty cool. She talked to us one-on-one about what her need was” (personal interview, 2018).

As a member of seizure watch, Amy was often seen as 'the mom' on her cellblock. “When we had new people come in,” Amy explained, “I would say, ‘Okay, none of my business, but I do kind of need to know if you have a seizure problem, if you can have seizures, if you're epileptic, if you have something that I need to be aware of.’”

While some guards made an exception for seizure watch, this kind of intimate touch and caregiving technically violates prison rules. Indeed, earlier in her sentence, Amy saved a woman in

her dorm from choking by performing the Heimlich maneuver. “In the cubby next to me, this tiny little lady, older than I am, she’s choking, literally choking on a pretzel. I heard the noise, I knew it, I got up, went around, and gave her the Heimlich.” The sergeant on duty inflected Amy for entering another prisoner’s bunk.

“I was touching another offender and I was in her cubby. Her attorney called. They were trying to charge her for, I don't even remember how they worded it, basically, she had invited me into her space and I'm not allowed to go in there. She was legitimately choking, and the other gal who was in her cube with her at the time, was panicked, didn't know what to do. They call mom, and I gave her the Heimlich. I was at fault” (personal interview, 2018).

Despite this constant threat of sanction, incarcerated women and trans folks insistently shared the labor of their daily care and reproduction. Through these practices of counter-conduct, they sought another way of life within and against the everyday crisis of care that prison creates. By sharing food, knowledge, touch, and labor, incarcerated women and trans folks crafted care commons necessary for not just surviving but for getting on together.

These commons should not be romanticized, however. Commoning can be messy, conflictual, and unevenly shared. While my participants did not discuss explicit exclusions, future research should not rule people be deprived or provided care according to divisions of race, class, sexuality, gender expression, or language. To be sure, one’s social networks seem to have facilitated or limited one’s participation in communal care. Where does this leave the unfriendly, introverted, or socially exiled prisoner? Where does this leave Regina? Moreover, fellow prisoners could frustrate one another’s collective care efforts. For example, Amber was no longer able to help the women in TEC after “apparently one of the girls had made an allegation that someone, not me, but someone was inappropriately touching [the older woman] while they were showering her, then no one could shower her anymore. I was so hurt” (personal interview, 2018).

I argue therefore that such care commons represent an uneven but nonetheless potent space of counter-conduct against the prison's care crisis wherein incarcerated women and trans folks struggle over their individual and collective reproduction as not just prisoners but as people, as social beings who receive and give care. Commoning thus becomes part of a larger reproductive struggle over whether and how the prison institution and possibilities for living beyond its carceral relations will or will not survive into tomorrow.

Carceral Capture and the Possibilities and Limits of the Prison Commons

In closing, I ask: what might be the political possibilities and limitations of such care commons within an institution like the neoliberal prison? On the one hand, commoning allows incarcerated women and trans folks the, albeit, meager resources to alleviate, if not resolve, the crisis of care in which they have been caged. They are better able to go to sleep not hungry, better able to withstand injury and illness, better able to make and keep friends, better able to cope with the mundane violence and deprivation of incarceration.

On the other hand, as a result of this collective care labor, prison institution is also better able to neglect, to confine, to cage on the cheap. The prison as an institution, incarceration as a social practice, and white supremacist, cis-hetero-patriarchal capitalism as a social formation all depend upon prisoners' coerced labor. This argument has most often been made, however, with a narrow focus on coerced, low-paid prison jobs involving historically masculinized economic activities taking place outside the home or 'in public': manufacturing, food preparation, welding, carpentry, and agricultural work. (Janitorial work proves a notable exception, though this work still involves cleaning 'public' facilities, not prisoners' cells.) People in prison are well aware of this. As Caroline explained, if there is a flu outbreak at Purdy, "they'll hand out masks because if something gets ahold in there it'll ... The prisoners run the prison. So, if half of the inmates are out with some sort of flu, then half of the prison isn't getting run. Food isn't getting cooked. Floors aren't getting

cleaned” (personal interview, 2017).¹⁰⁷ Less acknowledged, however, is how the prison depends upon prisoners’ *unpaid* labor, as well, and their unpaid *care* labor in particular.

Neither Mission Creek nor Purdy could run without prisoners’ unpaid care labor. Certainly, it would be a far more violent, hopeless place, less likely to attain even its meager goals of rehabilitation. To prop itself up, the prison daily expropriates incarcerated women’s and trans folks’ care labor. The seizure watch illustrates this. Amy and others directly stepped in to solve a care crisis and fill the care deficit created by the prison. This directly benefits the institution by lightening its “carceral burden” (Dolovich, 2009), decreasing prisoners’ health insecurities, and likely improving the prison’s efficiency, security, social stability, and budgetary bottom line. Indeed, as Amy explained, her work on seizure watch was “another reason why I was in the dorm for so long. Because I was making their life easier” (personal interview, 2018).

This reliance is tenuous, however, and even contradictory at times. After all, Amy’s work on seizure watch was technically in violation of prison rules. While some care labor by prisoners is convenient and even desired, other care labor is perceived as threatening, out of bounds. Almost all this care labor is technically illicit, criminalized in ways that effectively ease its coercion or suppression, whichever most benefits the prison institution at that moment. Today, one guard might confiscate contraband or punish two prisoners for hugging. Tomorrow, another guard might share in the same contraband, pretend not to notice, or ask a prisoner to perform the Heimlich maneuver to save a choking cellmate. Regardless, the overarching structure of coercion, carceral expropriability, and dispossession persists.

Glenn writes that “[i]n the United States, the social organization of care has been characterized by reliance on the private household, feminization and racialization of care,

¹⁰⁷ When asked if such dependence was a point of conversation in the prison, Caroline replied, “Sometimes amongst us. But it was not really something that was acknowledged by the staff or anything.”

devaluation of care work and care workers, and abnegation of community and state responsibility for caring” (2010: 6). This reliance, however, requires coercion, which under our White supremacist, cis-hetero-patriarchal capitalist organization of care has taken two forms: status obligation and gendered, racialized servitude. In the case of the prison, and the women’s prison in particular, incarcerated women’s and trans folks’ unpaid care labor is coerced via both these mechanisms.

First, in U.S. society writ large, feminized and racialized subjects are conscripted to provide cheap and/or free care, both in the household and on the labor market. The prison takes advantage of this when it expropriates incarcerated women’s and trans folks’ care labor. In short, the prison institution could not rely so easily or so heavily on prisoners’ unpaid care labor if the wheels were not first greased by white supremacist, cis-hetero-patriarchal capitalism modes of socialization. For example, during my interview with Caroline, I asked her why people took care of one another in prison. She replied:

“You know, the thing about women too is that we ... there’s a lot of shenanigans. But we are also really caretaker-ish sort of people. You know, by nature. I’m sure I’m being super-sexist or something and not feminist ... Who knows! But we are. Like we’re more naturally maternal caretakers, right? And so you have friends there. You can’t help but to make friends” (personal interview, 2017).

As Caroline here suggests, practices of mutual care from which the prison benefits depend upon prisoners’ subjection as women.

Importantly, Caroline’s comments also suggest the intrinsic reward, the sense of pleasure and purpose that she received from giving care in prison. Amy expressed similar sentiments. While her cellmates “hated the [dorm],” Amy “preferred the dorm. I really did. Everybody sort of saw me as the mom on the dorm ... that was a good fit” (Amy, personal interview, 2018). Madison worked as a free childcare worker for Purdy’s Residential Parenting Program, an unpaid job she nonetheless

cherished. “My favorite thing about being a caregiver,” she told me, “was when they're old enough to stumble around on their own, and you can hold their hand and walk with them” (personal interview, 2018). Nonetheless, as with all labors of love, the possibility of intrinsic reward does not negate its reliance on expropriation. As the Wages for Housework Campaign put it half a century ago: “They say it is love. We say it is unwaged work” (Federici, 2012: 15).

Second, the prison compounds this broader societal gendered, racialized status obligation with the added coercion of gendered, racialized servitude that comes with incarceration. As criminalized prisoners, people in prison, their bodies and their labors, are largely at the whim of the prison. This quasi-property right, which the prison holds over the prisoner, extends the logic of chattel slavery, as evidenced in the exclusion of prisoners from the Thirteenth Amendment’s constitutional protections against slave labor (Childs, 2015). While the prison does not explicitly command prisoners’ unpaid care labor, it nevertheless compels this labor through the carceral logic of jailor and jailee, free and unfree. If the prisoner refuses to go to work, she not only loses wages, but she is punished. This carceral logic in turn legitimizes the prison’s expropriation of prisoners’ unpaid care labor. Who cares, after all, if the prisoner does free labor?

The prison sets both these mechanisms of labor coercion into motion by inducing a crisis of care in which the physical, psychic, and social needs of incarcerated women and trans folks are not met. This care crisis in turn compels people in women’s prisons to “choose between two evils” (Glenn: 2010: 34). Go hungry or risk an infraction for borrowing and lending? Let an elder lie in her own feces or shower her yourself? Leave a cellmate to convulse or take on the everyday, unpaid labor of seizure watch? By creating such impossible choices, the prison offloads its responsibilities, both legal and moral, and incarceration remains just that much easier, that much cheaper.

Does this mean, therefore, that incarcerated women and trans folks should stop caring? Of course not. My point is rather that as with all social reproduction under hegemonic systems,

reproductive labor necessarily both reproduces dominant structures and, at least partially, resists, exceeds, and escapes them. This is true in material terms. When friends sit down to share a cake that they have bartered, begged, and stolen to bake, they are, if only for a few bites, more than just a prisoner. The same is true when they share a home remedy, pass along advice on a sexist doctor, shower a cellblock elder, or steal a hug in the hallway. It is also true in terms of prisoner subjectivity. The carceral subject, the carceral biocitizen, at least at certain times and places, is a commoning subject, able to not only imagine but also embody care beyond the biopolitical logics of commodity, scarcity, and devaluation that so typify the neoliberal prison. By highlighting the everyday work that incarcerated women's and trans folks' unpaid care labor does, my goal then is to highlight the conditions that make possible or impossible these fugitive practices of care. Moreover, by laying bare the systemic crisis of care behind bars and the subtle violence of carceral expropriation that seeks to paper over this crisis, I hope to formulate the conceptual terrain to demands more from the carceral state than mere scraps. If the demand of 'wages for housework' is not just a thing but a political perspective unraveling the enabling logics of racial capitalist cis-hetero-patriarchy, then how might we demand 'wages for housework in prisons' in a way that does not reinforce the prison but tears it down?

Conclusion: Abolition Healing

Under conditions of crisis, there is no mere defense of the status quo. It is not enough to prevent the worst and get the bad.

- Bini Adamczak

You're making me stay here. I don't have the option to do something else. So, now it's your responsibility to make sure that I have my needs met; and, you know, if we don't want to do that as a society, or if our society is not capable of doing that, then one of the big things that I advocate for is let us try doing it a different way.

- Claire, former Washington state prison

How [is] health tied to liberation?

- Michelle Murphy, *Seizing the Means of Reproduction*

As I write this, the Washington Department of Corrections is planning to open a new minimum-security women's prison in Grand Mound, Washington just 20 miles south of Olympia. DOC plans to open the prison "sometime in early 2020 pending the completion of the current remodel of two existing buildings and acquiring operating funds" (DOC, 2019c). In its bid for design proposals, DOC writes that the new prison will "efficiently address inmates' mental health, substance abuse treatment, and cognitive behavioral change needs, from the day they arrive at prison to the day they complete their time with Department of Corrections and successfully transition back to the community" (DOC, 2019d). While the Maple Lake Correctional Center would open with 128 beds, DOC plans eventually to expand the prison's capacity to 750, a 72% increase over the current number of bed between Purdy and Mission Creek. This increase would reflect a persistent carceral expansion in Washington state, where since 2012 incarceration rates have grown more than any other state save Arizona (Ghandnoosh, 2019).¹⁰⁸ While little has been made public about DOC's justification for the new facility, prisoners at Purdy and their families have long raised concerns

¹⁰⁸ Since 2012, twelve states have grown their prison populations. In all other 39 states, prison populations have fallen, albeit modestly in most cases (Ghandnoosh, 2019). In many jurisdictions, however, jail populations have been expanding at the same time.

about overcrowding. Purdy's Local Family Council, an advisory board that meets bi-monthly with prison staff, recently put out a statement condemning the ongoing relocation of prisoners from Purdy to the Yakima county jail where they have no access to programming, work, or the outdoors, which the Council considers a cruel stopgap. To solve overcrowding, the group recommends multiple administrative and legal solutions. They also advocate opening the prison at Maple Lake. In the face of such carceral expansion, how should prison abolitionists respond? Furthermore, how might the arguments I have presented here contribute to such an abolitionist project, especially considering DOC's claim to address prisoner health? Following Michelle Murphy, how might health be tied to liberation?

Reform vs Abolition

Prison abolition is “[n]ot so much the abolition of prisons but the abolition of a society that could have prisons” (Harney and Moten, 2013: 42). As such, rather than imagine abolition as the end of a singular building tasked with criminal punishment, prison abolition conceptualizes its target more broadly as an entire set of interlocking institutions, discourses, and ways of living together. Yet still, from movement to movement, there are multiple abolitionisms, each of which may refer to a revolution in the way we perceive harm, crime, and punishment (*i.e.*, penal abolition; see Magnani and Wray, 2006); to the end of all institutions based in relations of control and confinement (*i.e.*, carceral abolition; see Ben-Moshe, 2013); or to the dissolution of racial capitalism and the prison-industrial complex it has created (Gilmore, 2019). Of course, these projects often share deep affinities in their driving values, political analysis, and strategy. Where they can differ, however, is in their political horizon and sense of ultimate purpose. Is the goal to get everyone out of prisons or to revolutionize a political economy that depends upon routinized domination, exploitation, and disposal? Are prisons the center of abolitionist praxis or simply one starting point among many

within the wider formation of racial capitalist violence? My goal here is not to resolve this question but simply to highlight the complexity within abolitionist discourse and praxis.

Despite popular connotations, prison abolition is about much more than destruction. The abolitionist project calls for a complete reorganization in the way societies socially and spatially organize themselves, particularly in terms of the ways current power relations unevenly value human lives and respond to harm with organized violence. This reorganization will necessarily require creating something new. Because incarceration is a catchall solution to multiple social problems, however; we will need to create multiple new, democratic, liberatory forms of life (Ben-Moshe, 2013; DuBois, 1999 [1935]). Short of insurrectionary revolution, however, this change is unlikely to occur overnight. Liberation must be cobbled together from the rubble of our existing world. "The alternative lies in the 'unfinished,' in the sketch, in what is not yet fully existing" (Mathiesen, 1974: 1). As a result, prison abolitionists must continually sort and struggle through an unforeseeable series of decisions about which necessarily imperfect and partial actions we should take to achieve liberatory ends from imperfect means.

Within this framework, abolitionists continually debate the relation between abolition and reform, seeing the two not as binarily opposed but as existing along a spectrum with reformist reforms at one end and non-reformist reforms at the other. The question is not *either* reform *or* abolition but "what kinds of reforms are sought, and whether they will strengthen the system in the long run" (Ben-Moshe, 2013: 87; see also, Davis, 2003; Knopp et al., 1976; Mathiesen, 1974). The difference between reformist reforms and non-reformist reforms has largely been conceptualized in material and discursive terms. Reformist reforms "are situated in the discursive formation of the system as is, so that any changes are made within or against this existing framework" (Ben-Moshe, 2013: 87). As a result, reformist reforms ultimately "improve the system so it will act more effectively, so that the system gains strength and abolition becomes more difficult" (*ibid*). Reformist

reforms have been central to the long U.S. history of carceral statecraft and prison expansion, often claiming to correct injustice through techno-managerial solutions (*e.g.*, sentencing algorithms, policies targeting increasingly differentiated sub-populations) whose ultimate effect is to fine-tune the state's carceral machinery rather than question its underlying logic or shrink its social ambit (Murakawa, 2014). Prison reform has tended to ask “how *best* to run prisons, organize probation, or enforce fines, rather than question why these measures are used in the first place” (Garland, 1990: 3-4; see also Davis and Rodriguez, n.d.). The penitentiary itself was the result of penal reform (Davis, 2003; Foucault, 2012). Reformist reforms ultimately make actual prison abolition less and less thinkable.

By contrast, non-reformist reforms “imagine a different horizon” beyond existing frameworks of crime, punishment, safety, and well-being and “are not limited by a discussion what is possible at present” (Ben-Moshe, 2013: 87). Indeed, Ben-Moshe conceptualizes prison abolition as a dis-epistemology, “which is about both knowing and unknowing...giving way to other *ways* of knowing...letting go of attachment to certain ways of knowing” that rely upon modernist ideals of programmatic prediction, top-down prescription, and certainty (2018: 347). If we are to build something yet unknown, then how can we promise what it will look like? Abolition only promises that the future will be different and better than the present. In material terms, this means that any non-reformist reform in will focus on “abolish[ing] or remov[ing] parts of the system” (Ben-Moshe, 2013: 87). As Ruth Wilson Gilmore summarizes, a non-reformist reform is “any reform that does not extend the life or the scope of the prison industrial complex” (2015b). The distinction between reformism and abolitionism has both discursive and material elements. For instance, Aya Gruber and Benjamin Levin (2019) outline common discursive “carceral carveouts” by which seemingly abolitionist programs like the recent Voting Rights Restoration for Felons Initiative in Florida exclude people convicted of murder or sexual offenses (Waxman, 2018). In material terms, a reform

may seem to limit the scope of the prison system while actually just reterritorializing carceral power, as in the case of electronic monitoring systems that “further the reach of the penal regime to populations and actions that it had not dealt with before” (Ben-Moshe, 2013: 87; see also Kilgore, 2018). Distinguishing reformist reforms from non-reformist ones thus becomes a conceptual minefield that, because abolition is always a partly speculative practice under threat of constant cooptation by the neoliberal carceral state, cannot be completely mapped in advance.

Life Beyond Biology

Within this tricky terrain, how might we approach prison healthcare as part of an abolitionist project? In the face of systematically inadequate prison healthcare, what possibilities are abolitionists left with: shore up a violent system or leave incarcerated people in intolerable conditions for the foreseeable? Would improving prison healthcare be a necessary step along the road to abolition or simply reinforce and expand the purview of prisons, deepening the entanglements of carceral care? In short, it depends; but more importantly, this is the wrong question to ask. “The question is what kinds of reforms are sought, and whether they will strengthen the system in the long run” (Ben-Moshe, 2013: 87). Abolitionists might push for better healthcare in prisons and jails such that the cost of mass incarceration at its current scale becomes materially untenable and politically unpalatable, while still resisting the construction of new prison hospitals or clinical wards that ultimately expand the prison’s carceral capacity. As Reina Gossett and Dean Spade (2014) explain, abolitionists are constantly navigating this tension between addressing incarcerated people’s immediate needs, including healthcare, while maintaining a longer-term non-reformist vision for abolition.

This perceived tension between immediate needs and long-term vision, however, proves a false construct. If we hope to build an abolitionist program that addresses people’s whole needs, then I argue we must deconstruct and do away with this conceptual divide between health as

somehow categorically separate from the rest of political life, as though once incarcerated people's biological or medical needs are met then they might be addressed as social and political beings. This conception, so central to modernist and masculinist thought, surfaces in abolitionist thinking as well.

The abolitionist collective Critical Resistance outlines six possible steps towards abolition: first, preservation of life reforms (*e.g.*, ending capital punishment and “putting appropriate healthcare in place”); second, quality of life reforms (*e.g.*, improved education, drug and alcohol treatment, job training, and social activities); third, prison monitoring reforms (*e.g.*, external oversight); fourth, right to organize reforms (*e.g.*, allowing prisoners to organize without fear of punishment; ending solitary confinement); fifth, decarceration (*e.g.*, decriminalization, reduced sentencing); finally, community-based alternatives to incarceration. In this vision, health and healthcare feature largely as clinical, technical, or managerial matters. Appropriate healthcare is not available and it should be, the thinking goes. I argue, however, that health and healthcare must be central to every piece of the abolitionist project. As I have argued throughout these chapters, healthcare, whether inside or outside of prison, is not a simple straightforward question of access. In the case of prisons, to treat access as our endpoint rather than our starting point is to internalize the biopolitical logic of bare life, settling for mere biological preservation rather than society based in relations of care, well-being, and self-determination. “Medical treatment should be seen as a site of—rather than an alternative to—social and political contestation” (Pollock, 2012: 2). To be clear, this thinking exists inchoate within much abolitionist praxis. Yet, too often healthcare fades from abolitionist visions, eclipsed by a focus on criminal punishment.

Even within reformist circles, concrete programs for prison healthcare reform remain few and far between. In one recent exception, the University of Massachusetts Medical School (2018) lays out several proposals. Many of these reforms would prevent people from ever entering prison, including pre- or post-arrest programs “to divert individuals experiencing acute mental health and

substance abuse issues to appropriate treatment settings,” drug courts, and mental health courts (*ibid.*: n.p.). Others would be aimed at people leaving carceral institutions, including pre-release programs to coordinate continued care (*e.g.*, Medicaid applications; adequate medications upon release). Still others would change the substance of prison healthcare itself, such as standardized care protocols “that mirror community standards,”¹⁰⁹ treating substance abuse disorders as chronic illnesses, medication-assisted treatment modalities¹¹⁰ (*e.g.*, methadone), ‘compassionate release’ for sick prisoners, and prison hospices (*ibid.*). Each of these reforms can be evaluated along the spectrum from reformist to non-reformist. For instance, while pre-arrest programs prevent the disruptions of a criminal record or nights spent in jail, they often depend upon a police force (Codianni and Daryani, 2019). Similarly, creating prison hospices or tasking parole officers with facilitating newly released people’s continued care may improve people’s quality of life while extending carceral power further into the realms of health and well-being. My purpose here is not to offer an exhaustive evaluation but rather to question what these reforms lack at a foundational level and thus why they fail in abolitionist terms. None of these reforms address the fundamental disenfranchisement that comes with criminalization and incarceration.

In evaluating the tension between immediate reforms and abolition, Reina Gossett and Dean Spade advocate centering incarcerated people’s self-determination. As Gossett says, “the people most impacted by violence are powerful and capable to transform the world” (2014: n.p.). It is in this spirit that I argue healthcare must be not just a “preservation of life” or “quality of life” reform but central to every facet of abolitionist struggle. Prison healthcare should be monitored by

¹⁰⁹ This question of community equivalence, however, is neither politically nor geographically neutral. As Rachael, a medical resident and former intern with Health Services, explained, “I think that’s why [the community standard is] sooo nebulous, right? Like, what community? Where? Like, I don’t know, and I don’t think anybody really knows...Are we going to go based on Seattle, or are we going to go based on Sweden? Or like whatever prison is in, you know, Alabama? Like what are we, who are we judging based off of?” To put this in stark terms, what might prison healthcare look like if it were held to the standard of health defined by the World Health Organization? Is such a prison possible?

¹¹⁰ For a survey of medication-assisted treatment in U.S. prisons, see Nunn et al., 2009 and Rich et al., 2005.

independent third parties based in an ethics of care rather than a logic of punishment and involving substantial leadership and buy-in by formerly and even currently incarcerated people. This auditing should happen regularly and proactively, not just as a performative reaction to extreme cases of violence, as happened following the recent firing of the Monroe Correctional Complex's head doctor (Brunner, 2019). Moreover, prison healthcare should not be provided by a penal agency but provided instead by nearby state hospitals or, ideally, an eventual national health service. Prisoners need robust rights to organize, share their experiences of prison healthcare, consult with outside allies and clinicians, do research, read healthcare policy, and have real decision-making power when it comes to determining what they need. The current tier rep system is little more than a dead end, a performance of consultation without any redistribution of power (Featherstone, 2017). None of these reforms can guarantee abolition in the abstract. They will each require ongoing vigilance and struggle. At this moment within our carceral milieu, many of them sound unthinkable, even laughable. This is not because of any necessary truth, however; but simply because mass incarceration has so exiled prisoners from the imaginative field of political citizenship.

In previous chapters, I have sought to undo this separation between prisoner biology and prison citizenship. In Chapter 3, I argue that carceral care ultimately depends upon this conceptual and experiential alienation, reinforcing a power relation in which prisoners are understood either as sick bodies or mass consumers but never as patients deserving of care or citizens capable of political action. While incarcerated women and trans folks may have a formal right to healthcare, this right is effectively hobbled by administrative authorities, biomedical regimes of discipline and control, a paternalistic clinical culture, sexist medical policies, and a racialized, gendered neoliberal ideology that views prisoners as budgetary *drains* rather than as patients or citizens. Carceral biocitizenship, I argue, ultimately rests upon this reduction of the incarcerated person to the biology divorced from any social or political context.

Next, in Chapter 4, I extend this thesis to the question of prison food and health knowledge. I argue that the state-sponsored science of nutrition has been central to the production of a systematically malnourished food system, providing the biopolitical rubric through which to calculate prisoners' bare life. At the same time, however, I illustrate the risks of undertaking prison food reform using the standards of hegemonic nutrition. As a science based in White, middle-class food habits, however, nutrition science tends to privilege sexist, classist, and racist ideals of health. Nutrition by itself may moderately improve prisoner health, but its ultimate effect is to discount prisoner knowledge, reinforce top-down rule by experts, and, by reinforcing one-size-fits-all solutions, grease the wheels of mass incarceration.

Finally, in Chapter 5, I argue that any issue involving prison healthcare is always already a labor issue. Criminalization and incarceration dispossess incarcerated people of needed care and support. Moreover, the prison institution continually seeks to disallow any efforts by incarcerated people to care for themselves outside its own carceral imperatives. To compensate for this crisis of care behind bars, the prison coerces predominantly poor, Black, and Brown women and trans people to provide reproductive labor for free. Through everyday acts of caring for themselves and one another, incarcerated women and trans folks respond to, resist, and escape, albeit partially, the uncaring prison system.

Together, these chapters make the simple claim that a right to healthcare is not enough. Access to healthcare is not enough. As long as carceral care divides people's biological self from their social and political selves based upon logics of criminalization, rights and access remain mere tools to perhaps ameliorate but also fundamentally facilitate the biopolitical violence of mass incarceration. In these chapters, I have outlined three central terrains - subjectivity, knowledge, and labor - through which abolitionists on both sides of the prison wall might forge a politics that does not separate life itself from living.

Abolition Healing

Prison abolition requires not only reconceptualizing and undoing the division between biological and political life. To close, I wish to highlight how abolition will also require reconceptualizing how we understand in both spatial and temporal terms the ties between political and biological violence. As Jenna Loyd documents, since at least the 1960s people's health movements in the U.S. have challenged dominant ideologies that frame state violence as though it were separate from the state's responsibility to promote health (2014). As the stories of formerly incarcerated women and trans folks illustrate, this distinction between political and health-based violence is a fiction. Incarceration is state violence and as such it is inherently counter to health. Once we understand incarceration as state violence, however, then we must ask what healing from this violence might look like? How might healthcare play a role in the wider abolitionist art of healing from the ongoing violence of racial capitalism and mass incarceration?

On May 6, 2015, after decades of struggle, the Chicago City Council passed the Reparations Ordinance. From 1972-1991, under the command of Chicago Police Commander Jon Burge, more than 120 people, mostly African-African men, were tortured by city police, many using tactics they had learned in the Vietnam War. For decades, survivors' and their loved ones advocated for meaningful reparations, finally winning their demands in 2015. The ordinance guaranteed several key provisions, including free tuition and job training for survivors and their families, the creation of a history curriculum to be taught in Chicago public schools, and free trauma and other counseling services provided where survivors live (Chicago Torture Justice Center, 2016).

Reparations for survivors of systematic, racist police torture in Chicago is an important material step and imaginative north star for prison abolition. Abolition must not stop here, however; and we must not all carceral logic to normalize routine state violence by performatively atoning for its most extreme manifestation. What might it look like to build healing structures of care into all

our demands for abolition and reparations? As I have shown and as anyone who has been incarcerated knows, the effects of incarceration live on long after release. It is a slow, insidious violence. As we face the prospect of a new women's prison, we must resist the carceral logic that separate band-aid solutions in the present from their insidious afterlife and that separate prisoners' biological needs from their political desires and social selves. We will have to remind ourselves that, as Loyd (2014) argues, real health is not merely the absence of illness but the presence of individual and collective self-determination and freedom.

Appendix

Interview Schedule for Formerly Incarcerated Participants

1. Time at WCCW? How long? Time in jail? First time?
2. Before WCCW, your health? Experiences with doctors, hospitals, taking care of yourself, etc?
3. First arrived at WCCW, how health addressed? Receiving, any medical attention or health information?
4. First month in prison – how did you feel?
5. Some basics of prison? Race? Segregation? Cliques?
6. The physical environment like in the prison? Smell? The air? The water?
7. Did people – DOC staff or other inmates – talk about the water, good or not good to drink?
8. Typical day at WCCW. What did you do? Daily routine? Meals and snacks, moving around or staying put, exercising, activities, etc.?
9. Meals? Together, alone? Ever do cooking? A memorable meal? Visitation meals?
10. Food at WCCW? Food affect your body – energy level, mood, weight, appearance, skin, etc?
11. Did people – DOC staff or other inmates – ever talk about the food? What about?
12. If you got sick or injured? Did you ever get so sick you sought medical attention? What happened? If you did not want to go to the infirmary?
13. Doctors and nurses? Did you ever interact with them? What was that like?
14. Friends ever struggle with their health or seek medical care? What happened?
15. If people did not speak English? Translators?
16. Did people – DOC staff or other inmates – ever talk about the healthcare in prison? What about?
17. In your opinion, responsibility does the prison to take care of inmates?
18. How did you take care of yourself while at WCCW? How did people take care of each other?
19. Visitors? Folks on the outside supporting you?
20. Did people ever do home remedies? Special recipes? Alternative medicine? Woo-woo?
21. First months of being out, how did you feel physically? Did anything change?
22. Healthcare or taking care of yourself, what is different for you now that you're out?
23. If you could change the way things work in prison, what would you change?
24. Who else should I talk to?

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