

# Beyond Survival: A Qualitative Study of the Impact of Homelessness and Incarceration on Women's Health

FINAL Report

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## Abstract

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### Objectives

This study explored the health-seeking experiences, perceptions of risk, and the medical, mental health, and housing needs of females during incarceration and in the post release period.

### Methods

Four focus groups were conducted during the incarceration period in groups of four to six inmates. A skilled qualitative interviewer and a second study team member used semi-structured interview questions: 1) access to medical and mental health care; 2) medical and mental health needs; 3) housing needs; and 4) perceptions of risk to one's health and safety during the transition from corrections to the community. Additional demographic information including age, ethnicity, and housing status was collected. Interview transcripts, along with the interviewer's notes/reflections, were transcribed, and the files were entered into qualitative data analysis software (N-Vivo 10). Three of the study team members analyzed the transcripts independently to identify codes, which were categorized into themes and sub themes. They discussed their interpretations of the data and any discrepancies were resolved through discussion with other study team members. Themes and subthemes were then validated through "member checking" with two female inmates.

### Results

Twenty-one women participated in the focus groups. Women described how they enter incarceration in poor health and how they view incarceration as a means to access healthcare services. However, the transition back into the community represented a cross road that was highly dependent on housing status. If women were released into unsafe or unstable housing they immediately began living to survive and perceived a high risk for "returning to old ways" including recidivism into addiction and survival crime. This in turn led to a loss of any health gains made during incarceration. However, with stable and supported housing women perceived an ability to maintain health and provide a safe place to raise their children. They described a lack of gender specific healthcare and housing resources for women within the correctional system.

### Conclusion

Female inmates face a myriad of healthcare challenges, knowledge deficits, lack of housing resources and barriers to moving forward in life, These findings support the development of gender-sensitive health and housing programs for preventing or reducing drug and alcohol use, recidivism, and poor health among this vulnerable population.

## Executive Summary

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### Why is this research needed?

- Women are a growing population within correctional facilities worldwide.
- Women have unique and increased health needs compared to their male counterparts: there has been increased recognition of the need to provide gender specific health care for incarcerated women.
- The success of any health initiative initiated during incarceration is contingent upon successful transitioning into the community: housing status has been identified as an important determinant of health outcomes and re-incarceration rates.
- Little is known about the challenges female inmates face in accessing and maintaining health and housing during incarceration and as they transition into the community.

### What are the key findings?

- Women typically enter the correctional system in poor health and incarceration provides a period of stability when they are able to begin to address their health concerns: women described challenges in accessing gender specific health services during incarceration.
- Women described their ability to maintain health gains made during incarceration as dependant on housing status. If they are released with unstable housing, they describe a vicious cycle of homelessness, recidivism into addiction and crime and re-incarceration. With stable and supported housing immediately upon release, women perceived an opportunity to maintain health as well as provide a safe environment for their children.
- Women described a lack of resources for supportive housing when released from incarceration, limiting their ability to successfully re-enter the community.

### How should the findings be used to influence policy/practice/research/education?

Based on the findings of this study, three key recommendations can be made:

1. Health promotion and education: A community-based participatory resource manual should be developed describing common procedures within the correctional facility, including how to access currently available health care and housing resources. Additionally, a similar approach should be used to design gender specific health promotion and education programs for the female inmate population.
2. Incarcerated women's health program: A women's health clinic should be piloted and evaluated to address gender specific health issues including: screening, chronic disease management, intimate partner violence counseling, and birth control option.
3. Housing First for Health: A housing first model for the transition into the community should be piloted and evaluated for impact of health outcomes and re-incarceration rates.

## Background

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### Incarceration Rates

Worldwide, more than 500,000 women and girls are held in correctional facilities worldwide (van den Burgh et al., 2011). Most countries report that women offenders make up 2 – 9% of the prison population (Wamsley, 2006). In the past decade, however, the rate of imprisonment of female population has increased in comparison with men. In Canada, 11% of all provincial/territorial admissions (sentences of two years or less) and 6% of federal admissions (sentences of two years or greater) were women. Women also represented 13% of the remand population (Dauvergne, 2012). However, the number and proportion of adult female admissions to correctional facilities has steadily been increasing. This trend is more prevalent in remand and short sentence facilities where the percentage of female offenders increased from 9% between 1999/2000 to 12% between 2008/2009 (Dauvergne, 2012). Federally this number has also increased from 5% to 6% for the same time period (Dauvergne, 2012). While the number of violent offence charges committed by female offenders has also increased over the last three decades, most female offenders are incarcerated for non-violent or drug-related offences, with the majority either remanded or serving short sentences, resulting in a high turnover and 'revolving door' scenario (Quaker Council for European Affairs, 2007; Trevethan et al, 2000). As women have historically been a minority within incarcerated populations, correctional facilities are, to a large extent, designed for men with only small sections dedicated to women. Thus correctional facilities may not take account of the gender-specific medical and mental health needs of the growing female population.

### Inequalities

Another layer of complexity is the over representation of Aboriginal women within the correctional system. Canadian census data indicates that Aboriginal men and women make up 3% of the general population; Aboriginal women make up 35% of women admitted to an adult sentenced correctional facility (Mahony, 2011). The over representation of both Aboriginal men and women within the Canadian correctional system has been linked to socioeconomic deprivation, attitudes based on racial or cultural prejudice, substance abuse, intergenerational loss, violence and trauma. (Government of Canada, 2013)

These shifts in demographic trends within the criminal justice system have been putting new demands on correctional facilities and community transition programs. The World Health Organization (WHO) issued a declaration on women's health in prisons calling attention to gender based inequalities including not only sex-based differences but also differences in experiences that distinguish incarcerated women from their male counterparts. (Bloom et al., 2002; van den Bergh et al, 2011; WHO, 2007) Women in prison have commonly experienced: social exclusion (processes embedded in material and social inequalities) in their lifetime; sexual or physical abuse; alcohol or drug dependency issues (WHO, 2007); and inadequate healthcare access. They are more likely to enter the prison system with a sexually transmitted infection (STI) (Covington, 2007), and more likely to suffer from mental illness (WHO, 2007; Bastick et al., 2008). They often experience additional demands and responsibilities as the central care provider to their children. Thus women offenders often present with many complex and inter-related problems, which need to be addressed simultaneously in order to effectively enable them to move forward.

### Medical and Mental Health

Correctional facilities offer a unique opportunity to engage residents in medical and mental health care. Many of them come into incarceration "off the streets" and face a myriad of health problems that they had not dealt with prior to their arrest. Binswanger et al. studied nearly 7,000 U.S. jail inmates and found that women had a significantly higher prevalence of chronic medical and psychiatric conditions and drug

dependence when compared with men, and those differences remained even after adjusting for socio-demographic factors (Binswanger et al., 2010). Incarcerated women also report a high prevalence of risk factors for cervical cancer and inmates' rates of high-grade squamous epithelial lesions (HGSIL) are more than twice as high as that of the general population. (Proca et al., 2006) Female inmates also have a higher prevalence of HIV and other STI's than the male population (Altice et al., 2005). Accordingly, because women serve shorter sentences and have greater disease burden than men, women inmates serving shorter sentences have been shown to make more health care requests and use health care provider services more frequently than inmates with prolonged incarcerations (Hyde, Brumfield, and Nagel's (2000)). Yet despite the opportunity to address a wide spectrum of preventative care and chronic disease management, women report mixed perceptions of health care received in correctional facilities. Particularly, previous reports have raised concerns about difficulties accessing care or medication and non-empathetic health care staff (e.g. Douglas et al., 2009; Sered et al., 2013; Young, 2000).

### Discharge Planning and Homelessness

Sustainable benefits from any healthcare intervention initiated during incarceration are contingent upon discharge-planning programs that allow linkage to community-based health care providers. However, once released from incarceration women focus shifts towards basic survival needs and away from health. In a survey of approximately 700 women reentering the community, housing (71.9%), substance abuse (69.2%) and financial support (60.8%) were ranked as the top three problems upon leaving incarceration; medical (25.1%) and mental health (6.7%) were considered low priority (Freudenberg et al., 2007). The risk of homelessness or unstable housing is substantially increased post-release and this in turn is a critical determinant of health (Raphael, 2009). Compared to the general population of women, homeless women's health disparities include: higher rates of mortality; poor health status; mental illness; substance abuse; victimization; and poor birth outcomes (Teruya et. al, 2010; Schanzer et al., 2007). Regarding healthcare, homeless women are less likely to have a regular source of primary care (with subsequent increased utilization of the emergency department), cancer screening, adequate prenatal care, appropriate ambulatory care, and specialty care for specific disorders (Teruya , 2010; Gelberg et al., 2009; Kim et al., 2006; Weinreb et al., 2006).

Furthermore, a bidirectional link between homelessness and incarceration has been well established within the literature (Caton et al, 2005; Galea et al., 2002; Greenberg et al., 2008; Kushel et al., 2005; McNiel et al., 2005; NCCCHNC, 2002; Richie, 2001). This link is mediated by a variety of factors including mental illness, substance abuse, socioeconomic status, loss of employment opportunities, and disruption of social safety networks. Among women, longer-term homelessness has been associated with higher odds of incarceration (Weiser et al., 2009) and increased sex-exchange work (Weiser et al., 2006). Thus there are complex and multifaceted links between gender, housing status, incarceration and health.

## Study Objectives

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There is an overwhelming need to provide comprehensive health care services for female offenders as well as to decrease the barriers they face in accessing health and housing both during incarceration and when they transition back to community. This study explored the health-seeking experiences, perceptions of risk, and the medical, mental health, and housing needs of females during incarceration and in the post release period.

## Methods

The study was planned as a three part mixed methods study including: 1) A structured survey of a sample of female offenders concerning their current health and housing situation (note: preliminary results included at end of report); 2) three to four focus groups with 4 – 6 women/group; and 3) semi-structured individual interviews with a subset of focus group participants shortly after release. Please refer to *Appendix 1: Research Field Notes from Jail* and *Appendix 2: Preliminary Survey Results* for details. Herein, we describe the completed qualitative component of this study.

For this qualitative study, 60-minute face-to-face semi-structured focus group interviews were conducted from August 1st to September 30th, 2013. Each focus group consisted of approximately four to six women who met all the following eligibility criteria: 18 years of age or older; ability to speak English; ability to comprehend and consent to study procedures; housed within the general female population; and live in the encashment area of the city in which the correctional facility was located. Written informed consent was obtained from participants that met eligibility criteria. Participants were provided with an equivalent of \$10.00 worth of edible canteen item purchases.

### Setting

This study was conducted in a large remand facility in Canada. This maximum-security facility houses both male and female offenders and has a maximum capacity of approximately 2000. There are three female units with a maximum capacity of 172 women. In 2011-2012, a total of 2705 female offenders were housed in this facility for an average length of stay of 17.2 days. As of 2010, health care for all provincial correctional facilities (sentences of two years or less or remanded) in the province transitioned to the public health authority.

### Interviews

The interview guide was adapted with permission from Binswanger et. al. (2011) and revised by the multi-disciplinary study team members for content relevant to the study population. Interview questions addressed access to housing and medical and mental health care during incarceration and post-release into the community; overall housing and medical and mental health needs; and perceptions of risk to one's health and safety during incarceration and in the transition to the community.

Focus groups were conducted by two experienced (LK, CA, or DK) qualitative interviewers. In order to ensure the interviews were conducted in a culturally competent manner in keeping with Aboriginal values and traditions an additional study team member (VS or RM) with expertise in aboriginal health issues and traditional healing practices was also present during the focus groups. These team members were essential in creating an environment of trust and increasing rapport and comfort of individual participants. Please refer to *Appendix 1 (Research Field Notes from Jail)* for details regarding the planning, implementation, process and challenges encountered by the study team. Unfortunately, despite

numerous attempts to obtain post release interviews, we were only able to complete a single interview and thus could not use these interviews to validate the focus group data.

### Data Analysis

Focus group interviews were digitally recorded and uploaded onto an encrypted secure drive. Recorded interviews were then transcribed by a study team member (DK). A second study member (LK) checked transcripts against the original audiotapes to ensure accuracy. Interview transcripts were the primary source of data with additional sources including a brief participant demographic survey and interviewer notes and summaries. Transcripts were entered into N-vivo 10 qualitative data analysis software.

Two qualitative researchers (LK and DK) coded the transcripts line by line, and categorized the codes into initial themes, which were verified through weekly meetings with co-investigators (RA, CA). Once initial themes and emerging ideas were finalized they were presented to two female offenders that were not involved in the original focus groups to provide “member checking”. These women helped ensure the validity of our results and on practical issues, such as how to facilitate women’s health and housing initiatives as a consequence of our research. We included this step to engage the participants as the “knowers” of their contexts and environments (Tuhiwai, 1999). We then provided a summary of the findings to all study team members to obtain feedback.

### Ethics

This study received ethical approval through the University of Alberta Health Ethics Research Board. Additional operational and administrative approval was received through Alberta Justice and Solicitor General and Alberta Health Services.

## Results

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### Demographics

Participant demographics are shown in Table 1. Among the 21 female offenders that participated the average age was 32.4 years (range 20-49 years). Self-reported ethnicity was: 13(62%) Aboriginal or Métis; 4(19%) White; and 4 (19%) reported other ethnicities. Fourteen (67%) women reported having less than a high school education. Only four (19%) women reported having current stable and secure housing. In terms of health, 13 (62%) reported chronic medical or mental health conditions and 16 (76%) reported current drug and/or alcohol addiction. Thirteen (62%) reported having a regular doctor or healthcare professional seen in the community.

Table 2 depicts a thematic framework that summarizes the impact of homelessness and incarceration on health and stability. Themes are classified into three categories: 1) transition from community to corrections; 2) health (including medical and mental health and addictions) during incarceration; and 3) transition from corrections into the community. Homelessness emerged as an overarching category that ran through all categories and themes. The categories divided by breakpoints in time and are not mutually exclusive but provide a useful construct for understanding our results.

Figure 1 depicts the relationship between incarceration, housing status and health. Incarceration was typically viewed as an opportunity and period of stability during which health (including medical and mental health and addictions) became the priority. The transitional period into the community was viewed as a crossroad that was highly dependent on the transition into either stable or unstable housing. If the transition was to unstable or unsafe housing, women described increased transitional risks including relapse into addictions and criminal recidivism. This in turn increased the risk of poor medical and mental health. These factors then contributed to even more unstable housing and eventual return back into incarceration. However, if the transition was into stable and supportive housing women believed that there was less risk for relapse into addictions, criminal recidivism and poor medical and mental health.

### Transition into Correctional Facility from Community

Upon entry in the correctional system, women described various ways in which the environment immediately affected their health and wellbeing. Women described environmental challenges on initial incarceration with insufficient knowledge of the processes, procedures and resources within the facility. This led to feelings of initial disorientation and anxiety. This included a lack of knowledge of normal routines and schedules, procedures related to accessing medical care and medications, legal aid, canteen and phone accounts, and inconsistency among correctional officers. They did not know who to ask, which lead to feelings of fear and ignorance.

*The guards say "Ask your friend, maybe ask an inmate". .... This is my first time and I feel real stupid. ... if I knew what to ask, who to ask, I would have, I would have been gone a long time ago.*

*When you come here you don't know what time things are happening. You don't know what resources are there. You don't know where to go for legal aid, where you get your money for canteen. If you got a paper that got these kinds of things on it, when you first come in here, they you know about lockdowns, you know what times you can use the phones, you know what the rules and regulations are.*

*One guard will tell you this and another will start telling you the total opposite. So where do you go? What do you do?*

In addition to the initial feelings of disorientation and anxiety, women also described their emotional responses to being incarcerated. This included social isolation from the “outside” world including family, children and friends. There were also feelings of demoralization and institutionalization among the women who had experienced repeated incarceration. They try to phone family or friends just to talk and the people outside the prison still assume that the women are asking for money. They see others receiving regular visits from family and know that this support makes a huge difference.

*Being alone, being taken from my family, losing everything not necessarily materialistic stuff because that is not what matters, it's the structural - the whole life, family, security.*

*It just feels like almost no one is there for you. Like you're trying to make these phone calls and people say that they're going to help you and do whatever they can but on the other end they don't know because they're not the ones who are in here. They just like sitting here and waiting for something to happen on the outside for our benefit. It's almost like, no one cares and it really hurts. I know it takes a toll on a person. We're women but probably for men too.*

*I am not proud to be here. It's like when I was 20 and I was ok to be here. I am not happy to be here.*

*This time fortunately, I was not upset or sad, for some reason. I don't know if I am beginning to be institutionalized which I am hoping I am not.*

*It crushes like your pride and stuff like that.*

Women described characteristics inherent within the female population as part of the correctional environment. Some of these characteristics were not unique to the female population, but rather inherent to a wider “prison culture” including fear of enemies and bullies on the unit, forming trustful relationships, and the formation of “cliques” or groups.

However, women described a “sisterhood” and desire and opportunity for mentorship within the population. The women said it was hard to talk about issues concerning their children being taken away from them, or about behaviors that they are not proud of.

*I've been in the system for like 13 years now so I know a little bit more than the next person that comes in jail or from somewhere else and they don't know anything. You know sometimes you can't always just pass that information on in the unit sometimes they want the confidentiality or whatever or the privacy or maybe just being with those few women that they feel like they can trust. Having one professional person that a group of women could sit with and ask questions to, and talk to or give advice to.*

*I'm sure us women, we are feeling more comfortable talking to each other in here than we do when me and my friend(s) here are staying with another four of our friends and we are all tough stuff and you know what I mean? I'm sure you feel a lot more comfortable now doing this, don't we all? Even, not just you guys[referring to interviewers] but we[are]*

*all more comfortable in this kind of setting than when we are on the unit when we're all tough stuff and trying to be bad.*

In summary women described a feeling of disorientation and anxiety upon entry into a correctional facility due to lack of knowledge of the procedures, processes and available resources. This is compounded by emotional responses of social isolation and demoralization. However, women also felt that they could use their own knowledge and experiences to provide mentorship and support to each other.

### Medical & Mental Health and Addictions

We sought to better understand the health-seeking experiences, perceptions of risk and the impact of incarceration on the health of female inmates during incarceration. Women described incarceration as a tremendous opportunity to prioritize medical and mental health needs and seek addictions treatment. In the community, women live to survive and prioritize their medical and mental health as low within the context of numerous other challenges and more immediate demands: housing, food security, finances and addictions. However, incarceration provided a stable and structured environment with all resources "under one roof" in which women could begin to address long-standing neglected health issues.

*Your addictions are higher and you don't even think about your health. Being incarcerated then you start thinking about your pain. Sometimes incarceration can help. Then you can get help.*

*Sometimes for other women I notice this is their chance for getting better. Because when they are out there, they are too focused on trying to live, trying to get by, trying to find somewhere to sleep at night. Trying to make money whether it is to buy a burger at McDonald's, or trying to get their next fix or to buy women's feminine products or anything like that. Their focus out there is survival and in here it's maintaining that survival sometimes.*

*Like for some girls when you are out you don't think about your health, you don't think about your dental, you don't think about your eye, you don't think about anything that bothers you. And here it is good, you have basically everything under one roof and it's important for you to maintain a routine and look after yourself because you count, you count just as much as other people.*

*I think it [incarceration] does in a good way. It gives us time to look at us and our needs. Because when we are out there, we don't prioritize ourselves, we don't look at our needs. But here, we have lots of time to focus on us, so in here to see where we lack, what we need and when we are out there nobody really looks at us, where we lack or what we need. So I think in here, it is better for us because we can actually look at ourselves, maybe we should get our teeth cleaned or maybe I should get an eye exam, or something like that.*

Recognizing their poor health coming into incarceration and the short window of time to take advantage of that opportunity to access healthcare, health is described as an immediate concern. However, the women spoke of significant perceived barriers to accessing health services within jail: the request form process for accessing medical and mental health care; long waits; inability to access providers who could refill their chronic community medications; access to methadone and withdrawal treatment; and conflicting processes among healthcare staff.

*Because we have poor health coming in... Sometimes we need to see people faster and they don't do that. The guards just go just put in another request, just put in another request and it's not helpful, it's not getting anywhere they tell you and finally you are still sitting there.*

*Because a lot of women that are coming off of drugs and alcohol don't know what it is to feel normal...*

*They should have that option and maybe if they get help getting on the methadone program when they get here [they] will do a lot better because they wouldn't go back to those addictions.*

*Once again the waiting list is so long, being in jail and getting healthcare is difficult because you have to fill out forms, you have to wait whereas when you are out, you can go into any clinic and it's very easy all you have to do is write your healthcare number. But here it's difficult because of the waiting period. And then, even if you are sick now, and you put your form in, in a week or two you won't be sick so what's the point?*

*Yes there is a negative effect to it because...the waiting time it's so long like before your form even gets going or approved. And it's a long time especially if you are not here for a long period of time. That form you filled out is for nothing. And you just, you go out and you fall to the bottom of the list again. There is a good side to it and there is a negative side to it. The waiting list is too crazy. Yes there is other people and you do have to think about everybody that is in the building. It's a long wait.*

Women provided insight into the experiences with and attitudes of the healthcare staff within correctional facilities and the impact of the therapeutic relationship on their health. They recognized the uniqueness of their own healthcare needs and the importance of non-judgmental and supportive healthcare staff that have specific expertise working with women, incarcerated populations and "street people."

*No, no, no, we need nurses in here that dealt with street people, dealt with addiction, dealt with that kind of lifestyle so that when they are going to get people coming in here, they understand a little bit more.*

*Experience nurses or whatever healthcare [staff], that they should be especially prompt maybe even specially trained to deal with people who are in the correctional system, so that they are more aware of the different types of situations and scenarios that can be used in a correctional facility versus what just a normal person would be facing on the street. Because it is two completely different lifestyles and its two completely different types of needs that need to be met.*

*And if there were those people that could be there to help and understand those special types of needs, maybe that cycle could be stopped right there. Maybe that cycle could be stopped by a nurse in a correctional facility who is willing to say 'listen you know, I am willing to work with you because I understand where you are coming from, the types of things you are dealing with, the health problems you might have, the physical needs that you might have on the outside, so I'm going to work with you', and we're to focus on the type of lifestyle that you have not based on what an average normal person would be dealing with there.*

The women acknowledged also that they are a minority within the correctional facility compared with the male population. Yet despite this, they also recognized that they have specific health concerns that differed from their male counterparts that need to be addressed in a gender sensitive manner:

*There should be like certain health care system or section of the jail that deals with just the women's needs. Not men and women, where they ...only have this many ....per facility. Well if there was maybe one health care worker in the facility that dealt with just women it would probably cut down the time a lot to get their health met you know? And not going against all the men you might say oh my foot is sore versus something that is going on down there that may be a problem that could affect the whole unit. It would be an option. It would probably do really well if there was just someone dedicated to women's needs in the healthcare. Even if they have something like this once a month so that women could pass information to other women about it as well.*

Generally women viewed medical and mental health as a single entity, however they also recognized the opportunity that incarceration provided to specifically obtain a mental health assessment and/or diagnosis as well as link with mental health support services. When they are no longer under the influence of drugs and alcohol, they have to face the issues that they have been trying to suppress, so they said it was very important to them to see a psychologist or psychiatrist to relieve their anxiety. Interestingly, the women also spoke of a reliance on one correctional officer's that recognized mental illness, despite acknowledging that they are not trained to do so.

*She doesn't have to look like she's just a retard. She has severe depression, social phobia, and FASD and is really impulsive.*

*People don't know there are programs for mental health, they don't know the provisions for mental health that there are people in this building that can actually get them connected to something. They just come in here and do their time and get out. But really if you put them in mental health, then there's a lot of support.*

*I don't know how you guys could enforce this, it's more or less the guards that see this stuff and they don't know how to handle or not trained to handle that sort of thing, they're just guards, they're not trained to assess mental health or people with their mental health degree, so it's kind of stuck in a standstill really.*

Finally, during incarceration women also felt that there was an opportunity for health education. They described poor basic health knowledge and the associated risks. They saw incarceration as a time where they could learn more about women's medical and mental health as well as addictions.

*They don't know that some of the issues they have are health problems. Because some of these people never had people tell them it's not ok. That it's not healthy not to shower everyday, it's not healthy to have an open sore in front of everybody. For example my friend just recently there was walking around in her unit, she was telling that there were viruses that they didn't even know it was a virus until other people brought it to their attention and then they brought it to staff attention. That could be something that's spread amongst everyone else. So that puts everyone else at risk not only her because of that.*

*And it's just often these women don't know that the risks that they are taking and they are putting a lot of people at too because they do not know any better.*

In summary, women viewed incarceration as having positive impact on health with the opportunity to access healthcare services and education. However, women also perceived barriers to accessing care and prescription medications as well as at times inadequate support.

### Transition to Community from Corrections

We sought to better understand the health-seeking experiences, perceptions of risk and the impact of housing status on the health of released female inmates as they transition back into the community. Women described the transition as a crossroad that was highly dependant on housing status. Without secure and supported housing they described increased risk of relapse into addiction and recidivism into criminality. This in turn contributed to the low priority and increased risks to health. Conversely, with secure and supportive housing they perceived decreased risk for relapse into addiction and criminal recidivism and an increased focus on health maintenance and relationships with family and children.

Women described the concept of housing status as either survival housing or “shelter” or safe housing which they described as a “home”. Without a “home” at the time of release women described increased risks to personal safety and health. Even within their own home they will still get unwanted people who do not respect their desire to go straight.

*It's just basically going out 'cuz at home you are safe, right? And then you need a home to go to in order to be safe, right? And you don't have one, and there are a lot of things out there that can just go and take you away from reality for a little bit but when you come back to what? To nightmares that's what that becomes but you don't have to if you have a home, stay away from like, the bad stuff.*

*Women are having to put themselves at risk, in danger every day. Due to the fact that they don't have a safe place to call home or a safe place to go to.*

*If they had a safe environment to go to it would be a lot easier. They'd have somewhere, stable, they could call home. Where we don't have to worry about if we're going to be thrown out by 3 o'clock in the morning by some crack head, drunk. If you don't have any money left and they want you to go out and sell your ass or something. I mean there's a lot to it. People talk about it, but you know what? Us girls have actually lived it. Sorry, but if you're going to write it on a piece of paper but until you actually put yourself through on that sheet and you've lived that kind of lifestyle you don't know it. Reading a piece of paper and actually being in that environment and feeling those emotions run through your body wondering if you're going to get out alive tomorrow morning.*

Women also described the relationship between housing status and family and children. The ability to provide safe housing for their children seemed to empower women and failure to do so was demoralizing. Women also viewed family as important avenue for support and safe housing in the transition. However, they also viewed family and friends as being potential threats to their safety and the need to dissociate in order to maintain that safety.

*I think the biggest thing that could come across for a women, especially if she doesn't have a home, is where about will her children go. And if she has no family members, where will her children go? Will they get separated?*

*We want our lives. We want to get our kids. We want to be part of a something and we want to be something and if you have no place to go, well than you can't be something.*

*It's really embarrassing to not have anything but the clothes on our back, many of us have a child.*

*You can't do without your family. Where you going to live, how you are going to support yourself.*

*I know of a girl that had to disassociate from all her friends, even some family, to clean up and really stick home, close to her family and religion and she did, she managed to even quit smoking. So, I think it's really tough when you disconnect with those other people and influences that pull at you, and drag you back to use. It would make it too easy for you, I think it's for her it was to just cut all ties to all people even if its family members.*

Without release into safe and supported housing women perceived numerous transitional risks, most importantly a risk of "returning to old ways" to maintain survival. This included recidivism into addiction and criminality with resultant low prioritization of health. They deal with their aches and pains by seeking out ways to stay high. The feelings that they are trying to get rid of return when they are sober, and they "just want to push them down".

*You are left with no choice but 2 options: life or death what are you going to choose? They don't have a home ..... They come in here [jail] they get caught and they come in here because they didn't have a place to begin with and they don't have a place to go to when they leave...It's just like an endless circle. Because the fastest way to make money is what you were doing to get you into jail is an illegal way, to begin with. It's kind of like banging your head against the wall. It's really hard to get through the door when you keep walking into the wall.*

*So what ends up happening for most of us is that we end up going back to your ways, you know, you don't have a home, you don't have a job, so what are you going to do? You are going to go back to work the streets our ways. You are going to do - you are going to do something you need to do something to get that money, right, to survive? Even if you don't want to.*

*You could find yourself in an unsafe situation. Living with somebody, you could just be, like around violence. Usually, around unsafe situations. You could fall back into the seduction of drug addiction, alcoholism or whatever and you could use and you could relapse. And the health issues, you could just put yourself into unsafe situations and an unsafe home.*

*Women don't think of going to get Pap smears and stuff like that because when you are on the run you don't have time to stop at your family doctor and stuff like that.*

*I got cut in the head with an exacto knife. But I don't go to the hospital because the cops are there. You go to the hospitals then the cops are there. I don't want to be there because you get questioned. And I was wide open there was bone and everything.*

Women perceived significant barriers to accessing safe and supported transitional housing. These barriers included knowledge gaps for what resources exist, inability to access available resources because of previous behavior, or an overall lack of resources specific for women post release. The women that provided the “member checking” reiterated that the women need resources: a place to stay, food to eat, and a shower.

*And you got to really, really, really, really, really dig in for these resources. And not all of these resources are willing to help you because of your past or your present situation.*

*They 'set you up for failure. Don't have options for making right choices. Don't have the knowledge.*

*They do not have the proper resources for people when they are released from the correctional facilities at all, they should have court-mandated stuff, but they don't.*

*If you were just released and if you come in here homeless, you're going to leave homeless, that's how it is.*

In addition to transitional risks related to housing status, women also voiced frustration around numerous additional transitional challenges including: the need for medications that they were prescribed in prison; lack of transportation to get to appointments; long waiting lists to get into programs; barriers to accessing social services; lack of personal identification; and using women's shelters. One woman avoided her mother who was willing to pick her up because she wanted to get high as soon as she left jail; she suggested that it was more appropriate for a transition worker to pick her up at the jail.

*If they block the avenues out there for people. It's extremely hard for us to get out of jail. Because we have so many things going against us. Lots of us don't have ID. That's one thing. The stops you from getting one thing and if you..... it takes money it takes time. So until you have all of those things where do you go?*

*You have to get referrals and stuff like that and you know, like a I said, there's a long waiting list period sometimes and there's a lot of things that can distract while you are waiting and you and then your circle of what goes on normally starts to happen all over again and you end up here being incarcerated again.*

*It's ugly, it's gross, it's disgusting [women's shelters]! You're better off being safer with sleeping on the street and that's a bad thing.*

They also described difficulty accessing healthcare professionals with expertise and sensitivity with working with an inner city population. Once again the benefits of a non-judgmental therapeutic relationship were emphasized. Finally, they voiced concerns regarding the location of health services in the community with a perception that certain neighborhoods social environment can influence their susceptibility to drug and/or alcohol use. During the “member check “ interviews, the women talked about the difficulty maintaining a family physician relationship, and they do not want to wait for hours in

emergency or a walk in clinic, so they leave before they are seen and the health concern gets worse. Other times they just scared and do not want to know that they have a serious health problem like cancer.

*If you walk in a medical clinic they have a lump and you smell funny, they know that you're an addict, homeless or whatever. They are more likely not to see you.*

*Like, I've seen a lot of places that are going to shoot you down. Wow, I'm like, there's not a lot of doctors out there for people like us.*

*I don't know, at [clinic] it was the best experience she had with any doctor anywhere. She now has a family doctor that deals with her bipolar and all that. So she recommends [clinic] extremely. She loves it there. They are very professional. The ladies are very non-judgmental and frank. They don't care if you are coming in dirty and stinky or anything. I have watched them, those ladies treat that person that the same way they treated every other person, so she loves it there.*

Finally, women also provided insight into a number factors required for successful transition into safe and secure housing that would allow them to focus on maintaining their medical and mental health. This includes transitional programs that provide immediate supportive living post release; female mentors and support groups; a long-term "half-way" house model; help with money management; and locations away from certain neighborhoods that may trigger addictions.

*And you need to actually not be like boom not be, "oh ok you're getting out, but we can't see you until next month at this day at this time". It's gotta be immediate because it's the first couple days when you've got time on your hands you know, what are you gonna do first? Well it's the first thing you wanna do right? The first thought that goes through your head, "Oh I want a cigarette", or "Oh I want to get a drink, oh maybe I could go see so and so." right, and the next think you know you are back in the holding cell and right back where you started and you don't even know how it happened half the time, you wake up and you are back in here again.*

*Need almost like a baby sitter, but not a babysitter. A counselor or somebody that comes and picks you up when you come out of these doors; where you get dropped off. Takes you to a safe place or environment where you can have resources.*

*A halfway house or a place that we could go to once we've done our time and we got out that could be a stepping stone towards our goals and we wouldn't be such failures. A lot of us feel like failures, and [if] we have someplace that we could go to and [not] the circle of destruction all over again because we know we are going to end up here [incarceration] and sometimes we just don't want to keep doing that. We want to grow up.*

*People in jail if there is program where a person could to go when a person goes out if it was pointed out on the way out the door, that would be a good thing. Something before you go out the door maybe a lot of people wouldn't slip back into addiction.*

The women also described the need for "retraining" in order to live a different lifestyle and not revert "back to old ways".

*I think a lot has to do with re-training these women. Re-training them to be moms, re-training them to be strong women because I mean, a lot of the times we fall into a lifestyle that we can't get out of. We fall into a lifestyle that we can't get out of and it's time to change. We fall into the same routines and it's time to change those routines we don't have the resources, we don't have the knowledge to change these routines.*

*A lot of women they grew up with addiction, they grow up with abuse, they grow up with alcoholism, they grow up with all these sicknesses and this is the only lifestyle they know. I think it's for these women that are coming in and out, in and out [of incarceration], they need to be re-trained to a different life. That's all they know. That's all they grew up in. That's all they've seen from the time they are this high.*

*You know, sometimes it's not that because the options were not there for them, so you know what, they went back to what they know and it's just that cycle that goes with them. And if there were those people that could be there to help and understand, those special types of needs that need maybe that cycle could be stopped right there.*

In summary, women described the transition from corrections to community as wrought with challenges and risk. A successful transition into the community is perceived to be dependant on safe and supportive housing immediate upon release and failure to secure this housing led to an increased perceived risk of recidivism into addiction and crime.

## Discussion

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This study aimed to explore the health-seeking experiences, perceptions of risk, and the medical, mental health, and housing needs of females during incarceration and in the post release period. A purposive sample of female inmates was conducted, and saturation was reached after 21 women were interviewed in focus groups of 4 – 6 women. The context of the participants' lives was congruent with previous research that described the experiences of homeless and incarcerated women in relation to their health and risks to homelessness. This study provides a unique insight into the impact of housing status and incarceration on women's health.

The findings demonstrate that incarceration provides an opportunity to address significant health disparities. Many usual stressors, such as housing concerns, substance use, and food security are reduced during incarceration, and female inmates have the opportunity to focus on their own health. However, without adequate transitional processes into the community at the time of release into safe and supportive housing, the women described a tremendous risk for recidivism into addiction and survival crime and loss of any health improvements gained. Women in fact described a vicious cycle between incarceration, unstable housing and poor health that certainly has wider financial and social implications for society and policy makers at large. This study also provides evidence for potential future health and housing interventions in this population. In this section, we identify some key recommendations based on the findings.

### Health Promotion and Education Through Peer and Professional Educators and Mentoring Programs

The women in our study described lack of knowledge in three major areas: 1) common procedures within the correctional facility (accessing phone and canteen accounts, healthcare, legal aid, etc.); 2) basic health knowledge; and 3) available resources to secure safe housing in the post-release period. They explained the need for increased support from female peer and professional mentors during incarceration and upon release.

These knowledge deficits may potentially be corrected through gender specific health promotion and education programs. Correctional facilities typically offer health promotion and education programs in the form of self-help, peer education programs, and/or professionally facilitated life skills programs. Peer education programs have been commonly targeted towards HIV and STI prevention and testing, which have demonstrated a positive effect (e.g. Collica-Cox, 2013; Ross, 2006; Sifunda, 2008; Zack, 2013). While correctional facilities have increasingly adapted health promotion and education programs, few have been rigorously evaluated to determine if they achieved the desired effect.

For the purpose of our population, we suggest using a community-based participatory team approach to create a resource manual that is specific for female inmates outlining routine procedures and available health and social services. This could include a team of correctional officers, health professionals, Aboriginal health and cultural consultants, and members of the female inmate population to create the resource manual. Female inmates (appointed by the correctional officers on the unit) could then serve as peer orienteers for new women coming onto the general female population unit.

We also suggest using the same community-based participatory team approach to develop a collaborative peer and professional educator/mentorship programs. This should be designed to include “re-training” (life skills) program, self-help, support groups and women’s health education. In turn, female inmates could also provide education to the officers and healthcare staff regarding obstacles they face in seeking healthcare, therapeutic health professional relationships, and social services.

### Incarcerated Women’s Health Program

Most participants regarded incarceration as an opportunity to prioritize their health needs. Women traditionally enter incarceration in poor health (Dauvergne, 2012), make more healthcare requests (Hyde, 2000), and have short incarceration periods (van den Bergh, 2011). Therefore women interpret their health care needs as immediate and perceive barriers to access including: the request form process for accessing medical and mental health care; long waits; inability to access providers who could refill their chronic community medications; access to methadone and withdrawal treatment; conflicting processes and experience among healthcare staff; and the lack of gender specific considerations. These barriers are not unique to our population and are congruent with those previously reported (Douglas, 2009; Young, 2000; Sered 2013; Harner, 2013).

Given the high prevalence of chronic conditions and co-morbidity among women, further investigation is warranted to determine the most effective care delivery models for women at risk for incarceration, during incarceration, and during transitions back to the community. Existing literature suggests that male and female inmates respond differently to equal services (Lewis, 2006) and gender specific programming is required (Sack, 2004). Additionally, the WHO declaration of women’s health in prison stipulates that an important part of gender equity is acceptance of women’s preferences with regard to health care and that health services for incarcerated women should be individualized as far as possible to meet the specific expressed needs of the women (WHO, 2009). The high prevalence of cervical cancer risk factors (Binswanger, 2011) and abnormal pap smears (Proca, 2006) among incarcerated women in particular requires further attention.

For the purpose of our population we propose the development and evaluation of a pilot women’s health clinic occurring 1-2 times/month addressing: (1) Pap smear and mammogram screening programs for all eligible women; (2) Birth control options; (3) Chronic disease management; and (4) Intimate partner violence support and counseling. The clinic should be multidisciplinary and in collaboration with a community health clinic such that continuity of care can be maintained. Further, due to the increasing need for culturally competent and socially accountable physicians, the clinic could also support medical education for medical students or residents interested in inner city or women’s health. In order to address the women’s concerns regarding therapeutic relationship and experience of health care professionals as well as delays in accessing health care, consideration should be given to having certain health care staff interested in women’s health assigned to the women’s unit or perhaps even a women’s health nursing lead within the facility.

### Housing First for Health

The most striking finding of this study was the strong link women established between incarceration, health, housing status and recidivism into crime and addiction. This finding provides a solid basis for moving forward with the next steps required to address this vicious cycle. Participants described a lack of housing resources specifically for women leaving provincial correctional facilities and without such a resource health could not be made. Women suggested several programmatic factors that may contribute to successful community re-entry including immediate supportive living post release, female mentors and

support groups, long-term “half-way” house model, help with money management, locations away from certain neighborhoods that may trigger addictions, and “re-training” (life skills programs).

Thus women are describing housing that most closely encompasses “housing first” principles within a transitional housing model. Housing First programs are characterized by rapid re-housing in permanent, market accommodations without requirements around sobriety or treatment adherence, and facilitating access to specific resources (e.g., health, social, employment training) to support the attainment of resident centered goals. To date, two housing first models have been developed and empirically tested. In the scattered-site housing first approach, people are offered a choice of individual units scattered throughout a community and access to community based management and treatment. In the project-based housing first approach, residents are offered units within a single housing project, where they can elect to receive onsite case management and other supportive services. To date, housing first models have shown benefits in reducing rates of re-incarceration including: a 6-month reductions in jail time (Larimer, 2009); a significant decrease in drug-related arrests and incarceration days (Hanratty, 2011); decreased incarceration time associated with the amount of time spent in project-based Housing First for up to two years following initial (Clifasefie, 2012); and reductions in offending and reconviction among people who were previously homeless and have a current mental disorder, particularly with the scattered-site model (Somers, 2013). Additionally, Housing First programs have been associated with significant reductions in the use of emergency services and hospitalization (Culhane, 2002; Martinez, 2006; Gilmer, 2009).

For the purpose of our population, we advocate for a pilot project of such housing evaluating the effect on health markers and incarceration rates.

## Limitations

Participants were recruited from a single correctional facility and even though the experiences described were congruent with that described in the literature, our findings may not fully represent the experiences of women at other correctional facilities. Further research with women in other short-term correctional facilities might capture additional perspectives.

## Conclusion

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This study provides housing, health, and public safety stakeholders insights into the reality of the cycle of homelessness, poor health, survival crime, and substance abuse that women being released from incarceration face when they do not have adequate resources. The collective voices of the female inmates are both unified and representative of a population that continues to suffer from poverty, social exclusion, and marginalization. Women enter incarceration in poor health and use incarceration as a means to access healthcare services. For both men and women, incarceration may represent a sentinel event allowing health conditions to be identified and treatment initiated. This represents an important chance to provide evidence based screening, preventive care, and chronic disease management to a highly vulnerable population. This study's findings also emphasize the importance of housing status on the health of women being released from incarceration. Without stable housing, women are not able to maintain any health gain made during incarceration and live for survival instead. Thus increased supportive and safe housing resources for women leaving incarceration are critical for improved health outcomes among individuals with chronic medical, psychiatric, and substance-dependence disorders.

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## Appendix 1: Research Field Notes From Jail

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*Experiences from a Mixed Methods Study Addressing the Impact of Incarceration and Homelessness on Women's Health*

Correctional facilities have a profound influence on the health of our urban communities, especially low-income and minority neighborhoods (Binswangner, 2012). The primary function of a correctional facility is to remove individuals that pose a safety threat to the community. However, they also collect and concentrate individuals with increased rates of substance abuse, mental illness and chronic medical and infectious diseases and provide the opportunity to link vulnerable populations to much needed health and social services (Fazel, 2011; van den Bergh, 2011). Additionally, correctional facilities unintentionally contribute to the ongoing poverty and social exclusion of certain urban communities by reducing the employment opportunities of ex-offenders and by precipitating family separation or disruption, pushing children into formal or kinship foster care (Freudenburg, 2001). Thus the correctional system has profound and complex effects on the health of communities, particularly those urban neighborhoods with a high prevalence of individuals placed in the correctional system.

In the past years, the population of incarcerated women worldwide has been increasing (Wamsley, 2006; van den Bergh, 2011; Dauvergne M, 2012); in Canada, this has disproportionately affected Aboriginal women (Mahoney, 2011). Women typically enter a correctional facility in poor health and have more chronic medical and mental health conditions (Binswanger 2010) as well as a higher burden of infectious disease (including HIV and other sexually transmitted infections) when compared with their male counterparts (Altice 2005; Covington 2007). The wide range of issues that incarcerated women face provides an opportunity for conducting health research studies that could lead to improved health outcomes within the communities to which they return. Potential areas of research may include, screening for cervical and breast cancer; chronic disease management; screening and treatment programs for sexually transmitted infections and HIV; impact of linking correctional health and community treatment programs on decreasing morbidity and mortality of diseases, substance use, and recidivism; improvement of prenatal care; impact of mother's incarceration on children; transitional programs to promote successful transition to the community and interventions to decrease housing instability.

Unfortunately, the history of research on inmates is wrought with examples of coercion, involuntary participation, and the introduction of illness or disease without the knowledge or consent of the subjects (Cislo, 2013; Byrne, 2005). In reaction to these abuses strict regulations on such research were implemented and prisoners became a so-called "protected population" in research. This has led the correctional population to be one of the most under-studied populations in healthcare. We know far less about the health and health care needs incarcerated populations than those in the community despite innumerable health disparities. Yet, evidence is required to inform policies, procedures and treatments for this vulnerable population. In recent year, there has been a growing momentum for ethical and clinically focused research within this population. There are many issues that need to be addressed when thinking about conducting research at a correctional institution. Additionally, due to the over representation of the Aboriginal population within correctional facilities in Canada, it is imperative to conduct such research in culturally sensitive manner. This paper seeks to describe the processes and procedures used in implementation of a mixed methods study addressing the impact of incarceration and homeless on women's health. We will present some of the triumphs, challenges and insights we gleaned while conducting correctional research in health and healthcare delivery.

## A Shared Journey

This research project began when a diverse group of women came together to apply for a unique funding opportunity. This opportunity arose through a community-based, housing organization that provides leadership and resources towards ending homelessness in a medium-size Canadian city. Applications for seed grants were available for individuals interested in generating community-based research in key priority areas related to homelessness. This funding opportunity not only supported innovative partnerships between academic and community-based organizations but also recognized the vulnerable population of women within the correction system as a priority area for programs to help bridge community-based housing and support services in order to enable these women, *“to heal, stabilize, have their children returned to them and live together in a healthy, supportive, congregate environment”* (Homeward Trust). Although the study team included members with diverse expertise, each member had experienced first hand the frustration and injustice of the barriers imposed on these women in accessing and maintaining basic health and housing as they revolve between correctional facility and the community. It was this central experience that bound the team together and committed them to provide voices to the women who walk this journey alone. The funding application was put forward with the support of the correctional facilities security department. With great excitement, the study team was awarded the funding application in November 2012.

## The Site

This study was conducted at a large remand facility located in a medium-size Canadian city. Women represent a small portion of the total population; there are three women’s units with a capacity of 172 female inmates. Remand or “detention centers”, are pre-sentenced facilities where offenders await court proceedings. Remand facilities are an important entry point for engaging a traditionally “hard-to-reach” demographic into health care. Because women tend to commit non-violent or drug-related crimes, the majority of the female inmates within the correctional system are either remand or provincial facilities (Dauvergne M, 2011). Thus while a high number of women are seen at these facilities, lengths of stays are often short making interaction with care-providers during incarceration brief. A number of challenges in initiating effective programs have been identified in short-term facilities including: health care interventions related to chronic health disease management have been considered impractical because of the high rate of turnover and short lengths of stay; although not all offenders have short lengths of stay, determining which will be incarcerated for a significant period of time is difficult; offenders who are incarcerated long enough to begin chronic disease management are released into unstable community situations, which has been associated with an increased default rate. Regardless of these challenges, remand facilities provide opportunity for treatment, education, and harm reduction for a large number of underserved women. These barriers in fact highlight the need for resources and programs dedicated to discharge planning and reliable access to community-based treatment after release.

## The Planning

The planning of the research study started with regular meetings with multi-disciplinary team members began in January 2013. The study team consisted of twelve members who brought together expertise from Aboriginal cultural and health consultants, correctional and mental health, social work, infectious diseases, family and women’s inner city health, psychology, community correctional services and community engaged research. To ensure Aboriginal worldviews were a central part of this project, we

attempted to use a community-based participatory research (CBPR) approach to guide the study whenever possible. We understood that this would be challenging due to the high turnover and short length of stay of the female inmate population. However, through this partnership, although limited, we were able to understand the issues on a much deeper level. As such, a CBPR approach allowed alignment with guidelines for conducting research on First Nations, Inuit and Metis Peoples of Canada, which states that Aboriginal people should be given the option of a participatory approach to research (Tri-council Policy Statement, 2002).

The study was planned as a three part mixed methods study including: 1) A structured survey of a sample of female offenders concerning their current health and housing situation; 2) three to four focus groups with 4 – 6 women/group; and 3) semi-structured individual interviews with a subset of focus group participants shortly after release. Surveys, interview guides, study information sheets and consent forms were revised several times by the multi-disciplinary team. The interview guide was adapted with permission from *Binswanger, 2011* (Binswanger, 2011) and revised by the multi-disciplinary study team members for content relevant to the study population at hand. Interview questions addressed access to medical and mental health care during incarceration and in the community, overall medical and mental health needs, and perceptions of risk to one's health and safety during incarceration and in the transition to the community.

## The Long Wait

This study received ethical approval through the University of Alberta Ethics Research Board. Unfortunately, this process was delayed due the vulnerability of the population being studied and required a presentation before the full ethics board. Next we sought administrative and operational approval through the correctional facilities' research review process. Finally, we sought and received approval through the third and final review board, provincial health authority organization that was responsible for the correctional health department of the facility. Overall, the approval process took six months out of a twelve-month grant funding timeline.

## The Implementation

### *1. Focus Groups:*

As the momentum of the project increased, the implementation of the project was met with support from health care staff and officers within the facility. The study team presented an overview of the project to interested correctional health care staff and officers. Through this process, correctional facility staff were invited to participate in the research process to help recruit eligible women for the study. Eligibility criteria included: 18 years of age or older; ability to speak English; ability to comprehend and consent to study procedures; housed within the general female population; and live in the encashment area of the city in which the correctional facility was located. If correctional facility staff came across eligible women who were interested in participating in the study, they were asked to provide the potential participant with a study information sheet. Women on the general population unit were further made aware of the study through an advertisement poster. This poster was designed by an Aboriginal artist and a study team member and depicts the full moon, which encompasses the teachings of women. The poster artwork and symbolism are shown in Figure 2. Once eligible women were identified, the study protocol was reviewed and informed written consent was obtained by a study team member. Unfortunately, the number of study

teams members that could obtain informed consent was limited due to ethical considerations of coercion. Many of the study team members also provided healthcare to this population either within the correctional setting or in the community and due to this either existing or potential relationship could not ethically take place in this process.

Between August and October 2013, the focus groups were conducted. Each focus group was conducted in a room located in the healthcare unit. Focus groups were conducted by two-experienced qualitative interviewers (LK, CA, or DK). In order to ensure the interviews were conducted in a culturally competent manner in keeping with Aboriginal values and traditions, an additional study team member (VS or RM) with expertise in aboriginal health issues and traditional healing practices was also present during the focus groups. These team members were essential in creating an environment of trust and increasing the rapport with, and comfort of, the individual participants. A prayer flag that was used in a sacred pipe ceremony was gifted to the project to use as a “talking cloth”. The holder of the talking cloth was the only person in the circle that could speak. The concept of the talking cloth was that the prayer flag would be folded and sewn into a circle shape to weave and hold the narratives of all the women as they held the cloth and told their stories. The cover of the talking cloth would bear the same image as the artwork on the poster. After the project was completed, the prayer flag was tied to a branch on a tree, symbolizing the return of the women’s stories to Grand-Mother Moon. In total 4 focus groups including 21 women were conducted lasting approximately 60-90 minutes. Women were provided with approved edible products from the facilities canteen service worth \$10.00 per participant after completion of each focus group.

## *2. Surveys:*

Survey recruitment followed a similar process as the focus groups. Once eligible women were identified, the study protocol was reviewed with them and informed written consent was obtained by a study team member. In order for our survey results to reach statistical significance a total of 350 surveys need to be completed. The rate of recruitment was extremely limited as only a few study team members were not healthcare professionals and therefore eligible to obtain consent; additionally, the female population is small with high turnover making the number of eligible recruits low. Thus survey collection is ongoing at this time. Women who completed the survey were provided with approved edible products from the facilities canteen service worth \$5.00 per participant.

## *3. Post release interview:*

Post release interviews proved to be the most challenging. Numerous attempts and strategies were employed by the study team (LK, DK, DF, RM) to retain women within the post release period with limited success. Once released, post-release interviews became lower on the list of priorities after housing, food security, social assistance appointments, their dependents such as their children, work, and other appointments. We were initially unable to get a hold of many participants upon release as participant’s phones became disconnected, they returned to incarceration, or no longer wished to participate. Due to the labor-intensive process involved in making attempts to capture post release interviews and our limited success despite numerous attempts, we aborted further efforts. Instead, we recruited two female inmates who had experienced multiple episodes of incarceration to complete “member checking”. These women helped ensure the validity of our results and had experience with the post release period. Discussion primarily centered on practical issues, such as how to facilitate women’s health and housing initiatives as a consequence of our research. We included this step to engage the participants as the “knowers” of their contexts and environments. Women were provided with approved edible products from the facilities canteen service worth \$10.00 per participant after completion of the follow up meeting.

## The Delays

*“From the perspective of the correctional staff, safety always comes first, treatment is second, and research a distant third (if even considered)”*

*(Adapted from: Cislo & Trestman, 2013; Original: Trestman, Candilis, Silberberg, & Temporini, 2005, p.11).*

There are many challenges to conducting research within the structure of a correctional setting; these have been well described in the literature (e.g. Cislo AM, 2013; Byrne 2005) Correctional facilities are primarily designed and operate to provide a safe and secure environment and therefore they are for the most part a predictably unpredictable environment that can challenge even the best planned out research schedule. Some of the delays can be planned for and some require adaptability. First, correctional facilities are subject to cessation of movement due to medical or security emergencies, lock-downs, shift changes, lack of private interview areas, and the “head count” (the process by which all inmates must be accounted for and during which no movement in the facility is permitted); these events may delay or even bring to a halt the research in progress. Second, retaining research participants is also a challenge due to a variety of factors including transfers, releases, court dates, segregation, mealtime, programs, visits, and medical and legal appointments. Third, researchers also put increased demands on the facility by requiring officers for escorting visiting researchers, transporting inmates off the unit, and providing extra security.

Overall, it is best to resolve oneself to the fact that these challenges are inherent to the system and the research timeline will be disrupted and/or delayed; but this is a realistic part of conducting research in a correctional facility. Because our study team was comprised of many individuals that were either employed within correctional health or familiar with the correctional environment, many of these challenges were accounted for. Even so, our study was still subject to its fair share of many of these systematic challenges and delays.

## The Lessons Learned

Ongoing research is required to improve the health of populations involved in or affected by the correctional system, and to guide evidence based health and transitional programs and policies. However, conducting research within a correctional facility can be full of challenges as well as rewards. Reflecting on our experience of conducting research with female inmates, we suggest the following strategies.

**Aboriginal cultural sensitivity:** Although our research did not specifically target recruitment of Aboriginal participants, we recognized the importance of including Aboriginal cultural and health consultants due to the over representation of Aboriginal women within the Canadian criminal justice system. In doing so, we were able to engage the women in open and frank discussions during the focus groups by establishing an environment of trust. This allowed us to collect data that preserved the perspective and the cultural fabric of the women whose experiences were being studied.

**Community-based Participatory Research (CBPR):** We attempted to use a community-based participatory approach whenever possible, which also contributed to the strength of our results. Our study

team consisted of a diverse group of academic and community health care professionals and/or researchers with experience with working with this vulnerable population. Various members of the teams were involved with all aspects of the study including interview and survey design, data collection (interviews and surveys) and interpretation. We also were able to “member check” the validity of our key themes and recommendation with two female inmates who were considered as leaders on their unit; they spoke knowledgeably about their own experiences and from the group perspective. These women also helped design Figure 1, which is schematic description of our key results. However, notably missing from our community-based approach were the correctional officers and this is a limitation of our study. Through focus groups and informal discussions with participants, it was clear that certain officers on the women’s general population unit were respected and integral community members as well as mentors to the women. It is a critical duty of the study team involved in CBPR to identify all members interested or vested in the research at hand; moving forward, we will seek engagement with the correctional officers on the women’s unit to participate as study team members.

**Develop a project that supports the correctional facility:** The opportunity to conduct research within a correctional facility should ultimately result in benefits for the facility and its residents. It is therefore important to define an area of overlapping concern, interest, and/or skill. When such an area is defined, everyone is in a position to work collaboratively to overcome the inevitable challenges and delays. Our study teams commitment to the health and housing needs of these vulnerable women was a huge strength of the study. It is also important to share the research more broadly throughout the correctional facility to demonstrate the potential benefits of the process and/or findings. We plan to share our results with the correctional healthcare staff and officers and/or the women’s general population pending administrative approval.

**Knowledge and compliance of security regulations and procedures:** Safety and security are the priorities in correctional settings, and all else is secondary. All study teams members who are to enter the correctional facility must under go a criminal record check in advance; an itemized list of items necessary to conduct the research must be provided and pre-approved prior to entry; and there must be respect for contraband policies (cell phones, pagers, credit cards, etc). Sometimes, it may be difficult to understand the rationale for certain rules, but it is still essential to respect and uphold them and follow the direction of the correctional officers. Failure to do so may not only compromise the facilities safety procedures, but may also compromise the study, as the officers may view the team as a risk to the facilities safety and security protocol. Ensuring that study team members who are not familiar with the correctional environment receive a security orientation may help prevent such situations from arising.

**Timeline for completing research in a correctional facility:** The timeline for completing a research project in a correctional facility will take months longer than one in the community. This is not the fault of the correctional facility nor does it suggest lack of support for the ongoing research. Potential delays are due to: (1) ethical considerations regarding research with incarcerated populations; and (2) the systematic challenges inherent to a correctional facility. First, it took us six months to obtain ethical, administrative and operational approval for our study through three required institutional review boards; this ended up taking half of the grant timeline. This is despite the fact that one of researchers was familiar with all three institutional review processes and had prefilled out all the forms in anticipation of each process. Additionally, the study team had designed and prepared the surveys and interview guides ahead of receiving confirmation of grant funds and this could have delayed the process even further. Second, there are many predictable and unpredictable delays that can occur within a correctional facility that can delay the study timeline. Having members on the study team that are familiar with the functioning of the facility

is imperative in order to anticipate some of these delays. However, when planning the study timeline it's best to give more time for task completion than expected.

**Start simple and small:** It is important for the group of collaborators to work out any issues in the process before being challenged with a major initiative. Our original plan of a three part mixed methods study was quite ambitious. We spent a fair amount of time focusing on collecting the post release interviews and this took up valuable resources and time that could have been devoted to survey consent and completion. Even though we only completed one post-release interview, we were still able to validate the post release experience through “member checking” with women who had experienced the challenges of the post release period previously. Thus it is important to prioritize study objectives early and be flexible and creative with more readily available resources especially when challenges arise.

## Conclusion

Understanding and addressing the health of incarcerated individuals is one component of a comprehensive strategy to reduce population health disparities and improve the health of our urban communities. Many challenges exist in conducting research within a correctional facility. However many of these are addressable through partnerships with vested health and correctional staff within the correctional facility; in the community and in academic centers; by addressing the cultural needs of the population; and by empowering the population being studied through a community-based participatory research approach.