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Field Notes From Jail: How Incarceration and Homelessness Impact Women's Health

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Abstract

A multi-disciplinary team explored the journey they took with female inmates to develop a collaborative research strategy among the university, community organizations, and the correctional facility. The team consisted of academic researchers, inner city physicians, social workers, nurses, Aboriginal art therapists, Aboriginal cultural consultants, correctional healthcare administrators, and inner city chaplains from non-profit organizations. This paper describes how the team reflected on the journey to determine the impact of incarceration and/or homelessness on the health of female inmates, as they (the team) patiently waited for ethics boards and administrative approval; negotiated correctional center lockdowns; and became exhausted from trying to reconnect with women who were released from incarceration. The researchers discovered what kept them passionate about helping female inmates work through multiple hurdles that included housing, child custody, employment, probation appointments, and counseling. These administrative and operational challenges strengthened the team's resolve to support these vulnerable women.

Female inmates have a high incidence of mental illness, substance abuse, sexually transmitted infections, and healthcare needs relating to reproductive health and intimate partner violence. Our research team had the privilege of working with this protected population, releasing the voices of one of the most silenced and vulnerable populations in health care (Prilleltensky, 2005). Our collaborative team used a participatory action approach with the female inmates to address the impact of incarceration and homelessness on their health. The intent was to provide a deeper understanding of female populations within correctional facilities, regardless of the unpredictable nature of short-term correctional facilities, the complexity of establishing a participatory action team, and the challenges of upholding rigorous research strategies within a jail. We share some of our insights to encourage scholars from all backgrounds to conduct community-based research; to involve the female inmates in resolving their own issues; to pursue the collective answers provided by the women within the correctional facility; to leave products within the correctional facility, such as "A Woman's Guide to Health in Jail"; and to teach stakeholders to reflect on the voices of the vulnerable women that are returning to the cities and communities after incarceration.

Literature Review

The incarcerated women who took part in our participatory action research project are a subset of a growing worldwide group of female inmates (Wamsley, 2006; van den Bergh, Gatherer, Fraser, & Moller, 2011; Dauvergne, 2012). In Canada, there is a disproportionate number of Aboriginal women within the female inmate population (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, Marinovich, Khoshnood, Blankenship, Springer, & Selwyn, 2005; Covington, 2007). Upon release, these women often return to communities that suffer from poverty, health disparities, and social exclusion (Salmon, Poole, Morrow, Greaves, Ingram, & Pederson, 2006). They have been separated from family; their children may be living in formal or family foster care; and their employment opportunities may be decreased, all as a result of incarceration (Freudenburg, 2001; Binswanger, Redmond, Steiner, & LeRoi, 2012).

The wide range of issues that incarcerated women face provides an opportunity for conducting health research studies that could lead to not only improved individual health outcomes but also within the communities to which they return. 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 & Trestman, 2013; Byrne, 2005). In reaction to these abuses, strict regulations on such research were implemented and incarcerated individuals became recognized as a “protected population” by the research ethics boards. The result is that inmates are one of the most under-studied populations in health care (Bible, 2011). Additionally, due to the over representation of the Aboriginal population within correctional facilities in Canada, it is imperative to conduct such research in a culturally sensitive manner (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research, 2010). In recent years, there has been a growing momentum for ethical and clinically focused research to decrease health disparities within this vulnerable population (Cislo et al., 2013). Research that invites inmates to identify their needs and participate in the construction of appropriate solutions is very rare (Harris, 2010).

A Roadmap to the Participatory Action Journey Within A Correctional Facility

There are four legs to our research journey within the correctional world. First, we explain the unique focus of our study: understanding female populations within correctional facilities. Second, we discuss the partnerships that developed within our participatory action research team, including the funding and the passion and the multi-disciplinary collaboration. Third, we describe the actual implementation of the project, including surveys, focus groups, and post-release interviews. Finally, we discuss the “road less traveled”: the unpredictable environment within correctional facilities.

1. Understanding Female Populations Within a Correctional Facility

The large remand facility where the female inmates reside is located in a medium-size Canadian city. The facility accommodates 1,500 to 1,900 male and female inmates. Women represent a small portion of the total population; there are three women’s units with a capacity of 100 to 150 female inmates. Remand facilities, or “detention centers,” are

pre-sentenced facilities where inmates await criminal justice proceedings. These facilities are an important entry point for health care to reach a traditionally difficult population. Because women tend to commit non-violent or drug-related crimes, the majority of the female inmates within the correctional system are held within either remand or provincial facilities (Dauvergne, 2011). Further, female inmates suffer from high rates of mental health issues, drug or alcohol dependency, and blood borne viruses (van den Bergh et al., 2011). Women who serve shorter sentences have been noted to make more healthcare requests and use services more frequently than those with longer sentences (Hyde, Brumfield, & Nagel, 2000). However, women report mixed perceptions of healthcare services that they have received during incarceration. Studies with female inmates report difficulties accessing care and/or medication, and that healthcare staff are felt to be non-empathetic (Douglas, Plugge, & Fitzpatrick, 2009; Sered & Norton-Hawk, 2013; Young, 2000).

2. Establishing a Participatory Action Team

a) Funding Is Critical But Passion Is Foremost

This research study 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 aimed at 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 correctional system as a priority area for programs to help bridge community-based housing and support services to enable these women to heal, stabilize, have their children returned to them, and live together in a healthy, supportive, congregate environment (Annual Report 2015). Although the study team included members with diverse expertise, each member had experienced firsthand 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 facility's administrative department and was awarded in November 2012.

b) The Multi-disciplinary Collaboration

The planning of the research study started with regular meetings with multi-disciplinary team members in January 2013. The study team consisted of 12 members who brought together their expertise from Aboriginal cultural and health consultants, correctional health, social work, infectious diseases, family and women's inner city health, mental health, community correctional services, and community-engaged research. We understood that this would be challenging due to the high turnover and short length of stay of the female inmate population. To ensure Aboriginal worldviews were a central part of this project, we used a community-based participatory research (CBPR) approach to guide the study whenever possible. The CBPR approach allowed alignment with guidelines for conducting research with First Nations, Inuit and Métis Peoples of Canada, which states that Aboriginal people should be given the option of a participatory approach to research (Government of Canada, 2010).

3. Implementing the Mixed Methods Process

The initial research project was a mixed methods study that had three parts: 1) A structured survey of 330 female inmates concerning their current health and housing situation; 2) four focus groups with 4–6 female inmates; 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. This study received ethical approval through the University of Alberta Ethics Research Board. Unfortunately, this process was delayed due to 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 facility's research review process. Finally, we received approval through the third review board: the 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 12-month grant funding timeline, an important fact that the researchers must include in the timelines they provide to their funders.

a) Surveys

Survey 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. Even after this careful distillation of questions, the female inmates needed the research team to explain many of the questions because they were beyond their comprehension. For example, when the women were asked how many children they have, they did not know how to respond. While they are incarcerated, someone else is responsible for their children. They may have been responsible for their partner's children, or another family member's children, as well as their own biological children. When asked how many pregnancies they had, they wanted to know if that included miscarriages and abortions, and the babies that were taken from them at birth.

Preplanning was critical in the survey process; three individuals from our study team were selected because they had no conflicts of interest. After numerous attempts to access the women at their assigned units, the study team members established the best day and time to conduct the surveys was on weekends and holidays after the morning meal, because there were no court, legal or medical appointments and programming for the female inmates on those days. Alternatively, afternoons on weekdays were also noted to have less conflicts with the women's scheduling. Prior to entering the women's living unit, they prepared consent forms, contacted the canteen (also known as commissary) for food items, assembled the gift bags, and loaded the survey cart. By utilizing tools such as "bed boards," the team was able to identify new participants and keep a confidential record of those who had already completed surveys. The most feasible place to explain the study, obtain the consents, and conduct the surveys was on the women's living unit; otherwise correctional officers had to escort the female inmates to and from the Health Centre. Obtaining the consents just prior to administering the surveys was essential because the length of stay in a remand environment is often short with an unpredictable release date. Contacting the unit correctional officers in advance and briefing them on the purpose of the study upon arrival kept everyone informed. The survey team's positive attitude with both the correctional officers and the inmates was crucial to the ongoing success of the study.

A total of 331 surveys were completed. The female population is small with high turnover, which made the number of eligible recruits unpredictable, so any strategy to make the process more pleasant was critical. Our dedicated team discovered that sunny days were the most successful because the women could go into the enclosed outdoor areas to complete their surveys in relative privacy. This process took a year to complete.

b) Focus groups

The study team presented an overview of the project to interested correctional healthcare staff and officers, inviting them 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 living in the catchment area of the city in which the correctional facility was located. If correctional facility staff came across eligible women 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 made aware of the study through an advertisement poster. This poster was designed by an Aboriginal artist and an Aboriginal study team member. The artwork depicted the female figure standing in the light of the full moon; the moon encompasses the teachings of women. The poster artwork and symbolism are shown in Figure 1. Once eligible women were identified, the study protocol was reviewed and informed written consent was obtained by a study team member. Many of the study team members also provided health care to this population, either within the correctional setting or in the community, and due to this either existing or potential relationship, they could not ethically take part in recruitment or data collection.

Four focus groups totaling 21 were conducted, each lasting approximately 60–90 minutes. Women were provided with approved edible products from

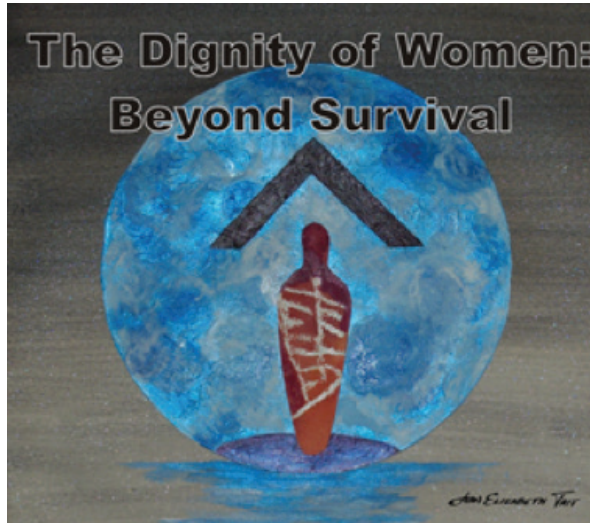
Figure 1: Poster Artwork and Symbolism

Design and Artwork

Rebecca Martell and Jean Tait, First Nation Art Therapist/Artist

Date

March, 2013



Description of Artwork

- Grandmother Moon = symbolizes the full moon, which encompasses all of the Teachings of Women.
- Water = symbolizes Grandmother Moon's control over the water on Mother Earth. Women are connected to the power of the moon and water through the flow of their menstrual cycle, in the creation of new life within the sacred water of their womb, and with the life force they carry into the world as female beings.
- Female figure wrapped in a blanket = symbolizes the creation of personal safety.
- Stylized skeletal form within female figure = symbolizes both inner strength and an awareness of physical health.
- Roofline over female figure = symbolizes the need for safe housing.

the facility's canteen service worth \$10 per participant after completion of each focus group. The focus groups were conducted between August and October 2013. Each focus group was conducted by two experienced qualitative interviewers in a room located in the healthcare unit. In order to ensure the interviews were conducted in a culturally competent manner in keeping with Aboriginal values and traditions, an additional Aboriginal study team member 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 used in a sacred pipe ceremony was gifted to the project to use as a "talking cloth." Originally a rectangular piece of cloth, the prayer

flag was folded and sewn into a circular shape, which symbolized Grandmother Moon on our project poster. Also taken from the poster, the stylized image of a woman was drawn on the face of the talking cloth and illustrated the inherent strength of every female being. Women in the focus groups who held the talking cloth were granted the right to speak without interruption. In this way the talking cloth controlled the flow of conversation. At the same time, as they held the cloth and shared their stories, the women wove their narratives into the very fabric of the cloth. Upon project completion, the stitches of the talking cloth were unraveled. Returned to its original state, the prayer flag was tied to the branch of a tree at the time of the full moon. This symbolized an unraveling of the women's stories, along with the return of their sacred thoughts and words to the care of our female protector, Grandmother Moon. The majority of our population self-identified as Aboriginal people and they expressed their appreciation for taking the time to make the focus group feel safe and using the talking cloth to ensure that their stories were honored.

c) Post Release Interviews

Post release interviews proved to be the most challenging. Numerous attempts and strategies were employed by the study team to retain women within the post release period with limited success. Once released, interviews became lower on the list of priorities after housing, food security, social assistance appointments, their dependents/children, work, and other appointments. We were initially unable to contact many participants upon release as participants' phones became disconnected, they quickly returned to incarceration, or no longer wished to participate. Due to the labor-intensive process involved in trying to conduct post release interviews and our limited success despite numerous attempts, we aborted further efforts after one interview. Instead, we recruited two female inmates who had experienced multiple episodes of incarceration to ensure the validity of our results based on their understanding about women's experiences during the post release period.

4) The Unpredictable Nature of Correctional Facilities

There are many challenges to conducting research within the structure of a correctional setting (Cislo et al., 2013; Byrne, 2005; Apa, Bai, Mukherejee, Herzig, Koenigsmann, Lowy, & Larson, 2012). One of the primary objectives of correctional facilities is to provide a safe and secure environment; it is a predictably unpredictable environment that can challenge research schedules. 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, and head counts. These events may delay or even cause cessation of the research. Second, retaining research participants is also challenging due to a variety of factors: transfers, releases, court dates, segregation, mealtime, programs, visits, and medical and legal appointments. Third, researchers put increased demands on the facility by requiring officers for escorting researchers, transporting inmates off the unit, and providing extra security.

These challenges are inherent to the correctional environment and the research timeline may 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 manageable. Even so, our study was still subject to many of these systematic challenges and delays.

Discussion

Imagine that you are entering a world that you have only seen on television; you are part of a team that will conduct a participatory action research study within a correctional center. Prior to beginning your research your team has to provide an itemized list of everything that is required to conduct your research; this list must be pre-approved by the officer at the front desk. You arrive at the correctional facility and discover that safety and security are the priorities in this correctional setting, and all else is secondary (Cislo et al., 2013). As a member of the study team you must undergo a criminal record check in advance and you are obliged to respect the contraband policies (no cell phones, pagers, credit cards, etc.). Failure to comply with correctional facility protocols may not only compromise safety procedures, but may also compromise the study, as the officers may view the team as a risk to the facility's safety and security. The next step is entry into the correctional facility to meet the extensive research team.

The research study team gathered in the boardroom is there to determine female inmates' lived experiences prior to incarceration, during incarceration, and post-release into their communities. Around the table there are 12 different health professionals and experts from within the correctional facility. The initial plan is very ambitious: a survey, focus groups, and post-release interviews. The team identifies several challenges: maneuvering within a secure correctional facility; accessing a vulnerable population; and reporting delicate information that affects policy and procedures within the facility and the community. This

paper described the research that was defined in that prison boardroom, and the personal and professional journey of four members of the research team. We explored what it takes to conduct participatory action research within a community-based setting, alongside members of a vulnerable population.

The opportunity to conduct research within a correctional facility should ultimately result in benefits for the inmates, the staff, and the facility (Cislo et al., 2013). Correctional facilities are unique, unpredictable, and focused on security; therefore, collegiality with the correctional officers is critical (Apa et al., 2012). Correctional officers were informed about the purpose of the study and the exact protocol that we would follow, which made it easier for the team to enter the correctional facility's units or bring female inmates to the health clinic for the focus groups. Also, assistance from employees working in the canteen and on the health unit was essential.

The team estimated that it would take three months to obtain consents and complete 330 surveys. Two of the research team members initially tried to collect consents on Mondays and conduct the surveys on Wednesdays. They realized that combining these tasks, selecting weekends and holidays to avoid conflicting activities, and conducting the surveys outside in the courtyard were essential strategies to reach this population. It took a year.

The 21 women who took part in the focus groups allowed us to experience their "intensive interaction" between the correctional system, the community, and their homes (van den Bergh et al., 2011). The four focus groups were conducted under proper security within the health unit. We recognized the importance of including Aboriginal cultural and health consultants because the majority of the women self-identified as "Aboriginal" (Mahoney, 2011). Therefore, we used a "talking cloth" that each woman held when she shared her wisdom, while the others demonstrated their respect by remaining silent. This culturally sensitive symbol helped the women engage in open and frank discussions and established 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.

The women shared their experiences about their past struggles with lack of consistent health care, precarious housing, nutritional needs, and finding a family physician after they were released back into their communities. Without ongoing support, these women may return to a vicious cycle of recidivism into addiction and survival crime when they return to a community. The findings from the research have been published by the research team in an article entitled "The Impact of Homelessness and Incarcer-

ation on Women's Health" (Ahmed, Angel, Martell, Pyne, and Keenan, 2016).

In this complex environment, the members of the community, both staff and inmates, served to guide the process of locating and using appropriate knowledge. Those who govern the correctional facility provided access into their complex system. The staff identified the appropriate participants within the community, and provided information about the resources available to the women in the correctional facility and the community. The female inmates kept it real by challenging the researchers to create more appropriate survey questions; these women helped interpret the focus group results by creating a graphic that represented the link between housing, health, and recidivism (Ahmed et al., 2016). The participants in our study said that by seeing the results of their focus groups they felt that their ideas had been liberated; their consciousness, confidence, and abilities were raised.

By sharing the research more broadly throughout the correctional facility and with stakeholders, we demonstrated the potential benefits of starting a Women's Health Clinic, which has recently been established at the correctional facility. The female inmates and the research team co-created a booklet for the female inmates and staff that details the resources within the correctional facility and the community. We have received correctional administrative approval to share our results with the correctional healthcare staff and officers and the general women's population using brochures, presentations, and workshops.

The aim of this research study was to facilitate the transfer of information throughout the correctional facility and its community, and to create opportunities to incorporate everyone's stories and exhibit the value of everyone's voice. Through reflection, discussion, and participation, this insular community acknowledged the political and cultural barriers and allowed widespread participation. The obstacles were eventually overcome, resulting in a new understanding that people can move beyond their current, undesirable condition, toward a less alienating situation where even the silenced people find their voices and speak their truth.

Lessons Learned

The timeline for completing a research project in a correctional facility will take months longer than one in the community (Cislo et al., 2013). Potential delays are due to ethical considerations regarding research with incarcerated populations and the systematic challenges inherent to a correctional facility.

Having members on the study team who are familiar with the functioning of the facility is imperative in order to anticipate some of these delays.

Our original plan to conduct 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 communities. Many challenges exist in conducting research within a correctional facility. However, these obstacles can be addressed 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 engaging the population being studied through a community-based participatory research approach.

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