

Forgotten Women: Incarceration and Health Concerns of Minority Women

Abstract: This paper will discuss incarcerated minority women's health conditions, and health education in prison. Issues related to health education of inmates, such as programs, cultural awareness and literacy will also be discussed. Finally, this paper will discuss issues related to medication access and adherence, and post incarceration referral services.

Key Terms: prison, health education, chronic and communicable disease

Women comprise 6.9% of the prison population and 12.9% of the jail population (van Wormer, 2010). Individuals awaiting trial or sentenced to less than a year usually are housed in jails. Individuals convicted of a crime or sentenced for longer periods are housed in prisons, halfway-houses, boot camps, or weekend programs. The term incarceration is used interchangeably for populations housed at jails and prisons, yet each population is defined differently based on sentencing or non-sentencing (e.g., suspected of a crime) (Bureau of Justice Statistics, 2013).

The number of incarcerated women has increased 757% since 1977 (Talvi, 2007). During the last decade, females have been incarcerated at twice the rate of males (Hall, Golder, Conley & Sawning, 2012; van Wormer, 2010). In 2012, there were 108,866 women prisoners in U.S. correctional facilities (Carson & Golinelli, 2013). The number of incarcerated minority women has also increased. In 2011, an estimated 26,000 inmates were Black and 18,400 were Hispanic women, about 44% of the total incarcerated population of women. These women have limited or no accesses to health care, poor health outcomes, and experience more criminal justice involvement than whites (Binswanger, Redmond, Steiner, & Hicks, 2011). Despite increasing numbers, minority women represent a critically understudied population in prison (Hall, Golder, Conley, & Sawning, 2012).

Incarcerated women have a disproportionate number of illnesses, often exhibiting higher rates of physical health problems than non-incarcerated women (Harner & Riley, 2013; Sered & Norton-Hawk, 2013). According to Hyams and Cohen (2010), incarcerated women are among the sickest and least likely to have easy access to health insurance and care. Minority women are identified as high risk for communicable diseases, substance abuse, and mental health illnesses that often require immediate care upon entry into the correctional system (Guthrie, 2011; Salem, Nyamathi, Idemundia, Slaughter, & Ames, 2013). Factors pre- and post incarceration such as lack of access to health care, education, poverty, domestic violence, and homelessness contribute to an increased risk for illness (Flanigan et al. 2010; Freudenbergin et al, 2005). Social and economic conditions, such as high rates of poverty, income inequality, unemployment, and low educational attainment, can make it more difficult for individuals to protect their sexual health (Dean & Fenton, 2010). In addition to disproportionately being affected by HIV/AIDS, incarcerated minority women may also have reproductive issues and chronic diseases (e.g., diabetes, hypertension, and heart disease) (Binswanger, Merrill, Krueger, White, Booth, & Elmore, 2010; Harner, & Riley, 2013; Harzke, Baillargeon, Pruitt, Pulvino, Paar, & Kelly, 2010). The purpose of this paper is to discuss incarcerated minority women's health conditions, health education initiatives in prison and community health upon re-entry.

Incarcerated Women's Health Care

Women's health is a priority of the National Commission on Correctional Health Care (NCCHC) for all incarcerated women (NCCHC, 2008). When inmates arrive at correctional facilities, health screening for communicable disease testing, vital signs, physical, and mental health assessment are conducted, and chronic health care conditions are identified. During this process, a medical and mental health evaluation of current and past conditions is conducted. Obstetrics and gynecological examinations are required as part of the initial screening to determine the presence of sexually transmitted infections (STI). Immediately, inmates are referred to the appropriate care providers for treatment-initiation and care continuity while incarcerated. Treatment consists of daily medication, monthly provider assessments and quarterly diagnostic evaluations, and individual or group counselling referrals (NCCHC, 2008).

Freudenberg et al. (2005) identified infectious and chronic diseases, mental health conditions, addictions, and violence experienced prior to or during incarceration as factors influencing health care continuity and affecting urban communities financially upon release. In addition, while incarcerated, medication noncompliance is a problem that challenges correctional health care providers. Inmates' noncompliance to treatment varies between asymptomatic and symptomatic health conditions, and fear of being labeled with mental or medical conditions (Freudenberg, 2001). Yet, incarceration can be an ideal time to address acute and chronic health conditions such as diabetes, heart disease, and hypertension. Jail and prison inmates have a higher burden of chronic diseases such as hypertension, asthma, and cervical cancer than the general population (Harzke, et. al, 2010; Nijhawan, Sallowy, Nunn, Poshkus, & Clarke, 2010; Sered & Norton-Hawk, 2013). Incarcerated women identified with chronic medical and mental health diseases at intake/receiving screening require clinical management to reduce disease manifestation while optimizing treatment interventions. National Commission on Correctional Health Care (2008) defines chronic diseases as:

“An illness or condition that affects an individual's well-being for an extended interval, usually at least six months, and generally is not curable but can be managed to provide optimum functioning within any limitations the condition imposes on the individual” (para. J-E 04).

Incarcerated women with chronic conditions requiring disease-specific care by an expert are referred to as secondary care. If an incarcerated woman does not respond to secondary care intervention and requires hospitalization or higher levels of specialty care this is referred to as tertiary care. The levels of care and legal mandates determine the treatment interventions and method used to ensure optimum care is provided to incarcerated women (Zaitow, & Thomas, 2003).

Incarcerated women are at a higher risk for Hepatitis B Virus (HBV) infection through unprotected sex with HBV-infected persons, injection drug use, and shared close living quarters with other inmates infected with HBV. Over the last decade transmission of HBV and Hepatitis C virus (HCV) increased making it a significant concern (Macalino, Vlahov, Dickinson, Schwartzapfel & Rich, 2005) and an urgent public health issue. HBV prevalence has been found to be 36%, and HCV infection prevalence was 34% (Macalino et al., 2005) in this population of women. Among prison inmates, 16%–41% are infected with HCV, and 12%–35% are chronically infected compared to one percent to one and a half percent in the US population. Individuals who test positive for the HBV for more than six months are diagnosed as having a chronic infection. While some people are able to get rid of the virus within a few months, with others the HBV still remains in the liver and blood. This characterizes them as chronically

infected and requires additional precautions and treatment (CDC, 2011; Oser, Knudsen, Staton-Tindall, & Leukefeld, 2009).

Approximately four to six percent of the TB cases reported in the United States occur among people incarcerated at the time of diagnosis (CDC, 2012). Minority women inmates are at a greater risk for TB than the overall population because of the risk factors for incarceration, and the prevalence of HBV, HCV, HIV/AIDS and STIs. Evidence suggests that the epidemics of HIV, STIs, and HCV disproportionately affect minorities, particularly Blacks, who account for approximately 45% of new HIV infections annually and have an HIV prevalence rate seven times that of White Americans (Flanigan et al, 2010). Many of the women were diagnosed during their incarceration yet acquired HIV in the community where access to care and medication was a challenge. Once diagnosed the stigma attached to HIV may interfere with seeking treatment until the illness becomes acute. The women fear HIV confidentiality will not be being maintained while incarcerated. Support is provided through HIV education and prevention counsellors, mental health professionals, psychologists, and social workers (Moore, Stuewig & Tangney, 2013).

The Correction Department, Public Health Consultants, and CDC initiated a program to identify possible interventions to address health conditions for incarcerated populations. The objective was “to promote healthy sexual behaviors, strengthen community capacity, and increase access to quality services to prevent sexually transmitted diseases (STDs) and their complications” (CDC, 2013). Prevention methods were made available for the high-risk pre and post incarcerated through collaboration between the community (Department of Health and Health Care Providers) and jail linkage programs which are designed to help incarcerated individuals prepare to return to their local communities. The prevention methods included education, early detection (screening), and treatment.

Mental or behavior health conditions impact 73% of incarcerated women in state prison and 75% of incarcerated women in jails (James & Glaze, 2006). Prior to incarceration the women are exposed to various harsh situations, such as domestic violence, substance abuse and sexual abuse. Incarcerated women who emerge from these environments require services before, during, and after incarceration, which may include community psychological counseling for mental or behavioral health and services to decrease the risk of recidivism (Salem, et. al, 2013). Anxiety, worry, fear, and depression are common concerns for the population (Leigey & Hodge, 2012). When physical and mental health conditions co-present it is difficult to determine the appropriate diagnosis and treatment.

There are programs specifically designed to address minority incarcerated women, such as Project POWER, an HIV/STI prevention/intervention program for incarcerated women delivered across an eight-week period in ninety minute sessions, (Fasula et al., 2013). The sessions incorporated group discussion, games, video clips featuring previously incarcerated women, behavior modeling, and role-play. Project POWER, aimed at HIV-negative incarcerated women with short sentences, is an adaptation of Project SAFE, a small group intervention shown to be effective in reducing risky sexual behaviors and STI incidence among African American and Mexican American women in STI clinics. HIV/STI prevention tools should be gender-specific and consider race for incarcerated women important considerations for the success of health education programming (Fasula et al., 2013). Engaging incarcerated women in individual or group therapeutic recreation may help them to adapt to the norms of the prison environment, develop a sense of normalcy while incarcerated, productively express angst and move towards recovery.

Post-incarceration women may be in need of mental and physical health follow-up as well as childcare, prenatal care, housing, transportation, and a host of other needs. Unmet needs contribute to re-offending, homelessness, and rearrests (DiPetro and Klingenmaier, 2013). Collaboration or partnerships between correctional facilities and local health care providers to plan or provide services within correctional facilities as well as arrange follow up care in the community upon release is key to helping these women address their health care issues. Without additional services post release any mental health gains which have been made during incarceration may be lost.

Health Education Programs in Prison

Low-income and low-education are obstacles that most incarcerated women struggle with during their lifetimes (U.S. Department of Education, 2009). The educational attainment level of incarcerated men and women is much lower than the general population, with about 60% of America's prison inmates considered illiterate. The 2003 National Assessment of Adult Literacy (NAAL) survey found that 1% of prison women demonstrated proficiency compared to 14% of household women. Minorities had disproportionately higher rates of illiteracy. The NAAL survey, which measure prose, document and quantitative literacy scores at levels of below basic, basic, intermediate and proficient, indicated that 15% of incarcerated Blacks performed below basic category in prose literacy. In the general US population low literacy costs \$73 million per year in terms of direct health care costs (U.S. Department of Education, 2009). Low literacy creates barriers to access to care, adherence to medical treatments and diminished health. With regard to incarcerated persons, to obtain medical services inmates must write a request; this presents a barrier for those with the lowest literacy.

Educational strategies for incarcerated women start during the intake and orientation process, once the medical needs of the women have been identified. Mandatory health education sessions are held individually with health care providers or counselors as well as mandatory or voluntary workshops or group sessions (NCCHC, 2008). Facilitated group programming and educational interventions are effective practices for raising awareness and working with Latinas and Black women, these cultures have a strong emphasis on family structure and community and many minority women may find working with others similar to themselves socially empowering (van Wormer, 2010). A concern that educators must note is respect for privacy of the learner/inmate. Printed brochures and pamphlets detailing a condition may inadvertently identify an inmate who has a particular disease to others, therefore these types of materials should be provided to all inmates to prevent disclosing individual health conditions. General public health campaigns throughout the facility should however be considerate of the multi-ethnic, multicultural population. These campaign materials should use strategies to reach everyone in the population by incorporating different languages, education levels, and diverse images of people. Providing health education to inmates can improve their knowledge of their health conditions, and increase their health literacy which may improve the health related knowledge of their communities. Programs should be connected to outside entities to ensure continuity of care (Hall, Golder, Conley, Sawning, 2012; Hyams and Cohen, 2010; Sered & Norton-Hawk, 2013).

Several state correctional departments are making attempts at refining the care given to incarcerated women. The state of Massachusetts developed "The Women's Health Policy and Advocacy Program" to promote the highest standard health care for all women and influence state policy (Hyams & Cohen, 2010). Although most former and current inmates in Massachusetts were eligible for some subsidized care before and after incarceration, they did not obtain medical care because the women were not aware of the available services in the

community. Future health reform efforts should address access inside the prison system and post-incarceration support (Hyams & Cohen, 2010). In Baltimore, Maryland, the JEWEL (Jewelry Education for Women Empowering Their Lives) intervention geared toward women involved in illegal activity combines health education, skill building, and economic empowerment to reduce drug use, HIV, and STIs risk. Minority women are at increased risk for drug use, HIV and STIs and can benefit from being engaged in programs which can effectively address health needs, along with economic or personal needs. This program teaches women how to make and sell jewelry to increase their self-efficacy to promote employment and avoid criminal behaviors (Pinkham, Stoicescu, & Myers, 2012).

“Correctional facilities provide an ideal opportunity to access, engage, and retain some of the most high-risk individuals for HIV and STI prevention initiatives” (Fasula et al., 2013, p. 204). Evidence-based risk reduction programs, which take place over several sessions or weeks, require a high rate of attendance and program fidelity to be effective. Addressing the specific health concerns of incarcerated women is also a concern of the Canadian prison system, which implemented several collaborative community prison programs (Granger-Brown, Buxon, Condello, Feder, Hislop, et al, 2012). In British Columbia, Canada the minority women population consists of mostly Aboriginal persons. In an effort to address the health education needs of this population the Canadian correctional system has used holistic learning and healing workshops for Aboriginal women, taught by elders in the community (Granger-Brown, Buxon, Condello, Feder, Hislop, et al, 2012). This is an example of a collaborative prison-community program, which included health screening and education, therapeutic recreation, nutrition, and exercise, and mother-infant programs. Some of the health and nutrition programs were designed by the women granting them the opportunity to use initiative, and be self-directed learners.

Return to the Community

Incarcerated women can benefit from risk reduction services when implemented during incarceration, upon release, and with post release access to care (Fasula et al., 2013; Granger-Brown, Buxon, Condello, Feder, & Hislop, et al, 2012; Pinkham, Stolcescu, & Myers 2012). Access to medical care after incarceration is a concern for many incarcerated women. There is often limited access to routine medical care in their communities. Research reflects that early treatment interventions and continuity of care can create an enhanced quality of life for women throughout incarceration in jails or prisons and upon return to the community (Sered & Norton-Hawk, 2013). Bridge and linkage programs identify inmates with certain mental or physical health needs and assist them in returning to their local communities by providing them with resources, helping them set appointments prior to release, establishing treatment plans, and ensuring they have copies of their medical records. An effective example of these types of educative community services is The Jail Linkage Program in Florida that is a part of the Florida Department of Health’s Corrections Initiative focusing on HIV-infected inmates (Florida Department of Health, Bureau of HIV/AIDS, 2006). The Florida Department of Health defines linkage as active referrals and follow up. The Jail Linkage Program is a collaborative effort that connects incarcerated individuals with the Health Department in their respective counties. The programs in the various counties include counseling, disease prevention education, health screenings, and additional follow up services which include other needs such as substance abuse counseling, support groups, transportation and housing. This program is vital to the needs of minority women in Florida where in 2008, the AIDS case rate among Black women was 20 times higher than that among White women. Also HIV cases diagnosed among Hispanics in

Florida between 1999 and 2008 increased by 76% (Florida Department of Health, Bureau of HIV/AIDS, 2006).

Health education opportunities and learning while incarcerated impact the women's health decisions made upon release. Post release care is imperative because untreated communicable illnesses have a detrimental impact on the families or communities of the previously incarcerated, if not properly treated. In addition, there are costs to society when measures are not in place to ensure continuity of care, which include costs for repeated and ineffectual treatments and for repeated diagnostic testing (Sered & Norton-Hawk, 2013). Public health risks related to untreated infectious diseases and disrupted psychiatric treatments are also of concern upon release for previously incarcerated minority women. Referrals to treatment services on the outside, including self-help groups and medical health clinics, are vital to stability post release (van Wormer, 2010).

Conclusion

Implementation of easy health care access, health education programs and treatment interventions during and post incarceration allow incarcerated women an opportunity to maintain medical treatment practices and have positive health outcomes (Hyams & Cohen, 2010). Effective health education programs and access to health care may empower incarcerated women during and post incarceration. In 2014 the Patient Protection and Affordable Care Act (P.L. 111-148) will allow incarcerated women to obtain health insurance coverage and access to care upon return to the community thus increasing the likelihood for continuity of care.

Correctional facilities must implement policies and guidelines that address incarcerated women's health care needs. Educators and health providers should partner with substance abuse, community outreach, and counseling (individual or group) programs in an effort to minimize or eradicate health concerns. Evidence-based practice reveals that a health education approach and early intervention with treatment and access to care can enhance life while incarcerated and upon release (Sered & Norton-Hawk, 2013). Varied educational approaches are needed to reach minority women inmates who speak different languages, come from different cultures, and have varying education levels. The ability of correctional facilities to apply evidence-based cultural and ethnically aware health education practices is an important factor in minimizing or eliminating the physical and mental conditions of many minority women inmates. More research needs to be conducted on the effectiveness of programs offered by Correctional Health Services and other providers reflecting on questions such as: Do health education programs promote health and lifestyle changes in a culturally and ethnically aware manner? Do health education programs aid in reducing health disparities among minority women? What are effective means to address acute and chronic health care needs for minority women during incarceration and post release?

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