University of San Diego

Digital USD

Dissertations

Theses and Dissertations

2006-06-08

Healthcare Encounters of Formerly Incarcerated Women: A Grounded Theory Study

Karen Sue Hoyt PhD
University of San Diego

Follow this and additional works at: <https://digital.sandiego.edu/dissertations>

Part of the [Nursing Commons](#)

Digital USD Citation

Hoyt, Karen Sue PhD, "Healthcare Encounters of Formerly Incarcerated Women: A Grounded Theory Study" (2006). *Dissertations*. 336.

<https://digital.sandiego.edu/dissertations/336>

This Dissertation: Open Access is brought to you for free and open access by the Theses and Dissertations at Digital USD. It has been accepted for inclusion in Dissertations by an authorized administrator of Digital USD. For more information, please contact digital@sandiego.edu.

UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
DOCTOR OF PHILOSOPHY IN NURSING

HEALTHCARE ENCOUNTERS OF FORMERLY INCARCERATED WOMEN:
A GROUNDED THEORY STUDY

by

Karen Sue Hoyt

A dissertation presented to the
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirements for the degree
DOCTOR OF PHILOSOPHY IN NURSING

June 8, 2006

Dissertation Committee

Diane Hatton, DNSc, RN, APRN, BC, Chairperson

Susan Instone, DNSc, RN, CPNP

Dorothy Kleffel, DNSc, RN, MPH

ABSTRACT

The adult correctional population in the United States soared to nearly 7 million people (Bureau of Justice Statistics [BJS], 2005). Over 2 million individuals were housed in prisons or jails in the United States. Nearly 7 percent (6.9%) were women (BJS, 2005). Recent trends in the adult correctional population suggest that there has been a stark increase in the number of formerly incarcerated women in the United States.

The purpose of this research was to explore how formerly incarcerated women perceived their healthcare encounters. The aims of this study were to answer the following questions. How did formerly incarcerated women perceive healthcare encounters? How did they describe difficult healthcare encounters? How did they describe successful healthcare encounters? What did they suggest to improve healthcare encounters?

A grounded theory method was used. The study consisted of interviews with 16 formerly incarcerated women at two different sites. Perspectives on healthcare encounters by formerly incarcerated women were explored utilizing a combination of individual and focus groups interviews.

Findings revealed the core category of an action/process during encounters of “going back-and-forth” within the context of a fragmented healthcare system. Participants sought care for multiple health problems. They often lacked money, health insurance, literacy, and knowledge. These problems prevented them from achieving successful healthcare encounters where their needs would be met. Other barriers to successful encounters were a lack of disclosure and stigmatization that sometimes led to feelings of shame and poor self-esteem. When helpful others such as friends, nurses,

and/or caring providers were present, the participants experienced successful healthcare encounters where their needs were met. The findings also revealed that some women, through persistence, realized positive encounters even when no helpful others and/or caring providers were there to assist them.

This study was important because it generated a substantive explanation regarding the perspectives on healthcare encounters by formerly incarcerated women. This study has the potential for developing new knowledge to inform nursing. This research also affords healthcare providers an opportunity to improve the healthcare of formerly incarcerated women and their families.

© Copyright 2006

Karen Sue Hoyt

All Rights Reserved

DEDICATION

**To all the formerly incarcerated women
who live in our world at the margins.
May you continue to be persistent and unrelenting
in your pursuit of successful healthcare encounters
for yourselves and your children.**

ACKNOWLEDGEMENTS

Writing a dissertation is an arduous task. I would like to begin by thanking my Chair, Dr. Diane Hatton, one of my doctoral professors who spent many hours with me during the development and completion of this dissertation. Diane, thank you for helping me find my voice. I would also like to acknowledge Dr. Susan Instone, an insightful committee member. Susan, thank you for grounding me during the process. Last, but by no means least, I owe an enormous debt of gratitude to Dr. Dorothy Kleffel who assisted me throughout the process, but especially during the initial phase of the dissertation process. Dorothy, thank you for your patience and support. I would also like to acknowledge research assistant, and friend, June Green, who kept me sane during the focus group process. I am equally grateful to Carmen Warner-Robbins, Karla Lomillio, Rosalind Corbitt, and Amy Adaigo, individuals who helped me gain entrée to the participants interviewed for this study. I am grateful to my father who always encouraged me to believe in myself. I am most grateful to my mother who instilled in me the quest to be a life-long learner. Mom impressed upon me, at a very early age, the value and importance of education. I am also especially appreciative of my family members and all my relatives for their constant love and support during this journey. But, most of all, I will always be eternally grateful to my husband, Ken, who reflected on, pondered over, read, and edited *many* drafts of each chapter with me. I also owe a huge debt of gratitude to my PhD support group, Donna Agan, Rhoberta Haley, Karin Reuter-Rice, and Nancy Coffin-Romig. This process has truly opened my mind and my heart to the inequities and injustices faced by the courageous women that I interviewed for this study. Thank you all for raising my consciousness. I will forever be attentive to your plight in this world.

TABLE OF CONTENTS

ABSTRACT.....	iii
DEDICATION.....	vi
ACKNOWLEDGEMENTS.....	vii
LIST OF TABLES.....	xiv
LIST OF FIGURES	xv
Chapter 1	1
Introduction and Statement of the Problem	1
Purpose and Aims	1
Background and Significance	2
Theoretical Perspective: Symbolic Interactionism	4
Summary	6
Chapter 2	8
Review of the Literature	8
Correctional Terminology and Statistics	9
Correctional Estimates	9
Probation and Parole Estimates	10
Probation Discharges	11
Backgrounds of Incarcerated Women.....	12
Characteristics.....	12
Disparities Among Minorities.....	12
Maternal Incarceration and Pregnancy	13
Circumstances Prior to Arrest.....	14

Criminal/Offender Profiles and the Prison Environment.....	15
Types of Crimes Committed.....	15
Overcrowding and Confinement.....	16
Geographic Issues and Visitation.....	17
Reentry into the Community.....	18
Relapse and Rearrest.....	18
Reducing Recidivism.....	20
Reintegration.....	22
Health Status of Incarcerated and Post-Incarcerated Women.....	24
Health Status of Incarcerated Women	24
Health Status of Post-Incarcerated Women	27
Post-Incarceration Syndrome.....	27
Health Access Issues Among the Homeless	30
Access Issues Among Post-Incarcerated Women.....	32
Healthcare Encounters	32
Negotiated Symptom Management Model	34
Mutual Withdrawal	37
Encounters with Mainstream Healthcare Services	38
Intercultural Healthcare	39
Othering in Healthcare.....	40
Nurse-Patient Healthcare Encounters	42
Interpersonal Relationships and Healthcare Encounters...	43
How Women Perceived Prison Healthcare.....	45

Social Construction of Healthcare	46
Perceptions of Healthcare	47
Gaps in the Literature.....	48
Summary	49
Chapter 3	51
Method	51
Design	51
Individual Interviews: Definition and Purpose.	51
Focus Groups: Definition and Purpose	52
Rationale for Using Focus Groups.....	53
Setting	53
Sample.....	54
Data Collection Procedure	55
Consent Procedures and Demographic Form	55
Interviews and Questions.....	56
Interview Procedure	56
Focus Group Procedure.....	58
Research Assistant	58
Research Standards	59
Trustworthiness.....	59
Credibility	60
Reflexivity/Reflectivity.....	60
Protection of Human Subjects	61

Risks.....	61
Benefits	62
Remuneration.....	62
Data Analysis	63
Coding Process.....	63
Data Analysis Standards	64
Personal Context.....	65
Chapter 4.....	67
Findings.....	67
Composite Case Study	67
Demographics	70
Age.....	70
Number of Children	70
Incarcerations.....	70
Other Demographic Information.....	71
The Explanatory Model	75
Conditions – Barriers	75
Contingencies – Facilitators.....	75
Multiple Health Problems	76
Physical Problems.....	76
Psychiatric Problems.....	78
Alcohol Use	78
Dual Diagnosis.....	80

Dental Problems.....	84
Other Special Problems.....	87
Lack of Money.....	87
Lack of Literacy Skills.....	88
Mandated Encounters.....	89
Negative/Unsuccessful Encounters.....	90
Prison Encounters	90
Post-prison Encounters	92
Positive/Successful Encounters	101
Prison Encounters	101
Post-prison Encounters	103
Summary	108
Chapter 5	109
Discussion.....	109
Summary of Major Findings.....	109
Meaning of the Findings: “Going Back-and-Forth”	110
Limitations to Generalizability	112
Implications.....	112
Practice.....	112
Meeting Health Needs.....	112
Meeting Preventive Health Needs	114
Meeting Underlying Needs.....	114
Providing Competent and Compassionate Care	115

Education	115
Educating Formerly Incarcerated Women	115
Educating Nurses and Other Care Providers	115
Research.....	116
Policy	117
Conclusion	118
REFERENCES	119
APPENDICES	128
Appendix A: Sample Flyer – Site A	128
Appendix B: Sample Flyer – Site B.....	129
Appendix C: Consent Form – Individual Interviews.....	130
Appendix D: Consent Form – Focus Groups.....	132
Appendix E: Demographic Form.....	134
Appendix F: Interview Questions – Individual Interviews.....	136
Appendix G: Interview Guide – Focus Groups	137
Appendix H: Institutional Review Board Approval University of San Diego ...	138
Appendix I: Human Participant Protections Education for Research Completion	
Certificate - Researcher.....	139
Appendix J: Human Participant Protections Education for Research Completion	
Certificate – Research Assistant	140

LIST OF TABLES

Table 1: Comparison of Health Status of Inmates with the United States Population	25
Table 2: Incarceration History of Study Participants.....	71
Table 3: Demographic Characteristics of Study Participants	72
Table 4: Other Participant Demographics.....	73

LIST OF FIGURES

Figure 1: Perspectives on Healthcare Encounters by Formerly Incarcerated Women... 74

Chapter 1

INTRODUCTION AND STATEMENT OF THE PROBLEM

At mid-year 2005, the adult correctional population in the United States soared to a new record high of nearly 7 million people (Bureau of Justice Statistics [BJS], 2005) or 3.2% of all United States adult residents. One in every 31 adults was either in prison or in jail, on probation, or on parole. Over 2 million individuals were housed in prisons or in jails in the United States. Nearly 7 in 100 (6.9%) were women (BJS, 2005).

Recent trends in the adult correctional population have suggested a stark increase in the number of formerly incarcerated women in the United States. The number of women under the jurisdiction of state or federal prison authorities increased 4.0% from January 1, 2003 to December 31, 2004. (BJS, 2005).

According to the BJS (2004), the number of individuals on probation or parole was nearly 5 million people. Women made up 23% of the nation's probationers and 12% of the parolees (BJS, 2005). Therefore, as many as 1.1 million women have been on probation or parole in the United States (BJS, 2005).

Purpose and Aims

Formerly incarcerated women have had many needs after release from prison or jail. Some of the most important needs involved their physical and mental health. Many of the women left prison or jail with the same health problems with which they entered. Others acquired new health problems during incarceration. Additionally, many formerly incarcerated women continued to have chronic, long-term healthcare problems such as

mental health and substance abuse issues. For a myriad of reasons, these concerns were not addressed (National Institute of Corrections [NIC], 2003). What was not clear, was how, where, when, why, and even if formerly incarcerated women accessed healthcare services.

The purpose of this research was to explore how formerly incarcerated women perceived their healthcare encounters. The aims of this study were to answer the following questions. How did formerly incarcerated women perceive healthcare encounters? How did they describe difficult healthcare encounters? How did they describe successful healthcare encounters? What did they suggest to improve healthcare encounters?

Background and Significance

Formerly incarcerated women have experienced high rates of physical disease such as AIDs, asthma, diabetes, hepatitis, HIV, hypertension, STDs, and mental illness (National Commission on Correctional Health Care [NCCHC], 2002). Evidence has supported the premise that many formerly incarcerated women left prison with dual diagnoses, defined as a psychiatric illness and substance abuse diagnosis that may include both drugs and alcohol (Office of Women's Health [OWH], 2003). Disease prevalence rates were higher for post-incarcerated women than in the general population (Human Rights Watch, 2004; NCCHC, 2002). Untreated individuals with communicable diseases released back into society might transmit these diseases to other members in the community. This problem also burdened the public health system. Screening individuals, treating them, and even preventing illnesses provided better disease control, improved

healthcare, and was cost effective. Evidence suggested that better health outcomes might contribute to reduced recidivism (Richie, 2001).

Women often continued to be the primary care givers of their children post-incarceration (Enos, 2001) and had the responsibility for their children's healthcare as well as their own (Luke, 2002). Therefore, the health of millions of children has also been at stake when the women were released from prison or jail. The same issues regarding disease control, healthcare outcomes, and cost effectiveness applied to the children of formerly incarcerated women.

Although the healthcare needs of incarcerated women was the focus of many federal agencies such as the OWH and the NCCHC, the healthcare needs of post-incarcerated women continued to be underappreciated (O'Brien, 1998). The focus of the NCCHC (2002) report was to improve the health status of soon-to-be-released prisoners. The study demonstrated that by improving the health of incarcerated individuals, public health also benefited through a decrease in the transmission of communicable diseases and a subsequent reduction in costs to the public in treating these diseases. The major limitation of this report was that it offered few, if any, practical strategies on how this group might obtain healthcare. In addition to access, the effectiveness of the healthcare encounter, both clinically and interpersonally, was another obstacle to the delivery of quality care (Campbell, Roland, & Buetow, 2000).

This problem was important to address as the over 1 million women who were formerly incarcerated had significant healthcare needs (BJS, 2004). Formerly incarcerated women merited adequate healthcare services. According to the United Nations Universal Declaration of Human Rights (1948), "Everyone has the right to a

standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (Article 25, p. 5).

Furthermore, women facing reentry into the community might have urgent and immediate healthcare needs if their needs were never addressed during incarceration (Young, 2000). The anecdotal experiences of this nurse researcher also supported that observation. As formerly incarcerated women reentered and transitioned back into society, nursing has had the opportunity to influence their healthcare. Nursing has been, at times, one of the only healthcare professions that might interact with formerly incarcerated women in healthcare settings. Therefore, nurses have needed to acquire knowledge and information about the healthcare encounters of post-incarcerated women to provide high quality healthcare.

Although several authors have emphasized the imperative to address issues outside of prison or jail (Bloom & Covington, 2003; Greer, 1998; O’Brien, 2001; Maeve, 2001; Richie, 2001) and other authors described the healthcare perceptions of incarcerated women in prison (Robbins, 1999; Young, 2000), there was no literature that specifically explored how formerly incarcerated women perceived healthcare encounters. Thus, the researcher sought out this area of research investigation.

Theoretical Perspective: Symbolic Interactionism

Symbolic Interactionism was the perspective that informed the researcher’s understanding of how formerly incarcerated women perceived healthcare encounters. Symbolic interactionism was based on pragmatism, concentrating on *action* rather than

on what individuals *were* as individuals or groups (Charon, 2004). It was from a consistency in *action* over time, that social scientists were able to infer personality. Society is any instance of social interaction where actors have cooperated over time and developed culture (Charon, 2004).

According to Blumer (1969), the term symbolic interaction referred to interactions that took place between human beings. Human beings *interpreted* each other's actions instead of just *reacting* to them. Individuals' *responses* were not made directly to the actions of one another. Instead, they were based on the meaning they attached to such actions. "This mediation is equivalent to inserting a process of interpretation between stimulus and response in the case of human behavior" (p. 180). In this study, it was assumed that formerly incarcerated women would interpret their healthcare encounters. They would bring meaning to these encounters based on the meanings they attached to past encounters.

Symbolic interactionism purported that individuals possessed a self and that self was described as an object of the actor's own action. In other words, the self was a social object and individuals were objects of their own actions. Individuals engaged in "mind action" or what might be called an inner dialogue (Mead, 1934, p. 107). Charon (2004) remarked that individuals regularly took on the role of the other. Symbolic interactionism addresses the notion that individuals proceeded along a complex and continuous path of action and it took into account the premise that individuals interacted with one another.

Human interaction was symbolic and people were symbol users. Individuals lived in a world of meaning created by those symbols (Blumer, 1969). Healthcare encounters were associated with a variety of activities, each with different meanings, including

getting health needs met, obtaining prescriptions, seeking counseling, or obtaining healthcare service referrals. The symbolic meanings associated with healthcare encounters affected how formerly incarcerated women thought about themselves, related to others, and how others thought and related to them. How formerly incarcerated women initiated or avoided a healthcare encounter, experienced the encounter, and decided whether or not a healthcare encounter met their needs, had to do with social and cultural learning. It also had to do with the *meanings* transmitted in settings such as the healthcare encounter. These meanings associated with healthcare encounters influenced the initiation and interaction of these encounters.

Utilizing symbolic interactionism as the theoretical framework to study the healthcare encounters of formerly incarcerated women was a natural fit. This theoretical framework guided the structure and order of the interview questions and was utilized to explore the perceptions, perspectives, and points of view of formerly incarcerated women in healthcare encounters.

As the number of incarcerated women rose, the number of women reentering the community after incarceration also increased. Formerly incarcerated women suffered from a host of healthcare problems such as AIDs, HIV, Hepatitis C, psychiatric illnesses, substance abuse, diabetes, asthma, and hypertension because these diseases might be poorly managed in prison or jail. Healthcare post-incarceration was important for a woman, her family, and the community.

Summary

In summary, the focus of this grounded theory study was to explore how formerly incarcerated women perceived healthcare encounters. This study consisted of interviews

with 16 formerly incarcerated women and explored their perspectives on healthcare encounters through individual and focus group interviews. Findings revealed that the women had many conditions that posed obstacles for them. During their healthcare encounters the women described an action or process of “going back-and-forth” within the context of a fragmented healthcare system. At times, the women experienced negative encounters where their needs remained unmet. In some cases, they had mandated encounters, such as drug testing that they deemed as neutral. In other instances, they deemed their encounters as positive. Their needs were met by helpful others and/or caring providers. Finally, through persistence some of the women realized successful encounters and their healthcare needs were met.

Chapter 2

REVIEW OF THE LITERATURE

The literature search included studies published from 1980 to May 2006. Key search words included incarcerated women, women in prison, women in confinement, imprisoned women, women offenders, women in correctional facilities, women in the criminal justice system, relapse, rearrest, reincarceration, recidivism, reentry, post-incarcerated women, formerly incarcerated women, women's health, women's healthcare, women's health status, women's health services, women's health behaviors, women's attitudes toward health, women's barriers to health/healthcare/health services, patient acceptance of health access, health accessibility, health utilization, health in prison, health access in prison, post-incarceration and health, incarcerated women and health, formerly incarcerated women and health, homeless and health/health status/access, vulnerable populations and health/health status/access, minorities and health/health status/access, ethnic groups and health/health status/health access, encounter, healthcare encounter, healthcare perceptions, healthcare experiences, healthcare interaction, healthcare relationship, healthcare negotiation, healthcare visit, primary healthcare visit, ambulatory care visit, emergency department healthcare visit, quality of care/services, and patient-provider relationships.

The literature review in this paper is divided into several sections. The first section provides information on correctional terminology, statistics, and estimates. The second section presents background information on incarcerated women. The third

section covers criminal/offender profiles and the prison environment. The fourth section discusses women's relapse, rearrest, reincarceration, recidivism, and reentry issues. The fifth section discusses the health status of incarcerated and post-incarcerated women and health access issues. The sixth section defines encounters and healthcare encounters, discusses perceptions and experience regarding healthcare. The seventh section describes how women perceived prison healthcare. The last section discusses the gaps in the literature.

Correctional Terminology and Statistics

The adult *correctional* population in the United States includes men and women incarcerated in prisons, jails, and those on probation and parole (BJS, 2005). The term *prison* generally refers to a place where individuals are imprisoned for greater than one year (BJS, 2004). The term *jail* refers to a local facility in a city or county that houses individuals in custody before they are tried at a hearing or those who have been sentenced for committing a crime and are serving time usually under 1 year (Cooke, 2002) but may involve up to 2 years in jail (Maeve, 2001).

Parole is defined as a period of conditional supervised release following a prison term (BJS, 2004). *Probation* is defined as the period of supervision in the community following conviction (BJS, 2004). Probation is usually an alternative to prison that may or may not involve time in jail (Cooke, 2002).

Correctional Estimates

Notably, the female incarceration population increased faster than the male incarceration, up 4% from 2003 to 2004, and accounted for 6.9% of all inmates (BJS, 2005). The number of women in state and federal prisons increased from 100,384 to

103,310 (BJS, 2004). Since 1995, there was an increased growth rate in the number of female prisoners at an average increase of 5% per year in contrast to the increased growth rate in the number of male prisoners of 3.3% per year (BJS, 2004). At midyear 2004, the Nation's jails housed 784,538 individuals and over 12% were females (BJS, 2004). The number of individuals in county jails across the United States rose by 22,700 in the 12-month period from June 20, 2003 to June 30, 2004 (BJS, 2004).

At midyear 2004, California, Texas, and Florida housed 4 out of every 10 female prisoners in the United States (BJS, 2004). California had the largest women's prison population in the United States with over 11,000 female inmates (California Coalition for Women Prisoners, 2003). Thousands of women were serving mandatory sentences in California's prisons and jails because of the "three strikes" and "zero tolerance" policies (California Coalition for Women's Prisoners, 2003). The number of women in prisons and jails in the United States increased dramatically, primarily due to nonviolent crimes such as drug abuse (BJS, 2004).

Probation and parole estimates. The number of adult men and women in the United States who were being supervised on probation or parole at the end of 2004 reached a new record high of more than 4.9 million people (BJS, 2005). At the beginning of 2004, 4 million adults were on probation (BJS, 2004). The adult probation population increased by almost 50,000, slightly less than one-half the average annual growth of nearly 3% since 1995 (BJS, 2003).

Nearly three-quarters of a million adults were on parole in 2003 and the parole population increased by 3.1% to nearly 24,000 men and women in 2003 (BJS, 2004). This represents almost double the average annual growth of 1.7% since 1995 (BJS,

2003). Over 3% of the adult population in the United States or 1 in every 32 persons was in prison, on probation, or on parole in 2003 (BJS, 2003).

According to the BJS (2004), women comprise 23% of all adults on probation or parole. More than 1 million of the probationers and parolees were either California or Texas (BJS, 2003). Of the total number of probationers, 50% are white, 30% are black, 12% are Hispanic, and 8% are from other races (BJS, 2003).

Probation discharges. Over 470,500 parolees were discharged from correctional supervision in 2003 (BJS, 2004). In 2003, of those in the community who were on parole, 13% were females (BJS, 2004). The Department of Justice reported that, of the nearly 2.2 million probationers discharged from supervision during 2003, three out of every five adults successfully met the conditions of their correctional supervision (BJS, 2004). About 83% of all parolees were under active supervision and were required to contact a parole authority in person, by mail, or by telephone on a regular basis (BJS, 2004). Forty-seven percent met the conditions of their supervision (BJS, 2004). Thirty-eight percent re-entered prison due to a new sentence or a rule violation. Nine percent absconded (BJS, 2004). It was reported that recently paroled women might even provoke a prison arrest, create additional jail time, or establish a new conviction record as a way to obtain the external supports of food, shelter, and safety since they could not make it on the outside (Bradley & Davino, 2002; Greer, 1998).

This review of correctional estimates revealed that women, when compared to men, were the fastest growing incarcerated population in the United States (BJS, 2004). At the same time, nowhere was the marginalization of women more tragic than in the prisons and jails of the United States (Beck, 2000). Thus, it was critical that society, and

specifically nursing, acknowledge these issues and address them (Maeve, 2001; Cooke, 2002).

Backgrounds of Incarcerated Women

Characteristics

Researchers noted that average age of an incarcerated woman in the United States was 36 years old (Center for Law and Social Policy, 2002). Incarcerated women were disproportionately African-American or Latina. They were poor, earning less than \$10,000 in the year prior to incarceration. They committed a nonviolent crime such as drug abuse (Jane Addams Center for Social Policy and Research, 2004; NIC, 2003). Three quarters (75%) of the women were not high school graduates and nearly one-half (49%) of the women were unemployed in the year prior to incarceration (Jane Addams Center for Social Policy and Research, 2004; NIC, 2003). Seventy to 85% had substance abuse histories prior to incarceration and 90% had been jailed for another offense prior to incarceration (Jane Addams Center for Social Policy and Research, 2004; NIC, 2003). Additionally, some of the women were estranged from their children and family members prior to arrest and many demonstrated poor relational skills with others ((Jane Addams Center for Social Policy and Research, 2004; Maeve, 2001).

Disparities among Minorities

At midyear 2004, whites comprised 44.4% of the jail population, while blacks made up 38.6%, and Hispanics made up 15.2% of the jail population in the U.S. (BJS, 2004). Other races such as Asians, American Indians, and Pacific Islanders made up only 1.8% of the jail population in the United States (BJS, 2004). Nearly 6 out of 10 inmates were a racial or ethnic minority (BJS, 2005). Therefore, minorities were

disproportionately imprisoned and people of color were incarcerated more frequently for the crimes they committed (BJS, 2004). When compared to Caucasians, African-Americans were given longer sentences for comparable crimes (BJS, 2004).

African-American women in the United States were also the fastest growing minority population of incarcerated women (BJS, 2004) and recent data revealed that 51% of the women in American prisons were African-American (BJS, 2003). This group was seven times more likely than Caucasian women to be incarcerated (BJS, 2003). African-American women were also more likely to be the subject of racial violence, physical assault, and sexual abuse by older female prisoners and male guards (Davis, 2000). Many of these abuses resulted in physical injuries, mental illness, pregnancy, and other types of maltreatment while they were in prison (Davis, 2000).

Maternal Incarceration and Pregnancy

Women under supervision by justice system agencies were mothers of an estimated 1.3 million minor children (BJS, 2003). Other reviews of women in prison report that up to 90% were single mothers (Chesney-Lind, 1998). Recent estimates revealed that 59% of women in federal prisons had at least one child under the age of 18 years; 44% of incarcerated men had at least one child less than 18 years (BJS, 2003). Nearly two-thirds (65%) of women in state prisons had minor children while approximately three-fourths (70%) of women in local jails had children under the age of 18 (BJS, 2003). Over two-thirds (64%) of women resided with their children prior to incarceration (BJS, 2003).

One-fourth of all female prisoners were pregnant or gave birth to a baby within the past year (Siefert & Pimlott, 2001). More than 1,300 children were born in prison

annually in the United States (BJS, 2003). In many states in the U.S., babies were taken away from their mothers immediately after the infant's birth. Some drug-dependent pregnant women were imprisoned or jailed to protect the health of the fetus. These neonates were born to mothers in jail or prison. Both could have serious medical conditions such as HIV or AIDS. Other newborns were born addicted to drugs or acquired fetal alcohol syndrome (BJS, 2003). Some of these infants were taken into state custody immediately after birth and became wards of the court while other infants were placed for adoption (Siefert & Pimlott, 2001). Depending on the circumstances, some infants of imprisoned mothers were adopted by other family members, relatives, or friends (Enos, 2001). Other infants spent their childhood years moving from one foster care home to another since it was extremely difficult to place children with chronic, long-term disabilities (Enos, 2001). Many mothers had difficulty connecting with their families when they left a correctional facility and found that resuming the role of mother was one of the most challenging of all of their reentry issues (Maeve, 2001; Richie, 2001).

Circumstances Prior to Arrest

Incarcerated women were twice as likely to come from a single parent home when compared to women in the general population (BJS, 2003). When compared to over one-third (37%) of incarcerated males, nearly half (47%) of incarcerated women had at least one family member who was currently in prison or had been incarcerated (BJS, 2003). Additionally, 33% of female prisoners and 25% of male prisoners reported that a parent or guardian abused alcohol and/or drugs in the home (BJS, 2003). Furthermore, physical and sexual abuses were also reported in the incarcerated women's population (BJS,

2003). Over one-half (57%) of women in state prisons for violent crimes reported they were abused as a child and/or adolescent and this abuse was cited as primarily physical and/or sexual abuse (BJS, 2003). One-third of incarcerated women reported abuse by an intimate partner at some time in their life (BJS, 2003).

Criminal/Offender Profiles and the Prison Environment

Types of Crimes Committed

Over two-thirds (70%) of women in state prisons were serving sentences for non-violent offenses (BJS, 2004) such as fraud, property damage, prostitution, and drug use (BJS, 2004). Over one-third (38%) of the incarcerated women's population were currently serving time for a drug offense (BJS, 2004). The number of women sent to jail for a drug offense was even higher and, although jail time did not always lead to prison time, many women eventually served prison terms if the addiction became more serious. These circumstances resulted in the committing of other crimes such as stealing to obtain money for drugs. These crimes led to arrest and conviction (Maeve, 2001).

Women's imprisonment for drug offenses in the "war on drugs" substantially increased over the past decade, nearly doubling the female inmate population (BJS, 2004). One-half of the women offenders in the state prison system also used alcohol, drugs, or both at the time of their offense (BJS, 2003).

Women were also imprisoned for violent crimes such as assault and murder. With over 2 million violent offenders in the United States, women accounted for approximately 15 to 20% of the violent offenders (BJS, 2004). Over one-fourth (28%) of the violent female offenders were juveniles (BJS, 2004). This violence may be the result of a dysfunctional family unit and may include substance abuse issues in the family

(Maeve, 1999; Maeve, 2000). Two-thirds of women imprisoned for violent offenses targeted someone with whom they were acquainted. This group was twice as likely as their male counterparts to target someone close to them (BJS, 2003).

Overcrowding and Confinement

Prison facilities inadequately cared for the increasing numbers of incarcerated women, as many of these facilities were originally created only for men (Amnesty International, 2004). The increased number of women prisoners due to the war on drugs led to overcrowding in the prisons (NIC, 2003); the United States appeared on the list of overcrowding offenders (Human Rights Watch, 2004). Even with multi-million dollar expansion programs such as those in California, prison facilities were insufficient to keep pace with the growing population of women convicted of crimes (Herivel & Wright, 2003). Overcrowding resulted in space constraints leading to violence in prisons and jails (Herivel & Wright, 2003). Increases in sanitation issues led to health problems including susceptibility for diseases such as communicable diseases like tuberculosis where prisoners were in close proximity to each other (NCCHC, 2002). Overcrowding may contribute to other health problems such as Hepatitis C, HIV, and STDs (NCCHC, 2002). Overcrowding may also result in human rights violations and abuse (Herivel & Wright, 2003). Overcrowding ultimately led to increased costs for inmates' medical care (Herivel & Wright, 2003).

In addition to the overcrowding, prisoners who committed harsh crimes such as murder were sometimes placed in more restrictive prison areas. These areas of confinement, known as super maximum facilities, confined prisoners for up to 23 hours per day in a cell (Human Rights Watch, 2004). Placing inmates into these cells could

result in serious physical problems such as sensory deprivation and dehydration and mental health problems such as depression, suicidal ideation, and even death (Human Rights Watch, 2004). Although few imprisoned women were confined to super maximum prisons, super maximum facilities violated the human rights of prisoners (Human Rights Watch, 2004).

Geographic Issues and Visitation

Historically, the United States had fewer women's prisons than men's prisons since fewer women than men were incarcerated (Chesney-Lind, 1998). The United States had over 100 female correctional institutions and although this was a 46.5% increase in correctional facilities for women over the past two decades, imprisoned women were still more likely than men to be incarcerated farther away from their homes (Chesney-Lind, 1998). More than half (60%) of imprisoned mothers lived over 100 miles from their children creating problems for visitation (Chesney-Lind, 1998). Distance from prison was listed by nearly one-half (43%) of incarcerated mothers as the primary reason why they had either infrequent or no visitation with their children (Chesney-Lind, 1998). Furthermore, some prisons and jails did not allow dependent children, those younger than 18 years of age, to visit a parent in a correctional facility. Moreover, when these children did get to visit a parent, the length of time of the visit is severely restricted (Maeve, 2001).

In summary, incarcerated women navigated through a prison system fraught with issues including overcrowding, confinement, and geographic problems, resulting in decreased visitation. To add to their plight, they also grappled with the issues of reentry into the community after incarceration. These overwhelming, and at times

insurmountable, circumstances were the reasons often given by this group as to why they relapse and recidivate. These situations sometimes lead to re-arrest and reincarceration.

Reentry into the Community

Relapse and Rearrest

Women released from correctional facilities faced a myriad of reentry issues as they transitioned back into the community. Several authors stated that the first few hours after release from prison or jail were the most crucial time for predicting whether or not a post-incarcerated woman would relapse and use drugs. This circumstance sometimes resulted in a return to prison or a life of recovery (Maeve, 2001; Richie, 2001; Travis, Solomon, & Wahl, 2001).

Another issue that led to relapse was the lack of oversight of women following incarceration. Due to the increased numbers of post-incarcerated women, less parole, probation, and other corrections officers were assigned to follow women after release from prison or jail (Maeve, 2001). While women who were released from prison were usually assigned a parole officer, women who were released from jail were rarely assigned a corrections officer (Maeve, 2001; Petersilia, 2001). This situation resulted in a lack of oversight and poor supervision, and led to rearrest for a similar crime or arrest for a new crime. These circumstances led to a prison sentence rather than a shorter jail term (Maeve, 2001).

Many of the barriers women faced were generally related to their status as women (NIC, 2003; Covington, 2004). Other authors noted that formerly incarcerated women had issues with stigma after they left prison or jail (Greer, 1998; O'Brien, 1998; O'Brien, 2001; Covington, 2004). In addition to managing stigma issues, women dealt with the

individual-level characteristics of being single parents and of having decreased economic potential due to their lack of education and training (NIC, 2003). At the system-level, post-incarcerated women lacked specific integrated services. These services focused specifically on women, such as wrap-around programs. These services incorporated a holistic and culturally sensitive plan that drew upon a coordinated continuum of services in the community. Without services that were more amalgamated and follow-up plans that were more comprehensive, these newly released women were at risk for rearrest (NIC, 2003).

According to the Bureau of Justice Statistics (2003), the three largest predictors of rearrest were: (a) being unemployed in the year prior to arrest, (b) having a previous history of a psychiatric hospitalization, and (c) having a prior arrest. Substance abuse was another major problem (BJS, 2004). This research had implications for formerly incarcerated women since many women had difficulty finding employment post-incarceration (O'Brien, 2001). For women who did locate employment, maintaining a job was difficult when illness was present. Some women also had psychiatric needs that were never addressed in prison or jail (Maeve, 2001). Some of these circumstances led to rearrest (Jane Addams Center for Social Policy and Research, 2004).

One study described formerly incarcerated women's risk for rearrest. Seventy-eight women in Rhode Island who were considered high risk for reincarceration and for HIV were assigned to the Women's HIV/Prison Prevention Program (WHPPP). Data were obtained from chart reviews and the prison database. Data were also obtained from a questionnaire administered to each woman regarding their individual needs prior to prison discharge (Vigilante, et al., 1999). More than half (55%) of the women in the

study were of minority status. Reductions in recidivism were found to be significant when: (a) there was continuity of care and women were assigned to the same primary care physician and social worker), (b) women were provided with peer counseling, and (c) they received an individualized discharge plan. Therefore, key findings were that recidivism might be decreased with comprehensive care, counseling, and a specific plan of care for each client (Vigilante, et al., 1999).

O'Brien (1998) reported on the issues and needs of formerly incarcerated women as they reentered the free world. Three overarching themes were expressed in the narratives of 18 recently released incarcerated women. The women identified the importance of: (a) basic survival needs, (b) internal assessment and choice-making, and (c) women's wisdom. Concrete survival meant having a place to go after prison such as transitional housing. Internal assessment and choice-making referred to how women reflected on the ways they would need to present themselves in the larger community including their post-incarceration behavioral choices (O'Brien, 1998). Women's wisdom referred to recognizing each incarcerated women's growth potential through self assessment and goal setting, sheltering them from the storm of prison by providing them with information and a protected environment, and by assisting them with rebuilding a web of connection through a support system and network of services as they transition back into the community. If all these conditions were met, relapse and recidivism were reduced (O'Brien, 2001).

Reducing Recidivism

Other researchers noted strategies for reducing recidivism. First, post-incarcerated women must establish an appropriate plan with their parole officer to fulfill the

conditions of their parole (O'Brien, 2001) and the conditions of parole mandate that this group recover from substance abuse to prevent relapses (Maeve, 2001; O'Brien, 2001; Richie, 2001). Second, women must locate employment and housing. Third, they might have to restore relationships within their role as a family member including regaining custody of their children upon release from jail or prison (Maeve, 2003; California Coalition for Women Prisoners, 2003; O'Brien, 2001; Richie, 2001). Fourth, the women were required to develop new social networks that incorporate non-criminal attitudes and behaviors after release such as making decisions regarding leaving significant others (Greer, 1998; O'Brien, 1998, Maeve, 2001; Richie, 2001). Each one of these tasks was overwhelming for women newly released from jail or prison. However, these tasks were not as daunting if the appropriate resources and support systems were available to formerly incarcerated women.

One example of a successful program to reduce recidivism was contained in The Safer Foundation Report Council of Advisors to Reduce Recidivism through Employment (CARRE, 2002). CARRE suggested strategies for reducing barriers to unemployment for women ex-offenders by mapping their road to reintegration. Key recommendations from this report were to: (a) support families, (b) improve access to safe, decent, and affordable housing for female ex-offenders and their families, (c) assist with the reconstruction of relationships, (d) address stigma management and elimination, (e) increase the odds for women to secure employment, and (f) address substance abuse addiction / convictions on the way to employment. Therefore, reducing recidivism by supporting formerly incarcerated women and their families, providing economic support including housing, and assisting with education and job training were ways in which

communities supported successful transitions and made reentry into the community an achievable goal.

Reintegration

Many formerly incarcerated women did not achieve successful reintegration into the community. In a landmark study by Maeve (2001), the author discovered that, for the most part, women failed at attempts of successful reintegration back into the larger society. Key findings were that women experienced an “onward and downward momentum of health indices (or devolution) with regard to economic status, general social functioning, intimate and family relationships, and physical and mental health status” (Maeve, 2001, p. 143).

The devolution of economic status occurred when women had no money to pay for housing, pay bills, or pay back fines. This circumstance was listed as the number one issue leading to recidivism for this group of post-incarcerated women studied. Economic status also referred to the inability to make money such as a lack of employment due to lack of training and education.

The onward and downward momentum of intimate and family relationships referred to the poor relationships that formerly incarcerated women had with their own mothers, their children, their family, and others. Many of the women had strained relationships prior to being in jail.

The concerns regarding general social functioning referred to the “social paralysis” that women experienced after release from jail (Maeve, 2001, p.161). Women stated they were caught off guard since they were released at odd hours of the day, usually between 10:00 p.m. and 6:00 a.m. They had no means of transportation and also

had no place to go. Other problems with reentry were women's inability to understand various social systems such as corrections, social security, welfare, school, and healthcare. This lack of ability to navigate and negotiate various systems in the larger society became a contributing factor to relapse, recidivism, and ultimately, rearrest and conviction.

The problems surrounding physical and mental status referred to the lack of resources for formerly incarcerated women. Three specific areas problems identified were: (a) gynecologic infections, (b) painful dental conditions, and (c) the need for mental health treatment or counseling. Other researchers who explored the reentry experiences of post-incarcerated women reached similar conclusions (Greer, 1998; Richie, 2001; Travis, Solomon, & Wahl, 2001).

In summary, the literature suggested that some women might never make a successful transition back into society (Greer, 1998; Maeve, 2001; Richie, 2001; Travis, Solomon & Wahl, 2001). On the other hand, other researchers suggested that this group might be successful in society if they had fewer obstacles, received integrated services including healthcare services, and had individual, family, and community support (O'Brien, 1998; O'Brien, 2001; Covington, 2004). Greater access to programs such as back-to-work, back-to-school, occupational therapy, and counseling programs were needed to become the number one priority for correctional facilities (O'Brien, 2001; Covington, 2004). Offering these services after release from incarceration must then become the larger community's agenda (O'Brien, 2001; Covington, 2004). Furthermore, by establishing these programs in prison, women released back into society may have had greater opportunities for success in dealing with circumstances surrounding post-

incarceration (O'Brien, 2001; Covington, 2004). On a larger scale, all levels of government must work toward less restrained conditions in the current correctional facilities (Human Rights Watch, 2004). Furthermore, society needs to work towards decreased periods of incarceration as the overall goal (Figueira-McDonough & Sarri, 2002; Herivel & Wright, 2003; Human Rights Watch, 2004). Ensuring that these barriers are overcome may prevent relapse and recidivism in formerly incarcerated women. Assisting these with their needs, in particular, their healthcare needs are perhaps the important consideration if women are going to make it on the outside.

Health Status of Incarcerated and Post-Incarcerated Women

Health Status of Incarcerated Women

Women who entered prison or jail had health issues that were usually not adequately addressed prior to their incarceration (Maeve, 2001; NCCHC, 2002). When women entered prison, they may have had the same types of physical illnesses as the general population such as asthma, diabetes, hypertension, but their prevalence rates were higher when compared to the U.S. population (see Table 1). For example, women had sexually transmitted diseases (STDs), such as gonorrhea and chlamydia (NCCHC, 2002). Approximately 3.5% of women in state prisons were HIV positive (NIC, 2003) and many were positive for hepatitis C (NCCHC, 2002). The incidence of HIV and AIDS in the prison population was seven times that of the general population (Cooke, 2002).

Table 1

Comparison of Health Status of Inmates with the United States Population

CATEGORY	CONDITION	PREVALENCE COMPARED TO U.S. POPULATION
Infectious Diseases	Active Tuberculosis	4X greater
	Hepatitis C	9-10X greater
	AIDS	5X greater
	HIV Infection	8-9 greater
Chronic Diseases	Asthma	Higher
	Diabetes/Hypertension	Lower
Mental Illness	Schizophrenia or other psychiatric disorder	3-5X greater
	Bipolar (depression) disorder	1.5-3X greater
	Major Depression	Equivalent
Substance Abuse and Dependence	Alcohol dependence	25% fit CAGE profile
	Drug Use	83% prior to offense; 33% at time of offense

Note. CAGE: Self-Report of Alcohol Assessment, C = Concern, A = Annoyed, G = Guilt, E = Eye Opener.

Adapted from BJS, 2004; NCCHC, 2002; NCJ, 1999.

One researcher's study of 14 women in the southeastern United States found that drug use was the number one health issue for incarcerated women (Maeve, 2001). This study examined women's health and social experiences following release from jail, using participatory action research and critical hermeneutic data analysis techniques.

In another study by Fickenscher, Lapidus, Silk-Walker, and Becker (2001) to assess the prevalence of behavioral risk factors and correlates of poor self-reported health, the authors noted that recently incarcerated women in the Oregon County Jail reported that they traded sex for money or drugs 43% of the time, had a history of intravenous drug use 50%, had a history of sexual 67% of the time, and had been physically abused 79% of the time. Additionally, two factors were associated with poor self-reported health and they included a history of physical assault and the use of heroin during the month prior to arrest (Fickenscher, Lapidus, Silk-Walker, & Becker, 2001).

Other researchers noted that women who were incarcerated sought out healthcare infrequently (Cooke, 2002) due to scheduling conflicts, limited access to healthcare providers, and, in emergency situations, lack of transportation from rural prisons to urban hospitals (NIC, 2003). The women usually had chronic physical problems (NCCHC, 2002) and it was estimated that 20% to 35% of women in prison went daily to sick call (NIC, 2003).

Women in prison also have mental health issues (Cooke, 2002). It was estimated that 25% of all women in state correctional facilities have been diagnosed with a mental illness including depression, post-traumatic stress disorder, and substance abuse (NIC, 2003). Additionally, there was evidence to support the fact that nearly 75% of incarcerated women had dual diagnoses, which is defined as a serious mental illness or

psychiatric diagnosis with a concurrent substance abuse diagnosis that may include both drugs and alcohol (Madeline, 1997; NIC, 2003; OWH, 2003). Two-thirds of incarcerated women were in need of psychiatric services at or soon after their initial incarceration (Pomeroy, Kiam, & Abel, 1998). Surprisingly, only 23% of all women in state prisons were on psychiatric medication (NIC, 2003).

Health Status of Post-incarcerated Women

There is a paucity of literature regarding the health status of post-incarcerated individuals. Several studies have identified a cluster of symptoms in the formerly incarcerated population known as post-incarceration syndrome (Gorski, 2000). The concept of a post incarceration syndrome has emerged from clinical consultation work with criminal justice system rehabilitation programs working with currently incarcerated prisoners. This concept has also appeared with the formerly incarcerated who have entered addiction treatment programs and community mental health centers (Gorski, 2000).

Post-incarceration syndrome. Post-Incarceration Syndrome was a physiological and psychological syndrome that occurred primarily in inmates subjected to prolonged solitary confinement. However, this syndrome was also found in individuals who were afforded little opportunity for advancing education, learning new skills or taking job training, or participating in rehabilitation programs. Post-incarceration syndrome included five major symptoms: (a) institutionalized personality traits and learned helplessness, (b) Post Traumatic Stress Disorder from both pre-incarceration and institutional trauma, (c) Antisocial Personality Traits acquired as a coping mechanism in response to institutional abuse known as the predatory prisoner environment), (d) Social-

Sensory Deprivation Syndrome where there is limited social contact and sensory stimulation, and (e) substance use disorders (Gorski, 2000). Post-incarceration syndrome co-existed with affective and personality disorders and in those with substance abuse.

One researcher purported that post-incarceration syndrome will continue to occur as long as there are extended periods of incarceration and more restrained conditions in correctional facilities. Unless this syndrome and the underlying illnesses that comprise this disorder are addressed, post-incarcerated women might lack the persistence and capability to address their healthcare needs after confinement.

Women were released back into society with many of the same healthcare needs as when they entered prison (Maeve, 2001). One study showed that by improving the health of incarcerated individuals, public health would also benefit through a decrease in the transmission of communicable diseases and a subsequent reduction in costs to the public in treating these diseases. However, the report fell short on ways this group might address these issues upon release.

Some research suggested that women might leave jail in a better state of health than when they entered jail such as prenatal care (Enos, 2001; Maeve, 2001; Richie, 2001). The reason for better health was due to the premise that many women who entered jail on drugs left drug-free, resulting in better overall health (Maeve, 2001; NCCHC, 2002). Additionally, many finally got adequate rest in jail (Maeve, 2001). This state of health was transient and the long-term impact was that the women were released with the same health issues as they had when they entered prison or jail (Richie, 2001).

Maeve (2001) addressed the healthcare of 14 post-incarcerated women and investigated their “devolution” where there was an onward and downward momentum of

the health indices of women newly released from jail (Maeve, 2001, p. 151). Key findings were that post-incarcerated women continued to have many physical and mental health problems that had not been addressed in jail. The specific problematic areas of health concern for the women were sexually transmitted diseases, dental problems, and mental health issues. They were unable to effectively navigate their way through the healthcare system. This was due to complexity issues such as a lack of knowledge about their own bodies and health issues (e.g., STDs), stigma issues, access issues, and lack of resources including counseling. All sought treatment in the emergency department when their healthcare needs became emergent. The women's continued inability to function socially was also integrally connected to their relapse and recidivism (Maeve, 2001).

The findings of Maeve's study revealed that formerly incarcerated women need healthcare services immediately after release from prison or jail, since many of their needs such as a lack of management for a chronic illness, might not have been met during incarceration (2001). Formerly incarcerated women, at times, had ongoing and even urgent healthcare needs. For example, health services normally provided during incarceration, such as the dispensing of prescriptions, might not be available to women on the outside (Maeve, 2001). Formerly incarcerated women needed to learn about their bodies and illnesses especially with regard to sexually transmitted diseases. Additionally, post-incarcerated women had to gain the skills necessary to access a healthcare system that was very complex. Meeting the needs of formerly incarcerated women and providing them with the appropriate healthcare services was an important step in supporting their successful reentry back into society.

Health Access Issues among the Homeless

Little information is known about the health access issues of post-incarcerated women. There was, however, some information about the health access issues among homeless women (Lim, Andersen, Leake, Cunningham, & Gelberg, 2002; Luck, Andersen, Wenzel, Arangua, Wood, & Gelberg, 2002).

Another study reported that up to one-third of post-incarcerated women might have been homeless shortly after release from prison or jail (Arrestee Drug Abuse and Monitoring Program [ADAM], 2003). This literature was of importance here because approximately one-third (33%) of arrestees reported, they were homeless at the time of arrest. Homelessness was defined as no shelter within the past 30 days over a 12-month period (ADAM, 2003).

Addressing the healthcare issues of formerly incarcerated women meant addressing their access issues. Post-incarcerated women were constantly confronted with obstacles that prevented them from utilizing preventive health, primary care, chemical dependency treatment programs and mental health/psychiatric counseling (Gelberg et al., 2004; Lim et al., 2002; Luck, et al., 2002).

In a study about how accessible medical care was to 974 homeless women, researchers discovered that the women had limited access to all types of medical care (Lim, et al., 2002). The findings suggested that the greatest barriers to healthcare were the lack of health insurance and a regular source of care. Researchers concluded that the key factors associated with improved access were obtaining healthcare insurance and having a single provider at the same site to provide continuity of care (Lim, et al., 2002).

There were also issues regarding the providers of care in relation to access. In a quantitative study of 73 clinics in Los Angeles County that provide care to homeless women, researchers noted several structure and process deficiencies regarding the healthcare services provided to these homeless women (Luck, et al., 2002). These deficiencies were that many clinicians who were working in homeless arenas actually lacked formal training in providing care to homeless women. For example, women were not formally screened for homelessness nor were they assessed for the associated risk factors with regard to homelessness. What was most astonishing was that the providers of primary care to homeless women lacked sufficient onsite health services that homeless women need such as mental health services, substance abuse counseling, reproductive, and ancillary health services (Luck, et al., 2002).

A qualitative study using grounded theory was employed to explore access to women's healthcare. This study, the first in a series of qualitative/quantitative investigations by the authors, was undertaken to identify external barriers perceived by homeless women in the Los Angeles area (Gelberg, Browner, Lejano, & Arangua, 2004). During the individual interviews of 47 homeless women, the authors explored the factors that these homeless women themselves perceived as barriers to accessing women's health. Many women listed barriers to receiving contraception and could only obtain two free condoms per day, for example. They lacked basic women's health services. Many of the women in the study stated that having children was important to them eventually, but when they tried to delay or prevent pregnancy due to their homeless situation, they were confronted with a myriad of issues such as a male partner who would not use condom. One finding was that health was not a priority for homeless women as they first sought

out food and shelter. Other barriers considered burdensome to homeless women accessing healthcare were transportation and scheduling issues, and stigmatization related to healthcare encounters by healthcare providers. The authors concluded that general, gynecological, and reproductive health services in Los Angeles County needed to be more accessible to women (Gelberg et al., 2004).

Access Issues among Post-incarcerated Women

Formerly incarcerated women had other issues surrounding their perceptions of healthcare. Often, women who were released from prison or jail lived lives of “forced dependency” where life’s decisions were taken away from them (Maeve, 2001, 146). In prison or jail, the women were told what to do and when to do it. Upon release, the women were then abruptly faced with having make decisions again. For successful reentry to occur, this group needed to learn new decision-making strategies regarding their health such as making a plan of care, following through with that plan of care, and then being accountable for that plan of care (Maeve, 2001; Travis, Solomon, & Wahl, 2001). Maeve (2001) also described a “social paralysis” for many women that began immediately after release (Maeve, 2001, p.161). Sometimes women were unable to negotiate many of the systems they had to access post-incarceration, such as federal and state agencies, schools, employment agencies, and medical care. This inability to navigate through these systems ultimately led to relapse and recidivism for most of the women (Maeve, 2001).

Healthcare Encounters

Existential psychologist Rollo May (1967) provided a definition of encounter when he wrote about psychology and the human dilemma. He argued that humans could

view themselves as both the subject and the object at the same time (May, 1967).

Humans can see themselves as objects to which things happen and are continually influenced by stimuli presented to them. Whether an individual responds to the stimuli or not depends on one's rationality. The ability to self-relate is what distinguishes an individual from the rest of nature. In other words, it is man's (sic) ability to be outside himself that is important. During an encounter, an individual stands outside himself, interpreting what is taking place. The encounter is then "what really happens . . . In this encounter I have to be able, to some extent, to experience what the patient is experiencing . . . the therapeutic encounter requires that we ourselves be human beings in the broadest sense of the word . . . (May, 1967, p. 108).

More recently, researchers investigated knowledge about illness and offered definitions of healthcare encounters (Dluhy, 1995, Haworth & Dluhy, 2001). Although the literature was void of this information in acute illness, there was some literature, which looked at knowledge regarding chronic illness. Based on meta-analysis of over 300 nursing articles over the past three decades, 20 conceptual categories and 6 major themes regarding knowledge about chronic illness emerged from the meta-analysis. The six themes listed were: (a) demands and challenges, (b) emotional and cognitive responses, (c) day-to-day tasks of living with illness, (d) being chronically ill in the culture of a "healthy" society, (e) changing interactional patterns with family and healthcare providers, and (f) potential life outcomes (Dluhy, 1995). Through their meta-analysis of chronic illness and the emergence of themes, a definition of healthcare encounter and a model known as the Negotiated Symptom Management Model were also developed (Haworth & Dluhy, 2001). They defined a healthcare encounter as "an interplay of the

participants (attributes and roles), the history and context of the situation, and value systems imposed by the discipline and society . . . All prior health encounters influence all client–clinician interactions.” (p. 7). These authors also purported that the healthcare interaction must incorporate within it the attributes of mutuality, respect, and trust. In addition to providing a definition of a healthcare encounter, the authors also promoted the utilization of a symptom model in which the healthcare encounter is a part of the interaction phase.

Negotiated Symptom Management Model

The Negotiated Symptom Management Model was created to assist the provider in understanding how patients expressed their symptoms, described their symptom experiences, and discussed their symptom management with the provider (Haworth & Dluhy, 2001). The interaction involved the *client* and health providers. The client and the nurse had *person attributes* which included age, gender, culture, primary language, education, socioeconomic status, knowledge, values, expectations, health beliefs, and communication styles. The client brought to the encounter the *additional attributes* of health status, pain, emotional states, symptom meaning, and cognitive status while the nurse brought to the encounter the attributes of therapeutic communication skills, interpersonal competence, and a holistic perspective. The *healthcare encounter* must also consider context, history, time, and the environment. Within the *interaction* were embedded the aspects of mutuality, respect, and trust. *Outcomes* were defined as accuracy of diagnosis, degree of symptom relief, and agreement on a course of action. Symptoms were defined as subjective measures of an underlying injury or illness process. The provider interpreted managing symptoms to mean that there was comprehension of

the individual's experience and the meaning associated with each symptom (Haworth & Dluhy, 2001).

Although the author did not test the model, their meta-analysis revealed that many complex factors might compromise both provider and patient satisfaction within the healthcare encounter. The significance for providers is the treatment of the individual, not their symptoms, though symptom validation and relief of symptoms is the primary objective. Appropriate symptom management is dependent on listening to and attending to the 'lifeworld' of the patient (Haworth & Dluhy, 2001). Thus, being cognizant of key areas of influence in the process promotes the achievement of the desired objectives in symptom management. These objectives focus on a correct diagnosis, symptom relief, and agreed upon plan of action. When integrated into appropriate settings such as chronically ill patient settings, successful healthcare encounters can be achieved. One of the most noteworthy aspects of the negotiated model was that when it was employed correctly, the playing field was leveled, placing the patient and the provider on equal footing during the interaction. The healthcare encounter took on an entirely different perspective for both participants. This model also affords the provider better sensitivity of what to expect before, during, and after a healthcare encounter.

Haworth and Dluhy (2001) stated that healthcare encounters possessed similar characteristics and listed the necessary constituents within their model. The healthcare encounter needed a patient and a provider. Next, there were various attributes considered including personal attributes of the patient and the provider, non-personal attributes specific to the patient, and non-personal attributes specific to the provider. Finally, other important elements that needed to be considered during the encounter included history-

taking and having adequate time during the encounter. Environment and context were other elements integral to the healthcare encounter (Haworth & Dluhy, 2001).

In summary, although this model described how nurses might more fully understand what the patient's expectations were for an encounter, it was lacking in several areas for patients. First, the model was a chronic illness model and therefore, might not be applicable for use in patients with acute illnesses. Although formerly incarcerated women might have had both acute and chronic illnesses, the model would need to be tested in patients with acute illness. Second, the model did not fully address the internal barriers such as stigma, self-esteem, and identity issues. As noted by other authors, (Greer, 1998, O'Brien, 2001) these internal barriers were important to consider during every encounter because many formerly incarcerated women failed to seek care if these barriers existed. Finally, although this was an evolving model, it only considered the client-nurse interaction phase of symptom management. The model may still have several advantages for formerly incarcerated women who see themselves as disadvantaged. Formerly incarcerated women may now have "negotiated power." A negotiated model by definition is not a power-over model. There is equal distribution of care, equitable services are provided, and equality of care is given. Furthermore, the use of the negotiated symptom model is by nature, holistic, treating the total individual. Therefore, this may be an excellent model for use in encounters with post-incarcerated women.

Moreover, it is imperative to understand about patient-provider relationships and formerly incarcerated women. The next section offers a broad overview of healthcare encounters, patient-provider relationships, and perceptions regarding healthcare.

Mutual Withdrawal

There is little information about patient-provider relationships and formerly incarcerated women. There is, however, some information about patient-provider relationships and homeless patients, specifically the homeless mentally ill (Chafetz, 1990). Chafetz (1990) suggested that during the care of mentally ill patients there are factors that contribute to a mutual withdrawal that occurred between patient and provider where both the patient and the provider mutually terminated the relationship because of many factors. These factors included a lack of resources such as food and shelter, the crisis of belief where the provider valued long-term outcomes while conversely, the patient preferred short-term outcomes, the absence of reinforcers where there was no visible treatment outcome noted by the caregiver, and the mind-body problem where providers were concerned about patient contagions and hygiene. Withdrawal symptoms between patient and provider included a retreat to biology, a return to a legalistic orientation, and a return to environmentalism, placing an emphasis on external factors both interpersonal and material that influenced the behavior of the patient. The author noted that mutual withdrawal could be pre-empted if providers looked beyond the resource dilemma, created meaning by obtaining information and reinforcement by finding common ground with patients, addressed the human factor, acknowledged negative meanings like blame to clients to resolve a provider's ambiguity, addressed mind-body problems, and learned to look beyond the current crisis of homelessness with their mentally ill patients (Chafetz, 1990).

This article described the factors that contributed to withdrawal from homeless clients and the forms of behavior that withdrawal could assume. The author also

described the measures to reverse withdrawal. The study's limitation was that the patient population was limited to the homeless mentally ill. Research data from other researchers stated that less than 30% of all formerly incarcerated women were homeless (ADAM, 2003). Furthermore, some post-incarcerated did not have mental health issues (NIC, 2003). This study may have implications for formerly incarcerated women who seek care and for providers who initially offer healthcare services and then, for various reasons, both mutually withdraw from the encounter. Perhaps mutual withdrawal could be prevented if healthcare providers could see beyond the client's resource issues, seek common ground with their clients, minimize client blame to resolve their own uncertainties, deal with mind-body issues, and focus on the client rather than their current situation of homelessness and mental illness.

Encounters with Mainstream Healthcare Services

Browne and Fiske (2001) described the economic, political, social, and ideological forces between patients and the dominant healthcare system. Through in-depth interviews of 10 First Nations women who lived in rural, northwestern Canada, the researchers studied the healthcare encounters between providers and patients with culturally different backgrounds from the viewpoint of the women. The findings of this qualitative study contained two themes, "invalidating" and "affirming" encounters. Invalidating encounters included: (a) dismissal by healthcare providers, (b) transforming oneself to gain credibility, (c) negative stereotypes about First Nation women, (d) marginalization from the mainstream, (e) situations of vulnerability, and (f) disregard for personal circumstances. Affirming encounters were: (a) actively participating in healthcare decisions, (b) receiving exceptional care, (c) affirmation of personal and

cultural identity, and (d) the development of a positive, long-term relationship with a healthcare provider (Browne & Fiske, 2001).

This qualitative ethnographic study demonstrated that First Nations women often believed that although there were many affirming behaviors there were also invalidating behaviors and issues of racism, discrimination, and other structural inequities that disadvantaged and marginalized them when they sought out healthcare services (Browne & Fiske, 2001).

This study has implications when exploring the healthcare encounters of formerly incarcerated women. For example, formerly incarcerated women may have had experiences that providers have never dealt with or even considered. Therefore, these differences in experiences might place the provider and formerly incarcerated individuals in different cultural perspectives. The study's limitation is that it only illustrated the characteristics of a healthcare encounter between western nurses and First Nations women. Cultural differences between the providers and formerly incarcerated women may or may not be as extreme. However, the finding that seemingly innocent behaviors performed by the provider such as being "dismissed" for knowing about their illness, can be interpreted by the patient as forms of racism and discrimination.

Intercultural Healthcare

Kirkham (2003) studied the politics of healthcare encounters and intercultural healthcare in Canada. Using an ethnographic approach, informed by feminist, postcolonial, and intergroup theories, the author "buddied up" with thirty-five patients and thirty-one nurses and formally and informally interviewed them. Two diverse, urban

community facilities in Canada were utilized in this study. Some participants were constructed as *belonging* in the healthcare system while others were constructed as *other*.

This study uncovered several aspects of intercultural healthcare. First, the complex nature of intergroup relations showed that belonging was linked to healthcare encounters. Second, this study uncovered the politics of belonging, primarily through implicit messages sent by nurse to patients about who belonged. Third, the importance of uncovering public discourses that said that certain individuals did not belong was addressed. However, the major limitation of this study was that it failed to offer specifics as to how nursing might address the problems surrounding the politics of belonging. Other aspects, such as the concept of “othering,” were important to consider when exploring the healthcare encounters of formerly incarcerated women.

Othering in Healthcare

Johnson, Bottorff, Browne, Grewal, Hilton, and Clarke (2004) identified the concept of *othering* in healthcare using an ethnographic methodology. A combination of individual interviews and focus group discussions with 80 south Asian immigrant women who had lived in Canada for 10 months to 32 years were utilized. The definition of othering was a process that identified those who were thought to be different from oneself or the mainstream, and it could reinforce and reproduce positions of disparity leading to domination and subordination (Johnson, et al., 2004). Three types of othering themes emerged: (a) essentializing explanations, (b) culturalist explanations, and (c) racializing explanations (Johnson, et al., 2004). Essentializing explanations were defined as stating overgeneralizations about race, culture, location, social background, or healthcare practices. Culturalist explanations meant that some healthcare providers used culture as a

reason to explain why some women were not receiving optimal healthcare. South Asian women's overuse of services was also attributed to cultural differences. Racializing explanations were defined as simplistic and patronizing generalizations about south Asian women based on appearance. Furthermore, Caucasian women were idealized and referred to when accepted practices were discussed by healthcare providers.

This study also described south Asian women's ways of coping with and managing the othering experiences. For example, to survive this experience some south Asian women distanced themselves from other south Asian women to be cared for as individuals. Some south Asian women minimized their outward actions. For example, they were quiet during childbirth to fit in with the other mainstream patients receiving care. Some women resisted othering by invoking their right to equitable healthcare services and encouraged other south Asian women to do the same.

Finally, the authors recognized that these individual interactions were embedded in a larger institutional and social context, the Canadian healthcare system that values equality and respect for diversity. These interactions were even used by south Asian women themselves to legitimize the healthcare system and explain that "good" healthcare at times, meant that the Canadian healthcare system did not take money from you for services, attempted to give good care, and tried to treat everyone equally.

The othering practices discussed in this article might have implications for the providers who care for formerly incarcerated women. Post-incarcerated women perceived themselves as different from the mainstream just as south Asian women did in this study. Formerly incarcerated women coped with and managed othering practices in similar ways.

This study also underscored the importance of providers becoming cognizant of othering practices. This awareness may lead to improved healthcare interactions with women from different backgrounds such as the formerly incarcerated. More importantly, this study identified that those in power must transform healthcare to make it a more equitable system of care.

Nurse-Patient Healthcare Encounters

Walsh (1997) investigated the phenomenon of the nurse-patient encounter. This study's focus was nurses' descriptions of their lived experiences during a psychiatric encounter. These descriptions were obtained through audiotaped interviews with eight psychiatric nurses. These nurses were employed in either an inner-city community psychiatric clinic or a large metropolitan psychiatric hospital (Walsh, 1997).

The results of the study indicated that the ending of the encounter seemed to contain most of the encounter's significance for the nurse. Another interesting finding was that the psychiatric nurse did not experience time in a linear way. Therefore, the past is no less meaningful for being past, the past is with us in the present, influencing our present actions.

There were several limitations of the study. First, the perspective was limited to the nurse and not the patient. This aspect must be more fully explored in relation to the patient during a healthcare encounter. Second, although the study uncovered the premise that relationships and encounters were intertwined, and that they were dependent upon one another for context and meaning, the study did not sufficiently explore the entire healthcare encounter. Finally, the author purported that the ending of the encounter

encapsulated much of the significance of the encounter. However, the author did not address the rest of the encounter.

Interpersonal Relationships and Healthcare Encounters

Fosbinder (1990) used ethnographic methods to examine nurse-patient interactions for the purpose of developing theories about patient satisfaction. Patient satisfaction was based on patients' perceptions regarding nurses' interpersonal skills. A private, acute care hospital in San Diego County was the site used to interview 40 patients and 12 nurses in the study. Four themes emerged: (a) translating, (b) getting to know you, (c) establishing trust, and (d) going the extra mile (Fosbinder, 1990).

Translating was defined as the action of nurses informing, explaining, instructing, and teaching. Getting to know you occurred through personal sharing, kidding, being friendly, and understanding. Trust was established if three attributes were evident. The nurse needed to: (a) know what she was doing, (b) be prompt, follow through, and keep the patient informed, and (c) be concerned about me. Finally, going the extra mile contained three elements: (a) clicking, which meant that an immediate rapport existed between patient and nurse, (b) developing friendship, and (c) doing the extra. A conceptualization of patient satisfaction with nursing care emerged from the research findings:

Patients feel satisfied with the nurse-patient interaction when nurses share their experiences, their likes and dislikes, their feelings with them... The ability to poke fun at the situation or to joke about something extraneous to the current situation helps the patient relax. When the nurse enters the room with a smile and acts happy, patients feel the nurse cares about them. The nurse who maintains eye

contact with the patient while letting them finish their sentence or complete their story promotes the idea that the nurse is on their level, and respects them. For most patients, the nurse who has planned ahead and knows what the patient needs, helps the patient to feel confident. For others, it is the prompt return of the nurse to the patient's room, the nurse's follow through on things the patient has asked for or about that brings confidence. Always informing the patient about what is going to happen to them, and explaining what the nurse and other team members are going to do, helps patients feel safe and secure in the hospital setting (p. 152-153).

The author was surprised to learn that patient satisfaction was based on patients' perceptions of interpersonal competence of the nurses rather than their technical skills. Fosbinder (1994) also noted that a patient's perception of quality healthcare and satisfaction with a particular provider encounter was significantly influenced by the interpersonal relationship. In this case, the interpersonal relationship was defined as the interpersonal competence of the provider.

Dingman, Williams, Fosbinder, and Warnick (1999), also provide evidence that nurse caring behaviors influenced patient satisfaction and became an important predictor of patient satisfaction. Eight patient satisfaction attributes were incorporated into five nurse caring behaviors and then they were evaluated pre-intervention and post-intervention in an acute care unit. Results of the study indicated the patient satisfaction attributes of "nurses anticipating needs and responds to requests" significantly increased. Furthermore, attributes that began as immediate priorities for improvement before intervention became major strengths after intervention. The authors also noted that for the

Caring Model to be effective and achieve greater patient satisfaction, this model needed to become an integral part of strategic planning process on each nursing unit and then be implemented throughout the entire organization. The authors also found that frequent reminders must be given to staff members to maintain the effects of the model (Dingman, et al., 1999).

The results of these three studies revealed that interpersonal competence was the overarching theme and the most important aspect of the healthcare encounter for the patient. These findings might have implications for formerly incarcerated women who might also feel that interpersonal competence of the provider was the most important characteristic the provider needs to possess. In addition to interpersonal competence (Fosbinder, 1990, 1994; Dingman, et al., 1999), having a competent provider (Haworth & Dluhy, 2001), meeting patients expectations (Dingman, et al., 1999) and being culturally competent (Browne & Fiske, 2001; Johnson, et al., 2004; Kirkham, 2003) were some of the needs that patients expressed as needs during healthcare encounters. Although these needs were important to consider, it was also important to consider the specific needs of specific patients, such as women in correctional facilities. Not only do incarcerated women have healthcare needs, they also have certain attitudes and beliefs about their healthcare perceptions during incarceration.

How Women Perceived Prison Healthcare

Women in prison navigate their way through a very different healthcare delivery system. Healthcare in prison can be negotiated, bartered, and even taken away. Although there were no studies regarding healthcare encounters of formerly incarcerated women, a few studies highlighted the social construction of health of incarcerated women and their

perceptions of healthcare in prison. These studies offered insight as to why post-incarcerated women had difficulty with healthcare encounters.

Social Construction of Healthcare

One study addressed the “adjudicated health” of incarcerated women through interpretive methods (Maeve, 1999). The health of 20 incarcerated women was explored over a 15-month period through weekly interviews to learn more about their social construction of health. The social construction of health was found to contain three dimensions, which included: (a) past understandings, (b) present understandings, and (c) future potential. Embedded within these dimensions, incarcerated women arrived at a concept of health that the author described as “adjudicated by powerful others.” In other words, health was similar to that of the adjudication of justice. Therefore, health was possible only “through the protection of others, and integrally connected with the idea of punishment” (Maeve, 1999, p. 57). Past understandings revolved around protection and punishment by powerful others such as childhood abuse. Present understandings centered on protection and punishment by the State where health was under the jurisdiction of the Department of Corrections. Future potential for health was described as protection through self-care. Future potential for the health of this group was based on what the women learned in prison and predicated on who they believed they could become after they were released from prison.

The findings generated from this study were that the women were dually grounded in both protection and punishment (Maeve, 1999). Incarcerated women in this study believed that “competence regarding health issues belonged to others, while the others, in this case, the larger society generally and the department of corrections

specifically, operated for a position of understanding health as a personal responsibility” (Maeve, 1999, p. 62). This study’s significance was that it highlighted two contrasting positions of healthcare in prison, that of either protection or punishment (Maeve, 1999). Correctional healthcare providers stressed inmate individualism and personal responsibility for health (Maeve, 1999). Although women in prison also viewed their health as their personal responsibility, healthcare personnel did not afford the women the opportunity to be individually accountable for their healthcare needs. Therefore, this study suggested that formerly incarcerated women might return to the outside world without the necessary life skills to manage their health individually.

Perceptions of Healthcare

Young (2000) described 15 women’s perceptions of healthcare and their treatment in a northwestern state prison in the United States. Through individual interviews, this qualitative study’s research question focused on medical care and the inmates perceptions of their treatment. Inmates were asked what health services they used in the past 4-6 months and how they felt about the care and treatment they received. While the author reported that women inmates had both positive and negative views about their healthcare, the women generally had negative perceptions of their care. Specifically, inmates related that their care was non-empathetic. At times, other inmates mentioned that they felt undeserving of care (Young, 2000).

Although the findings cannot be generalized from this small, qualitative study, the inmates clearly indicated that there was a lack of trust and mutual respect between the provider and the patient who was an inmate. Because women in prison related a negative

view of their healthcare, it is highly plausible that formerly incarcerated women may hold similar opinions about healthcare such as negative and non-empathetic views.

Gaps in the Literature

Several conclusions can be drawn from an extensive review of the literature. Gelberg, et al., (2004), Lim, et al., (2002), and Luck, et al., (2002) analyzed health access issue of homeless women especially the barriers that precluded them from services such as preventive health, primary care, chemical dependency treatment programs, mental health counseling, and psychiatric counseling. Although their findings regarding health access may have implications for formerly incarcerated women, their study populations were homeless women who may or may not have had a history of incarceration. Maeve (2001), O'Brien (1998, 2001), and Richie (2001) focused on relapse, rearest, reincarceration, recidivism, and reentry but there was little discussion regarding the healthcare of post-incarcerated women and no discussion regarding healthcare encounters. Though Fickenscher, Lapidus, Silk-Walker, and Becker (2001) examined the health needs of women in jail including the prevalence of behavioral risk factors such as trading sex for money or drugs. The study's focus was limited to women in jail and excluded women on the outside.

May (1967) defined an encounter and Haworth and Dluhy (2001) specifically defined the healthcare encounter and developed the Negotiated Symptom Model. This model may have relevance with formerly incarcerated women. Chafetz (1990) offered a different perspective, the mutual withdrawal of patient and provider, but this study was performed with the homeless mentally ill and not specifically with formerly incarcerated women. Other authors, Browne and Fiske (2001), Fosbinder (1994), Johnson, et al.,

(2004), Kirkham (2003), and Walsh (1997) offered perceptions regarding healthcare with various patient populations including First Nations women, south Asian women, and psychiatric patients. However, none of the authors offered information on the perceptions of formerly incarcerated women. Finally, Maeve, (1999) and Young (2000) offered the most information on how women perceived healthcare from a prison perspective. However, how formerly incarcerated women perceived healthcare encounters had yet to be explored.

Therefore, given what was known about how other groups of women such as homeless women, mentally ill women, and incarcerated women and how they perceived healthcare encounters, it was vital to gain an understanding about formerly incarcerated women's perceptions. The knowledge related to formerly incarcerated women was nonexistent with regard to their healthcare encounters perspectives. An extensive literature review found no journal articles that focused on the healthcare encounters of formerly incarcerated women. Although the healthcare of formerly incarcerated women has been addressed as they re-entered the community, how they perceived healthcare is unknown (Maeve, 2001, 2003; O'Brien, 2001; Richie, 2001). An analysis of the issues is essential if nurses were to understand the healthcare issues formerly incarcerated women faced.

Summary

In sum, the literature review focused on several areas. Background information on incarcerated women revealed that more women than ever in the history of the United States are on probation or parole in the U.S. (BJS, 2004). Therefore, there are many post-incarceration challenges for the women that include reentry issues, specifically healthcare

issues. Several aspects of the healthcare system and formerly incarcerated women's perceptions of healthcare encounters, at times, made it difficult for them to initiate, engage in, and have a successful healthcare encounter.

In sum, due to the paucity of the literature on the healthcare encounters of formerly incarcerated women, this study was performed to explore these issues. A grounded theory study utilizing individual interviews and focus groups was employed to explore the healthcare encounters of formerly incarcerated women.

Chapter 3

METHOD

The purpose of this grounded theory study was to explore how formerly incarcerated women perceived healthcare encounters. This research focused on the following questions: How did formerly incarcerated women perceive healthcare encounters? How did they describe difficult healthcare encounters? How did they describe successful healthcare encounters? What did they suggest to improve healthcare encounters?

Design

A qualitative approach, informed by grounded theory, was selected for this research. Grounded theory refers to “theory that is derived from data, systematically gathered and analyzed through the research process” (Strauss & Corbin, 1990, p. 12). Grounded theory, therefore, has a close relationship with data collection, data analysis, and the eventual theory that is developed (Strauss & Corbin, 1998). Grounded theory is an appropriate “fit” because this study focuses on process questions about changing experiences over time or its stages and phases (Morse & Richards, 2002) such as perceptions of formerly incarcerated women’s healthcare encounters and their interactions in these encounters. In accordance with this study’s methodology, the researcher conducted individual interviews and focus groups.

Individual interviews: Definition and purpose. Individual interviews are conversations that are "attempts to understand the world from the subjects' point of view,

to unfold the meaning of peoples' experiences, to uncover their lived world prior to scientific explanations" (Kvale, 1996, p.1). Face-to-face interviews are useful in exploring the differences between participants' experiences and their perspectives about an event such as healthcare encounters.

Focus groups: Definition and purpose. There are several definitions of focus groups. Merton and Kendall (1946) first established the parameters for focus group development. These researchers ensured that participants' specific experiences or opinions about the topic under investigation were taken into account and that an explicit interview guide was used. These researchers also ensured that the subjective experiences of participants were explored in relation to predetermined research questions.

Powell, Single, and Lloyd (1996) defined a focus group as a group of individuals selected and brought together by the researcher to discuss and comment on their personal experiences regarding a topic. Other focus group definitions included organized discussion and interaction (Kitzinger, 1994; 1995), and social events (Goss & Leinbach, 1996). Focus groups rely on interaction within the group based on topics that are supplied by the researcher (Morgan, 1997). Therefore, one of the major characteristics that distinguish focus groups from other forms of interviewing is the insight and data produced by the interaction between participants (Gibbs, 1997).

The main purpose of focus group research is to draw upon respondents' attitudes, feelings, beliefs, experiences, and reactions in a way that may not be feasible using other methods. Krueger (1988) defines a focus group as a planned discussion of participants assembled in a non-threatening environment to draw out perceptions and ideas (Krueger,

1988). This comprehensive focus group definition was the one used in the study to explore the healthcare encounters of formerly incarcerated women.

Rationale for Using Focus Groups

Focus groups were chosen in addition to individual interviews for several reasons. Although personal information may be more easily shared during an individual interview, one advantage of utilizing focus groups in addition to individual interviews is that, at times, a greater amount of information can be gathered in a shorter period of time (Krueger, 1988). Sometimes focus groups will also exhibit “synergy”, providing for a broader range of thoughts and the sharing of personal experiences (Morgan, 1997). Additionally, peer validation in focus groups can also serve as a catalyst for the expression of these perceptions and ideas (Krueger, 1988). Finally, researchers are able to observe the interactions between group members, which can provide valuable insights regarding the topic being studied (Morgan, 1997).

Setting

Two reentry recovery programs were selected for this study. Both were located in southern California. Site A was associated with a faith-based prison program. This transitional prison program assists women who are re-entering the community after prison or jail. This organization has assisted women after serving jail sentences or prison terms for nearly a decade. The rate of recidivism for formerly incarcerated women participating in this program was reported to decrease to 6% after the implementation of their program. In comparison, the average rate of recidivism is as high as 85% in other programs in the United States (Parsons & Warner-Robbins, 2002). This sample had the

potential to exclude women who were not willing to accept a “Christian approach to recovery.” Therefore, the researcher selected a second site as well.

Site B was a recovery program for women and men, many of whom had served prison and/or jail terms. This program has been in existence since 1966. This behavioral health services program is committed to providing a safe, secure environment for women, children, and families through a multidisciplinary approach that improves and promotes health, fosters learning, embraces diversity, and enhances quality of life in the community for those who want to recover from drug and alcohol dependencies.

The directors of these programs had indicated their support for this research in writing. The letters were forwarded to the University of San Diego Institutional Review Board. The researcher then signed confidentiality agreements at both sites, indicating that she would not disclose any information outside of the individual interviews or focus groups.

Sample

Women were recruited from a convenience sample of formerly incarcerated women identified by the researcher from information provided by Site A and Site B staff. The participants consisted of women who had been recently released from jail or prison, at least one month post-incarceration. The researcher recruited only adult women who were formerly incarcerated, who were willing to participate in a focus group or individual interview, and who met the following research criteria: English-speaking, willing to meet with the researcher for 1 to 1.5 hours, and willing to sign a consent form, complete a demographic form, and be audiotaped.

A flyer was distributed at each site (see Appendix A and Appendix B) and contacts were made at the weekly meetings at these sites. Staff notified participants of their eligibility. A convenient time for participation was scheduled by the researcher.

Data Collection Procedure

The 16 interviews were conducted between December 1, 2005 and January 5, 2006. There were 8 face-to-face interviews; 8 other individuals participated in two separate focus groups. Four individual interviews were conducted first, at Site A, followed by one focus group at the same facility on a different day. The data were transcribed within 24 hours of the individual interview or focus group session. At Site B, four individual interviews were carried out, one month later, followed by a focus group on a different day. The data were again transcribed within 24 hours of the individual interview or focus group session.

Six to 8 individual interviews and 2 focus groups were anticipated; eight individual interviews and 2 focus groups were successfully conducted. The data were saturated (Strauss & Corbin, 1998) after the completion of the interviews.

Consent procedures and demographic form. All study participants completed a signed a consent form and a demographic form (see Appendix C, Appendix D, and Appendix E) at the time of the interview. All participants received a copy of the consent form. The researcher briefly explained the study at that time. Participants, when necessary, were assisted in the completion of the consent and demographic forms. The question asked was, "In case anyone forgot their glasses, we will read the form to you," so as not to call attention to participants who were illiterate. Five participants (31%) were unable to read the forms. They were assisted in the completion of the forms.

Participant names were omitted from the demographic form and replaced by a number identifier. The participants were made aware of this prior to the interview.

Although they were never asked to disclose medical information, some participants added their medical diagnoses to the demographic form along with their prescribed medications.

After each interview or focus group, all completed forms were placed in a locked file cabinet accessible only the researcher. All study information will be kept for a minimum of 5 years before being destroyed.

Interviews and questions. Focus groups and individual interviews were conducted at the designated facilities using an interview guide (see Appendix F and Appendix G). The questions asked of the participants were: (a) "Tell me about a recent clinic or doctor's office visit since you left prison or jail?" Probes for this question included: "What made you feel good after your visit? What made you feel bad after your visit?" [and] "If you haven't recently gone to the doctor since you prison of jail, please tell us why?" (b) "How do you feel about returning to this clinic or doctor's office?", and (c) "Describe what you think a clinic or doctor's office visit should be like?" The probe for this question was, "How do you think your visit could have been made better?"

Other than the final question, the questions and probes were not modified. The last question was modified slightly in this way, after the second interview, "If you could wave a magic wand and you could make the healthcare system better, describe what you think a clinic visit, or doctor's office visit, or emergency department visit should look like and should be like?"

Interview procedure. In the event that one tape would not be usable (e.g., destroyed, recorded at a low volume), all interviews were audiotaped using two separate

tape recorders. The researcher read each question aloud and each participant was given an 8 1/2 x 11-inch piece of paper containing all interview questions. The interview questions were typed in large, 14-point font. This allowed the participant to refer to the questions at any given time and maximized the accuracy of the data collection. Based on the number of questions in the guide and the researcher's experience in obtaining baseline information, the researcher allocated 1 to 1.5 hours for each interview. All interviews were conducted within this time allotment.

The researcher followed the same line of questioning for each individual interview and focus group. On several occasions, the researcher was asked, during the interview process, for an opinion regarding medical care that various participants had received. The researcher, however, did not offer medical advice to the participants, nor were judgments passed on any of the medical staff or facilities that were mentioned during the interview process. In two instances, participants tried to get the researcher, who is a nurse practitioner, to examine them. The researcher also curtailed a discussion about one participant's current illness, redirecting her back to her own healthcare provider at a nearby community clinic.

Individual interviewing was a valuable way to obtain information about topics that were sensitive to participants, such as maltreatment by providers. In the opinion of the researcher, the participants who were individually interviewed generally seemed more willing than focus group participants to share vital information. They readily talked about their perceptions regarding their own healthcare encounter since they were being interviewed in a private setting. Individual interviews also yielded responses that were

rational and gave the researcher the ability to assess the participant's responses more fully (Denzin & Lincoln, 2000).

Focus group procedure. Three women participated in the focus group at Site A and 5 women participated in the focus group at Site B. Both focus groups were audiotaped. Ground rules were established prior to interviewing the participants including no cross-talking. Each participant was asked if she wanted to use a pseudo-name for confidentiality purposes. The participants decided to use their own names knowing that the tapes would remain confidential and only the researcher would listen to them.

Every question was read aloud and each participant was given a standard-sized 8 1/2 x 11-inch paper with all questions typed in large, 14-point font so that she could refer to the questions at any given time. This was done to maximize accuracy of the data. Based on the number of questions in the guide and the researcher's experience in obtaining baseline information, the researcher allocated 1 to 1½ hours for each group interview. Both group interviews were conducted within this time allotment.

One woman in the focus group at Site B left the group at the beginning of the interview after introducing herself. The researcher immediately stopped the tape to ensure that the participant was safe and was not upset by any of the events or circumstances that had occurred prior to the focus group. The researcher immediately brought the individual to the office of the program director. The participant stated that, "This has nothing to do with the focus group," and reiterated, "I just don't want to participate today." Therefore, this participant was excluded from the study results and findings.

Research assistant. A research assistant was enlisted for this study. This assistant was a master's prepared social worker with previous correctional experience. Her roles

and responsibilities in the study were to aid the researcher with not only the technical aspects of the study such as the setup and maintenance of all audio equipment, but to assist the researcher on the day of each focus group including acting as a greeter, serving food, and taking observational notes. Other responsibilities involved validation of the information obtained immediately following each of the focus group interviews.

Therefore, the research assistant provided additional support to the researcher, contributing to the overall consistency of the research project.

Research Standards

Research standards were an important component of the research process. The rigor of the design is the degree to which research methods are thoroughly and conscientiously carried out in order to distinguish important influences that occur during a study (Denzin & Lincoln, 2000). Research standards were considered to ensure rigor during the research process, especially during data collection and analysis.

Trustworthiness. Also known as validity in quantitative research, trustworthiness is a description of what the researcher does during the research process to assure the reader that their findings can be read with trust. In other words, their stated findings are the actual findings. To ensure trustworthiness, the approach used in this study was the use of multiple data sources by employing two program sites (Lincoln & Guba, 1985). This process assisted the researcher with trustworthiness and the systematic process of data collection and analysis helped to ensure trustworthiness (Denzin & Lincoln, 2000).

In qualitative research, in deciding whether the findings in an inquiry are trustworthy, the findings are put through the tests of credibility, confirmability,

dependability, and transferability (Lincoln & Guba, 1985). Reflexivity and reflectivity were also part of the design's rigor. Credibility, reflexivity, and reflectivity were addressed in the data collection section; dependability, confirmability, and transferability were addressed in the data analysis section.

Credibility. Credibility is defined as the researcher's ability to demonstrate that the goals and objectives of a study are accurately identified and described, based on the way in which the study was conducted (Lincoln & Guba, 1985). In the opinion of the researcher, credibility was established in this study by checking the accuracy of the audiotaped interview recordings of the interviews against the written data text (Strauss & Corbin, 1998). Credibility was also assured in this study by basing findings on the data rather than on the researcher's bias (Strauss & Corbin, 1990).

Reflexivity/reflectivity. Was also employed during the study. *Reflexivity* pertains to the values, beliefs, and ideas of the researcher and the process of making those assumptions explicit to the participants prior to conducting the study (Lincoln & Guba, 1985). *Reflectivity* pertains to thoughts and/or opinions of the researcher resulting from a consideration or idea (Denzin & Lincoln, 2000). The researcher met periodically with the dissertation committee to discuss data collection and analysis thus, helping to ensure reflectivity/reflexivity. The researcher also attempted to identify any preconceived ideas in writing by making a list of these ideas. The researcher reviewed these ideas periodically before embarking on the study to ensure that reflexivity and reflectivity were achieved.

Protection of Human Subjects

Approval for this research was obtained through the University of San Diego Institutional Review Board on November 15, 2005 (see Appendix H). The researcher met all ethical standards and all participants were assured confidentiality during individual interviews according to the *Human Participant Protection Education for Research Guidelines* (see Appendix I and Appendix J) and the guidelines established by the University of San Diego.

All data were coded using numbers. No participant names ever appeared on any of the data collection tools. All data were kept in a locked file cabinet in the researcher's office. Only the researcher had access to the data. All data will be kept a minimum of five years before being destroyed. If this information is published, the identities of the participants will not be revealed.

Risks. It was anticipated the women might have anxiety that would result from their disclosure of information. The researcher considered physical, psychological, and/or social risks that might occur, even if they appeared to be minimal. Although the women seemed quiet at first, they were not reluctant to "tell their stories" to the researcher. The women all appeared eager to have someone listen to their narratives.

One incident occurred with a participant during an individual interview. Prior to her interview, the participant felt anxious and wanted to see her doctor. Apparently, this participant had had some difficulty sleeping the previous night, and thought that she needed a "medication adjustment." She had tried, earlier in the day, to obtain a walk-in clinic visit at County Mental Health Services. When she arrived at the facility, she was turned away, since there was no provider to see her that day. She was told she could

obtain emergency services, if she needed them, at a facility 40 miles away. She became upset about this and informed her case manager of this fact. The case manager decided that this was not an emergency. The participant then scheduled an appointment at the same facility for the next day.

The participant decided to conduct the interview with the researcher. The researcher then made a clinical judgment that it was acceptable to proceed with the interview. The participant was informed that the interview would cease immediately if she wanted to end the interview at any time, for any reason.

There were no difficulties during the interview. In fact, when the interviewer asked the participant how she felt, she stated, "No, no. I'm very comfortable talking to you." The interview continued without any incident. Of note, specific referral agencies had been identified prior to conducting this research. These circumstances were discussed with each participant prior to each interview and focus group. Furthermore, the researcher notified the dissertation chairperson immediately after the interview had taken place. The chairperson agreed with the management of these events.

Benefits. The benefits in obtaining the data outlined in this study outweighed the potential for harm to individual subjects. The benefits of the study were to inform the literature and providers on how to bring about successful healthcare encounters with formerly incarcerated women. The potential benefits prevailed over the potential risks involved in this study.

Remuneration. Each participant received a \$25 gift certificate to a large, discount retailer. Participants were given a receipt acknowledging their gift certificate with a copy kept on file with the researcher. The participant who chose to exclude herself from the

study offered to return her gift certificate. She was advised that, according to the consent form, she was able to leave the study at any time and, therefore, could keep her gift certificate. Other expenses incurred by research participants might have included transportation costs such as bus fare, gasoline, childcare, and time away from other scheduled events. The participants were fed breakfast and lunch on the day of their scheduled interview.

Data Analysis

The researcher transcribed all audiotapes. Transcriptions were formatted on pleading paper with corresponding numbered vertical lines. This method was done to enable the researcher to write notes, observations, and code the data in the right-hand margin. Each page was also numbered consecutively.

Notes were taken at the end of each interview. An audio recorder was kept in the researcher's car. These recordings were transcribed as either the observational, theoretical, and methodological notes on the appropriate interview form. Demographic information from the womens' forms were entered onto an Excel spreadsheet after each interview. Audiotapes that had been transcribed, and notes that had been made in the right-hand margin, also served as part of the audit trail to develop the core categories, themes, and subthemes. These memos were written at the end of each interview day.

Coding process. The coding process began with the first level of analysis, *open coding* (Strauss & Corbin, 1998). Open coding is the analytic process through which concepts are identified and their properties and dimensions are discovered in data (Strauss & Corbin, 1998, p. 101). Through this coding process, concepts were categorized in preparation for the next phase of coding. An Excel spreadsheet matrix was

created to present each of the concepts. These concepts essentially remained the same after the third interview. The second level of analysis consisted of *axial coding*, relating categories to newly created subcategories. For example, coding was done around the “axis” of a category (Strauss & Corbin, 1998) and linked to a property and/or dimension. Subthemes were created around these larger categories. They were added to the matrix. The final level of analysis, *selective coding* was performed by refining and integrating the concepts (Strauss & Corbin, 1998). Data analysis for the focus groups and the interviews was accomplished by using the constant comparative method (Strauss & Corbin, 1990). Categories were compared from one focus group to another. Categories from the focus groups were also compared to the categories that emerged in the individual interviews (Strauss & Corbin, 1998).

The concepts began to take shape, into a substantive explanation of formerly incarcerated women's perceptions of a healthcare encounter. Analysis was performed in two ways. The actual words the participants stated such as “going back-and-forth” were used when possible; the words were also conceptualized at an abstract level to become the core category (Strauss & Corbin, 1998, p.126). This method is compatible with data analysis for focus group and individual interview methods (Strauss & Corbin, 1998). Finally, research standards were thoroughly and conscientiously carried out during data analysis.

Data analysis standards. *Dependability* was ensured by creating concise observational, theoretical, and methodological notes (Lincoln & Guba, 1985), avoiding premature closure of questions, and by exploring all pertinent areas of theme and thought (Strauss & Corbin, 1998). *Confirmability* was assured via an audit trail of the data and

through appropriate data analysis via notes, memos, and coding. This information was then traced back to original data sources (Strauss & Corbin, 1998). *Transferability* was considered in this study. During data analysis, for example, the researcher developed contexts that were applicable to other research studies (Lincoln & Guba, 1985).

Transferability was also achieved by inviting committee members to make connections between elements of the study and their own experiences and by applying the research findings to other settings and others contexts and with other disciplines and other theories (Strauss & Corbin, 1998). In summary, if a study meets the dependability, confirmability, and transferability standards, then the study is considered trustworthy (Lincoln & Guba, 1985).

Furthermore, the challenge in this type of research was to avoid bias and to allow all the participants voices to be heard. Avoiding bias and upholding research standards was performed during the study. In addition to the research standards, there were other considerations related to the experiences of the nurse researcher.

Personal Context

This study context includes a description of the researcher, including her life experiences, and perceptions of healthcare as a nurse. As a Caucasian woman in her 50s, and a nurse practitioner who works in an emergency department caring for incarcerated and formerly incarcerated women and men, this researcher was to have a unique vantage point with this vulnerable population. Although she had never been incarcerated, she has worked with individuals who have had these life experiences. She believed that she gained a sense of trust early on because of her nursing credentials and who she was as a person. Early on, she also believed she gained credibility with the women that she

interviewed because of the nature of her work. She thought they felt that she understood their circumstances. She was keenly aware during each and every interview, that knowledge about a certain patient population including their circumstances, their situations, does influence one's approach to interviewing and to particular interpretations within this study. She made every attempt to let them tell her their stories, without interjecting what she understood about certain diagnoses or various health standards and protocols. She did not provide them specific examples about the patient's she has cared for at her place of employment. Rather, she merely told them that, at the facility she was employed, their institution had been awarded the county jail contract. Although the participants came to know that she was a nurse practitioner and had cared for formerly incarcerated women, the researcher was careful not to take on two identities with the participants. She explained that she was in the role of a nurse researcher while she was conducting the interviews. This personal context was important during the study because a novice researcher, one without previous experiential information, may not have understood the women's perspectives regarding their healthcare encounters.

In summary, this chapter discussed the grounded theory method and focused on the methodology of the study. The next chapter, Chapter 4, will discuss pertinent findings from the perspective of formerly incarcerated women.

Chapter 4

FINDINGS

Composite Case Study

Anne is a 37-year old white female who lives in a recovery home in Southern California. She has 3 children who live with her relatives. The relatives have custody of her children. Anne has a high school education and she plans to go back to college but does not have a specific plan yet. She is currently unemployed.

Anne was recently released from jail where she served 6 months time for a drug crime. Now she is in a mandated court program and is having problems getting her health needs met. "My program wouldn't let me do the other program. They wouldn't relieve me from there for 6 months so that I do this program. So, then I went to a different regional substance use treatment program . . . going back-and-forth . . . went down to this program and I walked in there – no meds, completely depressed. I had a total episode." Another time, Anne said that she was so frustrated she "just got loaded."

Anne has other problems as well including a lack of money. "I didn't have the money to get my medications filled because I had to pay the rent," or "I can't even get on MediCal to help me with my problems." Anne also realized she has trouble with forms. "If we need MediCal, help us get our MediCal . . . because sometimes, for people like me, 'cuz I do have mental health issues and I forget things . . . and I need help getting all my paperwork done . . . my MediCal cards and stuff like that."

Anne was sometimes unsure of her medical diagnoses. "I was using birth control pills and got an STD. Had do you explain that?" Other times, she chose not to disclose certain information about her jail time. She also struggles with issues shame and guilt, "I didn't say anything (about my drug use) because I was just embarrassed. I was embarrassed that I was using drugs; that it wasn't a good thing to do. It wasn't right for me to do and I didn't want to be yelled at for that . . . So, I guess, for not telling him (the ED doctor who forcefully stuck the needle in her arm before anesthesia took place), that was my little punishment." Rather than being labeled as a drug addict, Anne worries too about being labeled with a psychiatric diagnosis. To her, a psychiatric label brings on more stigma than being a drug addict. Anne explained, "They try to tell me I had all kinds of mental illnesses and I know I don't have those . . . I'm just a dope fiend." Anne also worries that she might become dependent upon psychiatric medications, "I don't want be dependent on anything else."

There were friends that helped Anne get her needs met when she was sick in jail. She explains, "The girls [other inmates] will help you out if you need medication or something." Sometimes, however, Anne states she has to "get in somebody's face to get care." Anne talked about having to lie on other occasions to obtain free healthcare. When Anne told her provider that her "tubes had been tied," she could not get a free physical." In order to get a free physical, she had to lie and say that she needed contraception. In order to get her needs met, her medical records inaccurately reflected the purpose of her visit. At times, Anne receives healthcare serendipitously by taking, "somebody else's appointment."

Anne has also experienced problems at the clinic where her health needs were not met. In these instances, providers and staff were also not caring or compassionate. Anne explains, "You have to be drop-dead sick to get your meds" or "they just left me in the emergency department." She quoted her providers once who stated, "I'm not giving you any medication for that" or, even when she was still sick, the doctor said, "You'll be OK, everything is just fine."

Anne also relates stories of good doctor visits. When she knew that someone who had a doctor's appointment had been arrested, she took the appointment slot. "You just do it." Anne is a persistent woman, even when no one else is there to help her. Anne also says that friends help her sometimes when she is ill. "They just step in for you." Anne also says that some nurses have helped her. They "had heart" Anne remarks. Sometimes Anne is required by the court to get drug tested. Overall, Anne says she has had some good and some "not so good" visits. Anne says she will now continue to look for those people who are caring when she goes to the clinic. She will also seek out her helpful friends in the future when she is sick.

The purpose of this grounded theory study was to explore formerly incarcerated women's perspectives on healthcare encounters. This research focused on the following questions:

1. How did formerly incarcerated women perceive healthcare encounters?
2. How did they describe difficult healthcare encounters?
3. How did they describe successful healthcare encounters?
4. What did they suggest to improve healthcare encounters?

This chapter presents the findings of 8 individual interviews and 2 focus groups with a total of 16 participant “voices” in the foreground. This discussion includes the participants’ perspectives of multiple health problems, other special problems, and the results of healthcare encounters including unsuccessful, successful, and mandated encounters. This chapter begins with a summary of the demographic data and a discussion of the explanatory model of perspectives on healthcare encounters by formerly incarcerated women.

Demographics

Age. The 16 participants ranged in age from 22 years to 50 years ($M = 37.9$ years). This population was slightly older than the average age of an incarcerated woman in the United States ($M = 36$ years; Center for Law and Policy, 2002).

Number of children. Ten participants had children under the age of 18 years. Of the participants who were mothers, they had between one and six children. Most of the women had given custody of their children to other family members upon their incarceration. Some of the participant's children were placed in foster care and one of the women in the study had completely lost parental rights. In many cases, the women had legal but not physical custody of their children. None of the women could assume custody of and responsibility for their children at the time of the study. Interestingly, only three participants spoke of their children during their interviews.

Incarcerations. Participants were sentenced to jail terms between one and five times ($M = 2.9$ times). Crimes included possession of a controlled substance, shoplifting, robbery, fraud, prostitution, possession of a firearm, grand theft auto, and drunkenness in public. Most of the women were incarcerated for drug-related crimes. All of the women

were sentenced to jail time, with one participant serving prison time on two separate occasions. Four participants were jailed 5 times for an average length of incarceration of 13 months. The average length of incarceration was from 2 to 13 months (see Table 2).

Table 2

Incarceration History of Study Participants

Number of Incarcerations	Frequency of Incarceration	Average Length of Incarceration
1	2 participants	2 months
2	5 participants	14 months
3	3 participants	10 months
4	2 participants	5 months
5	4 participants	13 months

Other demographic information. Tables 3 and 4 highlight other demographic characteristics of the study participants.

Table 3

Demographic Characteristics of Study Participants

	Frequency
Race/Ethnicity	
White, non-Hispanic	10
Hispanic	4
Asian	1
Pacific Islander	1
Marital Status	
Single	6
Divorced	6
Separated	3
Married	1
Level of Education	
Grade 9 – 11	3
Grade 12	6
Some College	7
Employment Status	
Unemployed	11
Employed	3
Disabled	2

Table 4

Other Participant Demographics

	Frequency
Insurance Status	
No Insurance	8
Medicare/Medi-Cal	3
CMS	3
PPO	2
Living Arrangements	
Recovery Home	10
Single Living	4
With Family	2
Unsolicited Medical Conditions^a	
Dual Diagnosis	16
STDs	6
Hepatitis/HIV	4
Dental Problems	8
Respiratory (e.g., Asthma, Bronchitis)	6

^aNot requested but disclosed during interviews or written on demographic form but not requested.

Figure 1: Perspectives on healthcare encounters by formerly incarcerated women

The Explanatory Model

In addition to the demographic information, an integrative diagram is displayed in Figure 1 to reflect the perspectives on healthcare encounters by formerly incarcerated women. This model demonstrates the core category (Strauss & Corbin, 1998), of “going back-and-forth” as the frequent healthcare experience or action/process of formerly incarcerated women. These encounters were affected by multiple health *conditions* and other special problems in the *context* of a fragmented healthcare system.

Conditions – barriers. Conditions that served as barriers included: (a) lack of knowledge and inaccurate information about illness and/or disease, (b) lack of disclosure and concealment regarding illness or incarceration history, and (c) feelings of shame and poor self-esteem. In many instances, the *consequences* were associated with *unsuccessful encounters* where needs were unmet, and this circumstance ultimately influenced the women’s overall health.

Contingencies - facilitators. Key factors associated with *successful encounters* were the facilitators and included: (a) persistent women, (b) helpful others, and (c) caring providers. If these conditions occurred, the participants usually experienced successful healthcare encounters. Other scenarios supported successful encounters even if the women lacked persistence. In a few circumstances, women persisted even though they lacked the assistance of helpful others or caring providers. At times, they still realized successful healthcare encounters where their needs were met. Mandated encounters were neutral encounters, required by corrections. The women did not report these encounters as either negative or positive. The women viewed these encounters as “part of the process.”

Multiple Health Problems

Although the researcher did not ask the women to disclose specific health problems, the women wrote their medical diagnoses on the demographic form and offered additional information about their health concerns during the interview sessions. All reported either acute or chronic health problems at the time of the interviews. Some had both. Women identified physical, psychiatric, and/or dental health needs.

Physical problems. The physical ailments recorded by the participants included skin conditions such as abscesses, migraine headaches, asthma, chronic bronchitis, hypertension, and other cardiac abnormalities. They also listed arthritis, diabetes, thyroid problems, and infectious diseases such as hepatitis A, hepatitis C, and human immunodeficiency virus (HIV). Additionally, they related gastrointestinal problems, urologic problems, and gynecologic problems including sexually transmitted diseases.

“How do you explain that?” The women demonstrated little understanding of their bodies and their medical diagnoses. For example, although some had taken the time to obtain some form of contraception, they demonstrated a knowledge deficit regarding the transmission of sexually transmitted diseases. One participant stated, “I mean, I was using birth control pills and got an STD. How do you explain that?”

“Because I didn’t know.” Another participant remarked she “didn’t know” about many of the problems associated with being sexually active with a boyfriend who was an intravenous drug user. During her interview, she explained that her doctor had offered some guidance about having sexual relations with her partner. This woman commented on her physician’s medical advice.

“You shouldn’t be with this person because if he’s using and if you sleep with him or have intercourse with him, you may contract something from him.” And, I did...because I didn’t know. I got an infection and it happened more than one time but I got treated for it...

“Who knows?” One participant explained that she was worried that she may have contracted hepatitis C. She explained that she had used intravenous drugs for over a decade but had never been tested.

I’ve been an IV drug user for close to 10 years and when you’re out there running around; you gotta do what you gotta do. So, now I know I need to get tested for hep C. I don’t know if there’s any symptoms for Hepatitis C, I mean, I could have had it for the past 10 years. Who knows?

“What are the symptoms?” Another woman, conveyed her lack of knowledge regarding her Hepatitis C diagnosis when she stated, “I’ve had Hepatitis C for years. What are the symptoms and prognosis?”

“My annual Pap.” Few of the women were familiar with the concept of preventive screening. During one interview, a menopausal woman casually mentioned, “I need to have my annual mammogram” and another stated, “It’s time for my annual Pap smear.” However, most of the women explained they only scheduled themselves for a Pap smear as a way to get their contraceptive needs met. They admitted they had never thought of the exam as a part of a preventative health screening program.

Therefore, participants frequently had a knowledge deficit about their illnesses. They were also lacking appropriate information about their diseases. Additionally, most of the women admitted they had health issues that existed long before they entered prison

or jail. They mentioned that when they were on drugs or using alcohol they did not care about themselves or their health. However, when they entered prison or jail, they were forced to abstain from drug and alcohol use, became sober, and eventually became more conscious of and interested in their health.

Some of the women with chronic healthcare conditions were *coincidentally* released in a better health state than when they entered prison or jail. To illustrate, one participant with chronic bronchitis and asthma was sent to jail for possession of a controlled substance. She related a story of being able to “get all my respiratory inhalers to take care of my asthma when I was in jail.” While this woman finally took some interest in herself, she did not receive much information about her health from the correctional providers in planning for follow-up care after her release from jail.

In sum, although many of the women did not have the appropriate healthcare information, most appeared to be interested in their overall physical health post-incarceration. However, they also had other healthcare issues, specifically psychiatric problems.

Psychiatric problems. All of the women reported that they had psychiatric health needs, including problematic substance use. Participants reported drug use as their primary health problem. Substances included prescription drugs such as Vicodin, Oxycontin, marijuana, methamphetamine, cocaine, and heroin. The other most frequently used substance was alcohol.

Alcohol use: “The little drink mixer.” Several women reported they were *alcoholics*. One described how she began drinking when she was 11 years old. She stated

that she had been an alcoholic, in addition to her other addictions, for at least 15 years before she quit drinking.

Interviewer: You'd been drinking since you were 11?

Participant: Yeah, I used to be my mom and step-dad's bartender. You know, their friends would come over and I was the *little drink mixer* and I had to taste test everything. They would have wine tasting things all the time and my sister and I got to drink the leftovers and it was very sporadic when I was growing up, but, when I was about was 17, I drank all the time. Both my parents were alcoholics and it was just something that was *normal*. So, I drank, a lot.

There were other stories of alcohol use. Some were arrested several times for the same abuse.

"Been arrested four times." Another participant indicated four of her incarcerations resulted from alcohol use for driving under the influence (DUI).

I'm 47. I have a young daughter; I've been here...from the local jail which I spent 20 days at and that was basically first time there in jail. And, I've been arrested three times before for the same thing. I was also diagnosed with anxiety and depression and I'm on meds for that...

Other psychiatric problems reported by the women included diagnoses of anxiety, depression, bipolar, schizophrenia, and intermediate explosive disorder. Interestingly enough, participants did not specifically elaborate on their psychiatric diagnoses except to discuss them within the context of their *dual diagnosis*, defined as a substance use disorder and a psychiatric disorder.

Dual diagnosis. Many of the women reported having a dual diagnosis. Several of the women reiterated they had received their psychiatric diagnosis within the past year at the time of release from jail or prison. The women were over 35 years of age and stated they had been junkies and had struggled with mental health issues for years.

Some of the participants wanted to *conceal* their mental illnesses. They were more comfortable with the *drug addict* label than the *psych patient* label.

"I'm just a dope fiend." One woman, whose prison time spanned 20 years, related that she had just received her dual diagnosis this year as a person with "bipolar paranoid schizophrenia."

I mean, there are so many mistakes going on...all of a sudden, you're diagnosed with all these things. You know what I mean? All these mental illnesses. That you don't have. They tried to tell me, I had all kinds of mental illness and I know I don't have those. *I'm just a dope fiend.* I'm an addict.

In addition to not wanting to be stigmatized with yet another label, most of the women chose not to disclose their psychiatric diagnoses. For others, they were fearful of becoming drug addicts by taking psychiatric medications.

"I don't want to be dependent on anything else." Some participants worried about becoming addicted to drugs again, so they did not take their prescribed psychiatric drugs. One participant stated that after leaving jail, she no longer took her psychiatric medication because she "no longer needed them" and now she "felt better." She also reiterated and expressed fear that she would use drugs again if psychiatric medications were prescribed for her. She conveyed her story about why she will no longer use her prescribed psychiatric medication.

Participant: I myself chose not to because of my last withdraw(al) experience. I don't ever want to have to wake up and feel that way and *be dependent on anything else* ever again and there's the people that say you're not very happy maybe you need Prozac may you need this. Well, you know, for me I just...
(pause).

Interviewer: Why do they say you're not happy?

Participant: Well, because you know sometimes I've been grouchy in the years that I've been clean. They see that I'm moody, mood swings up-and-down, but, that's just life. I mean everybody feels, you know, upset, or happy, or depressed, or pissed off at one point or another whether or not they have to understand myself. I mean. I know, for me, I can't use any, any drugs that's gonna alter my moods. I might like it and then I might choose to continue doing it and try something else and try something else. So, I keep my hands off all of that mess. I don't want to get involved...

Another participant, also diagnosed with a psychiatric disorder in prison, relayed her reasons for not wanting to "become addicted" again. She too had made the decision not to take any prescribed psychiatric medication post-incarceration.

I'm not on any type of...Paxil...or all that stuff. I'm not on none of that because *I'll get addicted* to it because it's mind-altering. I've taken Seraquel but no surprise, I got addicted to it real quick. So, I don't take none of that stuff...

Other mental health problems. In addition to substance use (i.e., abuse) and being labeled as a person with dual diagnosis, the women also grappled with other issues that

resulted in psychiatric health problems. These included emotional concerns regarding shame and worthlessness. These participants related their distressing stories.

"My little punishment." The first woman related several stories about how much guilt and shame she experienced when she was seen in an emergency department for an abscess with cellulitis of her forearm. The physician performing the procedure anesthetized her arm but did not wait for the anesthetic medication to take effect.

Participant: There was blood poisoning happening about 4 days later. I had the line going up my arm and so, I had a no choice. I knew I had no choice. So, anyway, I went to the hospital for treatment...(I) went into the emergency room to have them look at me. (They) put me back there. The ER doctor again, when he raised my sleeve, he could see that I was an IV user. He gave me a shot of something for pain and then he numbed my hand. But, within 30 seconds of numbing my hand, I think the two people that were there were interns and they were watching it---they took a couple of gasping breaths, because he put the scissors into my hand and he opened it up and twisted it. It did not have enough time to be numb.

Interviewer: But, you didn't say anything?

Participant: I didn't say anything because I was just embarrassed. I was embarrassed that I was using drugs, that it wasn't a good thing to do. It wasn't right for me to do and I didn't want to be yelled at for that basically. So, I guess for not telling him, that was *my little punishment*.

In addition to feeling stigmatized, this story also illustrates this woman's lack of disclosure regarding her illness. She was embarrassed about her substance use problem

and wanted to conceal it. Her feelings were confirmed when there was retribution by the provider.

"I shouldn't be there." The second woman described how worthless she felt when she sought out a healthcare provider. She reflected on how unimportant she felt during a recent healthcare encounter.

Participant: You know, they're supposed to be caring. They're in the medical field, the caring field. You're to care for others. They should be, they're supposed to be professionals and they're supposed to be caring. I wish their attitudes were better towards that instead of being so hard and calloused. You know what I mean?

Interviewer: How does that make you feel?

Participant: It makes me feel like...*I shouldn't be there*, like I need to find a different doctor or something.

"We've all had a lot of trauma." This woman indicated she struggled with issues of shame and stigma after being sexually abused. She spoke briefly about her abuse when she said, "... most of us inmates have had a lot of trauma in our lives. You know what I mean? *A lot of trauma...*" She related her emergent need for psychiatric evaluation after relating her unfortunate story of molestation and rape. She went on to state that her previous incarcerations were partly a result of her problematic life after being sexually abused. This abuse led to drug use. The drug use led to a jail term. Therefore, this woman attributed her drug use to previous abuse.

In sum, women were confronted with a myriad of mental health problems. Having so many concurrent physical and psychiatric problems made healthcare encounters

difficult for them. These conditions led to negative encounters on many occasions. Their needs remained generally unmet.

Dental problems. In addition to their mental health needs, probably the most neglected condition of the women was their teeth. Dental needs represented an arduous challenge for them because medical providers did not want to examine their teeth. All of the women suffered from damaged, diseased, or abscessed teeth. Some dental issues were the result of poor overall health, lack of previous dental care, and the use of substances that caused tooth decay such as alcohol, drugs, and tobacco. Many of the women were aware that their use of methamphetamine and the acid nature of the drug caused a distinctive tooth decay pattern on the front of their teeth. This contributed not only to their poor dental health but to their poor appearance. Although some of the women were able to obtain dental care, most of the women resorted to having their teeth extracted to rid themselves of the constant pain.

"I got the teeth pulled." One woman told her story of having to get her teeth extracted because they were infected from decay. She was also experiencing dental pain.

I still had the abscessed teeth so the recovery home put me on a waiting list here. It took about three months before I was seen...And then I got the teeth pulled. I was released January and it was the end of March before *I got the teeth pulled*.

"One extraction per year." Another woman described her issues surrounding access to dental care. She described her difficulties in obtaining health insurance to get her teeth pulled.

Participant: I can't even get on Medi-Cal to help me with my teeth and county services *only pays for like one extraction?* You know.

Interviewer: One extraction per year!

Participant: They just said one. And I need a whole plate. These are the only teeth I have.

"They finally gave me a shot." Finally, nearly all of the women in the study had teeth needing repair or required some type of dental service. Many of the women mentioned that they had not been able to obtain dental care during their time as an inmate or upon release from prison or jail, and consequently, they used the emergency department (ED) as a last resort. One woman recounted her unfortunate dental treatment in the emergency department.

Yeah, like when I went to the same hospital from the old days...I never had my insurance card on me because it was on file. Like I got seen right away and then like I had a abscess for my teeth, not too long ago, and after my insurance was cut off and they wouldn't even see me because there is nothing they can do for me. And, I came back a second time cause it was really bad. *And, they finally gave me a shot of antibiotics...*Cause like my whole face was swollen.

Some described circumstances where negative consequences were associated with their care. In some instances, the women experienced delays in treatment for their dental abscesses and the resulting facial cellulitis required hospitalization. When the women were finally able to find a dentist, the treatment involved merely pulling their teeth.

"Running around with no teeth." One participant related a story about her inability to obtain a new set of dentures. The participant stated that she was given a set of teeth and had lost or misplaced them while she was in jail. She stated that she was told by her dentist that her insurance would only cover one set of dentures every five years. She

explained that she would now have to wait for three more years before she could request another set of teeth. She explained her predicament in this way:

My dentist says he made me some dentures and so I went back in 2005 and I needed more because I had lost them but I don't remember him giving me them in 2003. So, I went to Mexico and bought them...He says he gave them to me. Maybe he didn't but, he says he won't give me no more until 2008. *So, now I have to run around with no teeth* because I can't go to Mexico cause I'm on probation...I can't afford it. Yeah, he said I have to wait 5 years.

"It's bad for employment." In addition to the damaging effects on their general health, most of the women who had teeth in poor repair stated that they were unable to obtain employment because of their physical appearance. One participant remarked, "I don't have no back teeth. *It's really bad for employment.*"

"It hurts my esteem." The same participant also discussed her feelings of low self-esteem. She related how she felt she was now regarded by others.

Yeah, and so now I have to run around like this and I mean it's really awful because I don't like the way I look and *it hurts my esteem* and so I don't really want to talk to anybody.

"I can't even eat." This woman also explained how this circumstance resulted in her inability to eat and chew food properly when she remarked, *"I can't even eat, you know, real well. It takes me a long time to eat things. I don't have no back teeth."*

Hence, as with physical and psychiatric issues, dental issues posed a serious problem for the women. Most sought treatment at low-cost clinics and had their teeth pulled. Others received no care at all. Some ended up in emergency departments with

urgent condition. Sometimes women were even hospitalized for complications associated with dental disorders. In addition to multiple health problems, the women also had significant personal issues that interfered with their ability to meet their healthcare needs.

Other Special Problems

Lack of money. Clearly, the most significant issue faced by all the women was their lack of money. Many times, the lack of money translated into survival needs such as buying food, finding shelter, and getting clothing. Consequently, at those crucial times, health was not a priority.

"I didn't have the money." One participant made the decision to pay her rent rather than obtain her psychiatric medication. During a focus group, she bantered with another participant.

Participant C: But \$20 is a lot of money...

Participant A: Not really.

Participant C: Oh, it is if you're paying for your rent, you know.

Participant A: Well, yeah...(pause)

Participant C: So *I didn't have the money* to get my meds filled...

"I had no money for bus fare." One woman related a story about missing her medical appointments because she had no money. She stated, "I've missed lots of appointments because of no transportation, or, not even bus fare. I'm not going to make any excuses but, *I didn't even have money for bus fare.*"

"I had no money to pay for my meds." One participant talked about how difficult it was for her to obtain her Paxil medication post-incarceration. She said, "I mean, I knew

I needed to get...the meds, but at the same time it was going to be a problem because *I didn't have any money to pay for my meds.*”

Lack of literacy skills. Some women also had lacked basic literacy skills. They had difficulty reading and writing. They had problems completing other competencies such as the ability to communicate using other resources.

“It’s just so hard for me.” One participant commented on her difficulty in paying her bills, “ . . . you know, normal people work and pay bills...and there's no reason why that I shouldn’t be able to do that. *It’s just so hard for me . . .* ”

Other participants were deficient in health literacy. They had trouble obtaining, processing, and understand basic information and services needed to make appropriate decisions regarding their health. For example, another participant emphasized personal issues with regard to lack of medical insurance and the need to have assistance with completing the medical paperwork since she was diagnosed with a psychiatric disorder.

“We just need some help.” ...I think if you don’t have any kind of medical insurance, that they should have something to *where they can help you*, you know. I do believe that it's the law that if you're homeless and you have no insurance, three times a year you can be seen in a clinic. I'm not homeless but I don't have the insurance right now so this is one of those times.

This situation also points out the need for others to assist them with basic skills. Furthermore, these circumstances became even more problematic for a woman who lacked basic healthcare navigational skills. She related the following information.

Participant: Make sure that if we don’t have medical insurance, if we’re just coming out of jail, of course we’re not going to have medical insurance. Maybe

have a social worker that'll help us get a medical card and...if we need Medi-Cal, help us get our Medi-Cal...Because sometimes, for people, like me cause I do have mental health issues and I forget things...*and I need help* getting all my paperwork done and getting my things, my medical cards and stuff like that because I just simply forget...Yeah, somebody to help...for those of us that need help---*to have help there for us when we need it.*

Again, this example highlights the need for assistance from helpful others. Faced with many personal hurdles regarding the lack of money, competing priorities, social role commitments, and other issues, healthcare encounters became difficult for the women. They usually had no health insurance and could not afford care. All these complicating factors made health encounters difficult.

In summary, women reported multiple health problems including physical, psychiatric, and dental ailments. They stated they were persons with dual diagnoses. They related how they suffered from feelings of shame and worthlessness. At times, they denied their illnesses. In addition to all of those issues, they had other personal problems. As previously noted, the women attributed their relapses to their inability to afford medications. These encounters were deemed “negative”, “positive”, or “mandated” by the women.

Mandated Encounters

The mandated encounter was one required by the correctional system. These were non-patient initiated encounters. An individual such as a drug court counselor might order frequent, random urine tests for the purposes of screening for illegal substances. In other cases, participants were required to have certain laboratory tests performed for the

purposed of obtaining information regarding the women's overall health status. One woman described her *mandated encounter* neutrally when she was sent to a clinic for a required liver panel drawn for Hepatitis C.

I'm in day treatment and part of the requirement is that I go get my physical exam and um, I also have Hepatitis C so it's good that I get my liver panel checked or I probably wouldn't have done it---because I'm not sick but it's required by my counselor.

The women interviewed for this study displayed neutrality in these situations. Although they did not like the requirement of having to be drug tested, they saw it as a necessary means to an end. A negative drug test meant the women were on their way to being eventually released from the correctional system. In other instances, there were patient initiated encounters. Some were described by the women as positive; others described them as negative encounters.

Negative/Unsuccessful Encounters

Most of the women had multiple, complex health problems, no money, and lacked basic literacy skills. Many reported feeling ashamed. Furthermore, they all indicated that they struggled with more than one barrier simultaneously. The women felt they were already set up to fail because they were overwhelmed and so they just gave up. These insurmountable obstacles usually led to unsuccessful or negative encounters, both in and out of prison.

Prison encounters. During incarceration, the women's physical, psychiatric, and dental care needs were under the jurisdiction of the correctional health system. Many of their healthcare needs remained unmet during their prison or jail terms.

"Drop dead sick." When asked to describe a recent healthcare encounter, the participants recounted their poor prison healthcare experiences. The first participant described in detail how women had to be *drop dead sick* in order to be seen by a healthcare provider.

Participant: Prisons are worse than jail sometimes...

Interviewer: Prisons are worse. Okay. Tell me about a bad visit then that you had in prison. Did you get to see anyone?

Participant: Well, it just took me a long time just to get my docket to go to the doctors. You have to ask to see the nurse first then you wait for hours and hours, sitting outside and then, it depends on which nurse you get whether you get to see the doctor. If it's a nurse that really doesn't care about you, that don't care what you're saying, she's not even going to let you see the doctor. It depends on whether or not you're *drop dead sick* and I mean falling out sick will you get to the doctor.

Interviewer: Did you get to see the doctor that day?

Participant: No, the nurse just wrote me some cough drops and some Tylenol, that's all.

Interviewer: And you were sick?

Participant: Yeah.

This story illuminates the lack of caring by healthcare providers. There were others who related similar tales.

So they stripped me. This participant also described her negative jail experience when asked to recall a recent healthcare encounter. She vividly described her recent jail experience.

So I went to jail. And they put me in a holding tank for 48 hours--- a suicide watch---for 48 hours. *They stripped you down* naked and they close you in there with nothing---without your glasses and stuff. So that was their solution to dealing with someone who's going through panic attacks---to close them up in this small cell. When the psychiatrist came on duty, they decided that, "Ok, yes. She seems like there's no suicide issues here." So they released me into general population and I spent 7 days in jail, without medical, without psychiatric care, without the medication that I was on. *So they stripped me* from the medications too. I eventually got out of there...

To summarize, when asked to discuss healthcare encounters, some women talked about their prison encounters stating that the "medical care is subpar at best." In general, these past prison encounters were usually negative ones resulting in unsuccessful visits where they did not get their healthcare needs met. One woman stated she was labeled as "the difficult patient." The healthcare that the women received in prison or jail may have influenced their perceptions of post-prison healthcare encounters.

Post-prison encounters. In post-incarceration scenarios, women stated they too had difficult encounters. Many of these experiences resulted in unsuccessful healthcare visits with unmet needs due to "back-and-forth" healthcare experiences, being shuffled around to various providers and to various healthcare facilities in order to obtain care.

"I had a total episode." One woman related a story about how she had gone to a community clinic for a physical ailment but also wanted to renew her prescription for the psychiatric medication she was taking. She was told she would not be able to obtain a prescription for her medications. She needed to obtain her psychiatric prescription medication through the county system. She also explained that her psychiatric medications would only be covered when written by a designated provider in that system.

Interviewer: So you went to Mental Health up here... which is how you are getting your meds?

Participant: Well, no ...they assigned me to a clinic right here. They gave me the temporary mental health services and...assigned me to a regular clinic...nobody wants to give me psych meds. So, it's back-and-forth...I go to the regular clinic for the heart condition (and)...blood pressure medication...some kind of antibiotic for the abscesses until my dental name comes up, and to get a prescription for the Motrin or Naproxen...And, this doctor was brand new to the community clinic and was treating me for the anxiety disorder which she should've been treating me for bipolar but she just saw me in an episode and thought I had an anxiety-panic attack thing going on so she gave me Zoloft so I started with 10 mg, then 20 mg, then 50 mg, then 75 mg...at the end of 4 months and I said, "If you give me one more milligram of this I'm going to shove it up somebody's butt because it's making my manic moods, so manic, and then when I come down I want to rip somebody's head off." And I said, "This is not the medication for me. I can't stand it." So she said, "Okay."

Then the nurse said, "How are you getting anxiety meds here through the clinic? And I said, "I don't know. I don't want to take them anyway." (*laughs*). "I don't want anymore medicine. This is crazy. And, I just heard that you might back charge me for all these visits and medications because it's not covered under my county mental health services." ...So I still haven't heard that it's going to happen...I may have to pay \$600...

So, yeah, then I said, "What can you do for me? You're taking me off this medication (*snaps her fingers*) just like that?" She said, "I'm gonna detox you in 8 days." ...she detoxed me in 8 days. I was so sick. I was getting up and throwing up and I had diarrhea. I lost 15 pounds. It was horrible.

Interviewer: Why was it important to detox you in 8 days?

Participant: Because my county insurance was running out... and she referred me to County Mental Health. I went in to County Mental Health. They said they couldn't help me because I was in part of a drug rehab, drug court program. So, they sent me to a regional substance use treatment program. I went to that program and they said they couldn't see me because I have no insurance, no Medical and I'm part of drug court and they can't. I'd have to get a permission or a release from drug court to be able to do their program. I couldn't do the program simultaneously. My program wouldn't let me do the other program. They wouldn't relieve me from there for six months so that I do this program. So, then I went to a different regional substance use treatment program, *back-and-forth*...went down to this program and I walked in there...no meds, completely depressed...*I had a total episode.*

This episode illustrated the central theme of “going back-and-forth” regarding healthcare experiences that nearly all of the women experienced post-incarceration. This woman clearly described her back-and-forth circumstances within the context of a fragmented, convoluted, complex healthcare system. This woman demonstrated how, even though it was a negative encounter, she did not give in to the system in this situation. In another circumstance, however, she just gave in and used drugs.

“And so I got loaded.” This same woman angrily related her story about another negative healthcare encounter. Her inability to obtain her psychiatric medication ultimately resulted in her reincarceration 3 days after release from jail.

I was just taken off of it cold turkey ‘cause I was released without a prescription. I couldn't even get them to write a prescription for me even if I had somebody to pay for it...I was coming down off the medication. I was feeling horrible...*and so I got loaded.*

Many women relapse when they have difficulty overcoming many of the healthcare barriers with which they are confronted. Furthermore, it is also difficult for them to even obtain adequate healthcare.

“They said everything was fine.” One participant reported she was misdiagnosed with a medical problem. She described her visit to a local clinic and also discussed her delay in diagnosis with regard to her gynecologic problem.

“I, really like that clinic because they're caring. I mean, and, if they think there's something more than just the initial problem wrong, they'll go a little bit further with it like, when they saw that I had a urinary tract infection--- got the urine

results back, found out it wasn't that. So, the doctor said, "Well we're gonna take it a step further and give you a pelvic exam." So, that's what they did. They did the pelvic exam and then they called me with the results, a week later, and *said everything was fine*. (This woman later found out she had an STD).

This example illustrates several points. Although this woman seemingly left the visit, and initially labeled her visit as a positive encounter with caring providers, she was upset later when she learned she had been misdiagnosed. She also realized some time later, when talking with her counselor, that she lacked knowledge about disease transmission regarding STDs and this resulted in the omission of crucial information to her health provider. This situation may have also resulted in misdiagnosing her STD. Additionally, there were other examples of negative healthcare encounters.

"I'm not giving you any." Another participant described her unfortunate healthcare encounter at a clinic where she did not receive an antibiotic medication. This resulted in an unnecessary hospital admission a few days later.

So, I went to the neighborhood clinic...and, the doctor came in and I told her that I'm kinda of short of breath and I have asthma and I feel all my mucus is a little green now and I feel I need antibiotics now. And, she took a stethoscope and listened for a second to my chest and said, "Well I don't hear any wheezing, so you don't need any antibiotics." And, I said, "I'm telling you I do need antibiotics. She says, "No, I'm not giving you any." And, I asked her if she can give me some. I know myself and I need some and she refused and said, "All, I'm giving you is a breathing treatment and that's it. And use your inhalers."

(She) had the nurse come in the room, give me a breathing treatment, and she walked out of the room. And I was really upset about it. I left and 2 days later I went to the emergency room where they said, “Go tell that idiot doctor that you saw, that the reason she didn't hear any wheezing is cause you have absolutely no airflow on this side of your lung, and, they admitted me because my blood pressure was 70/50 and 60/50 and my oxygen (saturation) was 89 and 88% and they admitted me. They refused to give them (antibiotics) to me...and then two days later they admitted me for pneumonia.

This story illuminated another negative healthcare encounter. In this case, there was associated morbidity. She experienced so many back-and-forth encounters with this clinic. She admitted later, however, that she initially waited to go to the clinic when she first learned she was ill. These participants experienced other negative encounters as well.

“They just left me.” Some women in crisis who accessed the emergency department had difficulty obtaining care. One participant relayed her frustration with care during a psychiatric crisis.

Participant: This particular time when I was released...I was having a psychotic episode. So, I went to the hospital emergency room. My father took me there and what I remember of that is... I sat...on a gurney in a hallway... freaking out, needing attention... and I didn't understand what my mental condition was really. And all I knew was that I was bipolar ...so if don't take my medication then, you know, or if my medication needs to be adjusted, I have a psychotic episode...And instead of them helping me *they just left me* on a gurney for 9 hours...My dad was giving me Seraquel (in the ED) ...every hour just to try and knock me out. And

that's how bad of an episode I was having...I waited...and then all they did was a urinalysis. They only cared if I was on drugs. As soon as my urinalysis came back negative they said that they found a psych bed for me, 40 miles away...My dad said, "Why won't you just admit her to this hospital right here. She's in dire need." It was just horrible...So, I remember what he did. He just (*pause*) put me in the van and he said, "I'm not letting you go to any place like that"...So, my dad wrapped me up in a blanket 'cause it was late at night and he took me home...

This case is illustrative for several reasons. Initially, this woman felt stigmatized because of her previous drug history since she had been a frequent visitor to this hospital. Therefore, this woman did not get her healthcare needs met. Ultimately, however, she did have an assistant, her father, who supported her as a helpful other and she was later admitted to a psychiatric facility where she was evaluated. Finally, this story revealed that, initially, there were no caring providers. There were other instances where providers were unsympathetic and lacked compassion.

"No heart for it." Several participants described encounters where providers did not want to concern themselves with the women. There were many narratives that could be categorized as having "no heart for it."

One participant related in detail her no-heart-for-it story regarding her session with a group counselor. This story was told within the context of her recent group therapy meeting.

They just recently started a group for dual diagnoses and I had a counselor that was like, a real seasoned counselor, running and facilitating new groups. And, so, she's a dual diagnosis herself and she's *got a sort of heart for it*. So, I thought,

okay, this is going to be cool because they've accepted Medi-Cal there at drug court now for this group. So, now the counselor gets bogged down with...She's got her caseload and it's already overwhelming. Then she takes on this new group that's sorta gonna be like her project and she's got a heart for it. But, then when she realized what's involved in the paperwork and that she can't use the same tactics such as yelling at them, that these groups with people with mental illnesses that they have, especially the ones they're like schizophrenics and things like that. You start screaming at them and you get somebody in a psychotic episode and you're in big trouble...she's got no heart for it.

Women recited other stories of how providers had no-heart-for-them. For example, after using heroin for several days, one woman was never confronted about her drug abuse by her provider. She concluded that the provider just did not want to deal with her drug problem.

Interviewer: "Did you want to be confronted?"

Participant: "Not when I'm there. No. As I look back in my head, I realized that, it's so easy to manipulate the healthcare profession into giving you drugs. And, it's very limited that I find someone that I can't. I think that the doctors...they don't want to deal with it at all, because they're not interested, and it's not the kind of medicine that they want to practice, or, they're really are a good doctor and they will try to bring it up and then they realize, you know, they only have a little bit of time with you. So, what are you gonna do?"

Furthermore, one participant discussed her no-heart-for-it experience when she had to have blood drawn. She described her disgust regarding the lack of professionalism and training of some of the nurses.

Interviewer: That's not good. The last time you were seen for endocarditis, were you seen by a nurse or a doctor?

Participant: Yes. I was seen by three nurses. They were trying to get a sterile blood draw out of me, and they just jabbed and poked...instead of taking their time and doing it where I'm saying. I was a junkie for 26 years. I know where my veins are and I know how they work....If they would have just slowed down and took their time. They woulda got their sterile blood draw. But they were just busy jabbin' and poking saying, "Oh, I can't do this." Four times being poked is enough!

Interviewer: How did that make you feel?

Participant: Oh, pretty disgusted...I felt like I got stuck for nothing because they never got the blood sample.

Interviewer: They never got it. So then what happened?

Participant: Then they wanted to send me out to a lab to where they could draw my blood but I don't have no medical insurance so I can't go down to it to get the test done.

Probably the most riveting story of no-heart-for-it was reported by a participant who chose to describe her past prison jail experience during her interview rather than a recent post-prison experience.

Participant: I delivered a baby in prison. It wasn't so bad that they didn't give me pain medication the entire time. What really bothered me is that I was shackled the entire time. Come on, where was I gonna go?

To summarize, the previously noted stories illustrated negative encounters during and after incarceration. These unsuccessful encounters were the result of back-and-forth encounters from a fragmented healthcare system devoid of providers who cared. Fortunately however, the women realized some positive healthcare encounters when certain elements were present.

Positive/Successful Encounters

Many of the women worked the system to get their healthcare needs met. Although the women in this study demonstrated persistence regarding their health prior to incarceration, their ability to manage their own healthcare was clearly evident when some of the women entered prison.

Prison encounters. At times there were caring providers but sometimes the women had to enlist helpful others such as other inmates to get their health needs met. These resourceful, resilient, and capable women displayed persistence and perseverance.

"The girls will help you out." When asked to describe a recent healthcare encounter, one participant chose to describe a previous prison healthcare experience. This woman shared her story about how she obtained antibiotics for her infection.

Participant: So, I had the other girls come in finally and gave me antibiotics.

Interviewer: So do the other girls just save their antibiotics? Or, do you use, sort of a voucher system?

Participant: I didn't have to pay for mine *but the girls, if you have a good friend they will help you out.*

Interviewer: So that's really how you get your antibiotics?

Participant: That's how I got everything I needed in prison.

A few women stated they got their healthcare needs met by providers. Here is one woman's story about how she discovered she finally had a psychiatric diagnosis. She related her prison discussion during a visit with her physician.

Participant: I did get to see the medical doctor (in prison) after the second episode with the blood pressure. She gave me the antibiotics and the Lopressor and she talked to me about the staph infection and she talked to me about my drug addiction and she was running me through at first like you would, "Next, next, next" and I broke down into tears with her. And when I did that she put everything down and she took a minute with me. And, she just talked about methamphetamine and what it does to your body and how old I was and was I ready to stop...

Interviewer: How did you feel when she did that?

Participant: I felt better. A lot better...because she was taking the time to look at me, first of all, and not just pass me through the room.

To summarize, the previous examples describe not only the utilization of others including inmates and/or providers to arrive at a positive outcome. The women were also resourceful in obtaining care. In addition, there were other encounters, post-incarcerations that resulted in successful healthcare encounters.

Post-prison encounters. In post-incarcerations scenarios, some women stated they had positive encounters because of caring providers. Others reiterated that their successful healthcare visits were due to their own capabilities, their own persistence. Some related stories of both.

"I didn't get in somebody's face enough." One woman described her back-and-forth experiences at a primary care clinic after being released from jail. She wanted to obtain her psychiatric medications but was caught in a complex situation because she only had a note from a medical provider and not a psychiatric provider after release from jail.

And, I said, "Look, this is my story... You don't have a doctor that comes in here for people that come in off the street and that have no medical insurance and is dual diagnosis?. And, they said, "Oh yeah, we have a physician that comes in twice a month or three times a month or whatever." I'm like, "Well, okay. Well, let's *do it*. I mean, I was here before why didn't you do it then." I mean, I guess I didn't get in somebody's face enough... So then they made me an appointment... I was just seeing if I could see a (psychiatric) physician... to get them to prescribe me these meds... I had a psych report in jail. But, I didn't really have the psych report, I had a doctor's report.... But, because it was a psych report written by a doctor but they gave me psych meds... it just took a little but more doing...(but sometimes)... you never get medication---(*long pause*)... Unless you're really lucky... Unless somebody, just, somebody like a recovery program member or whoever *steps in for you*..... When you have a doctor's note and you're supposed to be treated for certain things you don't always (get treated)... so, I went to my (drug

court) program director...(and) gave me an appointment...at the beginning of the month... But, I said. "This is what I've been through. And I told him about...the *back-and-forth* and I said, "You know what, I just need my medication... That's all I need. And I'm going out of my skin right now. It's been 3 weeks since I've had anything. I've detoxed off the other stuff... and...now I'm afraid I'm going to get loaded again...I don't want to, I've gotten this far...I'm probably not going to, but, it's running through my head...so here I am and you said, "It's an open door policy and I need some help..."

Rather than giving up, this participant used her back-and-forth situation to her advantage, working the system to obtain a needed healthcare appointment. She displayed persistence which resulted in a successful encounter where her needs were met. She also employed a helpful other, someone who stepped in for her to achieve a successful result. Women found other creative ways to realize positive healthcare encounters.

"Contraception to get care." This participant told a story about her back-and-forth experiences. She learned how to get *free care* at a local community clinic. Free care meant that a woman had to agree to obtain some form of contraception at the healthcare visit and receive an annual health physical. However, this woman did not need contraception. She previously had a tubal ligation. To gain *entrée*, the nurse omitted the woman's past surgical history on the assessment form so the woman could get her physical exam. The participant agreed.

Participant: They have a free visit. The way you get your free visit is if you need birth control. Well, my tubes are tied. So, not until I get in the back, and this young guy's interviewing me and writing down the questions and he says, "What

kind of birth control?" And I said, "Well, my tubes are tied." "Well, that means you don't qualify." I said, well then, "Pretend like I didn't say it." And then he said, "OK." And then he went and got my paper and tore it up then and then he filled out another one and then he said, "Let's just say you use condoms."

(laughs). So I did. So I could get my free visit. *(pause)* I was kind of...feeling uncomfortable because I was falsely representing, you know, that I'm not taking care of my birth control needs 'cause really I did. So in a way that that kind is irritating...

This is another example of a formerly incarcerated woman's working the healthcare system to obtain her annual physical exam. She demonstrated aptitude and capability. Additionally, someone else also stepped in to assist her with her needs. There were other instances where this was the case.

"Somebody else's appointment." At times, chance was the reason women were able to see a healthcare provider. By displaying persistence, the women used the circumstance at-hand to their advantage to secure healthcare appointments.

This participant related a story about how she coincidentally secured an appointment with a mental health services provider to finally obtain her psychiatric medications. Apparently another individual on parole was rearrested and therefore unable to make his scheduled mental health appointment, making his appointment slot available. She described her back-and-forth experiences with the psychiatric healthcare system which ultimately led to a successful encounter.

Interviewer: And, that's how you got the appointment (for your medications)?

Participant: That's how I got the appointment.

Interviewer: Someone else's appointment (who failed to show up because he was arrested that day).

Participant: *Somebody else's appointment.* And, it's because I just kept asking. I mean for 3 or 4 days, I was motivated because I thought, you know, I got 8 or 9 months in my (recovery) Program. I'm in Phase III. I'm on my way to finally completing something...

This story displayed this participant's ability to be unrelenting until she achieved a successful healthcare result. This situation also highlighted the use of the helpful other. This formerly incarcerated woman worked in collaboration with a psychiatric counselor who stepped in to assist in the facilitation of her positive encounter. In addition to helpful others, women relayed stories of caring providers, those who "had heart."

"I kinda liked it." One of the women stated she liked receiving all of her healthcare at a local community clinic. She reiterated that her provider really cared for her.

My last experience at the doctor, I'm, *I kinda liked it.* The lady was real nice to me, the doctor. She was really nice to me and she treated me. And, she asked me a lot of questions, though, about because, I told her I was also a recovering addict. You know what I mean? She started asking a lot of questions about it and made me think about it...She took a long time with me...

"They treated me well." Another participant stated that she, too, had a positive healthcare visit in an emergency department.

Participant: Well, I just had a good one...I went in for a car accident. The nurse was awesome and we talked about school and we were talking about what I

wanted to be and we were talking about the accident. We did the accident report and ... The visit was good. I felt good about it. *They treated me well.*

"It was a good visit." One woman relayed her successful healthcare visit when she told her story about going to a neighborhood clinic.

Participant: "So, I had gone to the clinic. I actually had been sick for about 3 or 4 weeks and it went away for like 3 days. Then it came back with this veraciousness. It was really bad. I couldn't get out of bed. I was miserable (*coughs*). And, so I had gone to the neighborhood healthcare clinic. I had an appointment. I was there may be a half hour before they took me in, you know, which was pretty good, considering how awful it was that day I did a breathing treatment. I got a shot of antibiotic and of Lidocaine, and they sent me home with an inhaler, and antibiotics, cough syrup, and I'm, I mean they were pretty-- the nurse is kind of snotty when she first came so I kinda chalked it up to the fact that she was really busy and a clinic with about a hundred people waiting to be seen and probably a hundred more later that day so, it was alright though. *It was a good visit."*

The women found ways to circumvent a convoluted healthcare system to successfully get their needs met. In other instances, they were unrelenting in getting their healthcare needs met. They persisted. For others, successful encounters were credited to their healthcare providers. Finally, some visits were not described as positive or negative by the women, but, merely as *mandated* visits.

Summary

The voices of the women were the focus of this chapter. The explanatory model was used to develop the perspectives on healthcare encounters by formerly incarcerated women. The composite case served as an exemplar of this model. The next chapter discusses the findings associated with the related research. A theoretical perspective is also presented.

Chapter 5

DISCUSSION

This chapter summarizes the study findings discussed in Chapter 4 and conceptualizes the complex processes regarding the perceptions of healthcare encounters of formerly incarcerated women. Major findings are described from a theoretical perspective and supported by the literature presented in Chapter 2. Limitations to generalizability along with implications for practice, education, research, and policy conclude this chapter.

Summary of Major Findings

Formerly incarcerated women described the action/process of “going back-and-forth” healthcare encounters within the context of a fragmented healthcare system. Pre-existing conditions such as multiple healthcare problems and other issues including a lack of money and health insurance, served as obstacles to successful healthcare encounters. Barriers included a lack of knowledge and inaccurate information, lack of disclosure, and feelings of poor self-esteem, shame, and stigmatization. Multiple barriers led to unsuccessful encounters resulting in unmet needs.

When facilitators were present for the formerly incarcerated women like helpful others, and/or caring providers, participants usually experienced successful healthcare encounters. Additionally, the findings revealed that some women, through persistence, realized positive encounters, even when no helpful others and/or caring providers were there to assist them.

Additionally, some women described mandated encounters. These were encounters required by probation and parole officers. The women did not regard these healthcare visits as negative or positive, but merely encounters that were a part of the post-incarceration process.

Meaning of the Findings: "Going Back-and-Forth"

The core category in this study relates to "back-and-forth" encounters that women described as they dealt with a disjointed healthcare system. This descriptive term was used by the participants who were sent to various providers in a fragmented healthcare system. In many instances, they circumvented the system to get their healthcare needs met. Consequently, the women generally found healthcare visits complicated and inconvenient.

These concerns became more problematic for those who had a myriad of health problems and other barriers such as a lack of money and literacy issues. Many reported negative health encounters, as their healthcare needs remained unmet. In some instances, the women gave up from system fatigue; they made no attempt to seek further healthcare.

This phenomenon is consistent with several authors (Greer, 1998; O'Brien, 1998; Richie, 2001) who reported similar back-and-forth encounters of formerly incarcerated women. Maeve (2001) found that formerly incarcerated women had difficulty obtaining comprehensive healthcare.

This core category of "going back-and-forth" is consistent with literature on other vulnerable populations (Diamant, Hays, Morales, Ford, Calmes, Asch, et al., 2004). Additionally, fragmentation of healthcare has also been described in the literature with regard to other vulnerable groups such as low-income women. Issues regarding disjointed

healthcare have been widely reported in the literature of impoverished individuals with multiple health problems (Gelberg, Andersen, & Leake, 2000; Luck, et al., 2002).

Some participants had facilitators who assisted in the management of their health problems after jail or prison. However, this finding was inconsistent with research conducted by Maeve (2001), who reported that in all of her interviews with formerly incarcerated women, relapse and recidivism occurred due to healthcare system fatigue. Maeve sought to identify the factors relative to successful community transition. She found that women did not successfully achieved transition back into the community in a manner that supported themselves, their families, or the community. The women she interviewed experienced an “onward and downward momentum of health status or evolution of the following processes: economic status, physical and mental health status, intimate and family relationships, and general social functioning” (p.151). Other researchers reported successful healthcare encounters of marginalized adult women, but when certain contextual issues such as stigma were present, unsuccessful healthcare encounters ensued (Gelberg, Andersen, & Leake, 2000; O’Brien, 2002; Richie, 2001).

In this study, even though participants continued to have back-and-forth healthcare experiences, some women either circumvented the system, had helpful others, and/or had caring providers to help them meet their needs. The researcher also noted that if the womens’ actions were self-directed, they were unrelenting in their efforts to get their needs met as they moved back-and-forth between encounters. Then these formerly incarcerated women usually achieved successful encounters.

Limitations to Generalizability

Limitations to generalizability in this study are consistent with qualitative methodology (Strauss and Corbin, 1998). First, women were interviewed at two locations in Southern California, one a faith-based recovery organization and the other, a residential recovery home. These circumstances may have biased the results as the sample potentially excluded women not willing to accept a faith-based approach to recovery. Next, this sample was also limited to women who were successfully transitioning from incarceration to community living by entering a recovery program or living in a sober home. Therefore, women not in recovery were not in this study.

Moreover, the focus of this study was from the perspectives of formerly incarcerated women. Therefore, other perspectives such as providers were not considered in this study. Avoiding bias and allowing all of the participant's voices to be heard was another challenge during the study. However, every effort was made to eliminate researcher bias when coding, categorizing, and analyzing the data to arrive at this substantive explanation. Other committee members read the memos and analyzed the data to enhance trustworthiness.

Implications

Practice

Meeting health needs. When asked about recent healthcare encounters it was also interesting to note that the women talked about both recent prison *and* post-prison healthcare experiences. They recounted stories about multiple health problems including physical, psychiatric, and dental health needs. These concerns have been well-documented in the literature (Maeve, 2001, Richie, 2001; O'Brien, 2002). One of

nursing's challenges is to provide a "one-stop-shop approach" to formerly incarcerated women, offering affordable primary care including gynecologic services, mental healthcare and counseling regarding substance use, and full-service dental care. This is a practical example of how comprehensive care with wraparound services might be delivered to the women. In the current healthcare system, providing referrals for the women as they go "back and forth" among various providers is an arduous task. A specific model of care, that begins in the correctional system, is another example of how continuous, comprehensive care can be provided to the women.

In addition to multiple health problems that were both physical and psychiatric, dental needs represented one of the most difficult challenges for post-incarcerated women. This is consistent with the literature that focused on the care of formerly incarcerated women (Maeve, 2001) and homeless women (Luck, et al., 2002). Currently, dental care is not usually considered a part of a *medical* visit unless the patient has an emergent need, for example, an abscessed tooth requiring emergency department evaluation and treatment. This is consistent with other reports of formerly incarcerated women's dental needs (Maeve, 2001). If a dental school is nearby, the patient may be referred for free or low-cost dental services provided at a reduced rate or on a sliding scale. Some individuals were able to *work the system*, getting their healthcare needs met. While the general population gets their dental caries fixed with fillings, the women get their teeth pulled as their treatment. Most sought treatment at low-cost clinics and had their teeth pulled. Others received no care at all. Some ended up in emergency departments for an urgent condition. Sometimes women were even hospitalized for complications.

Nurses need to meet the needs of formerly incarcerated women by providing more in-depth screening histories and physicals, identifying dental problems. The challenge for nursing will be to locate appropriate dental providers for women who usually have multiple dental and oral health issues. Complicating factors include their lack of money and lack of dental insurance.

Meeting preventive health needs. Some of the women in this study were not familiar with the concept of preventative screening. This finding is consistent with other studies of not only post-incarcerated women (Maeve, 2001) but that of other disenfranchised populations (Diamant, et al., 2004). While these researchers studied the delays and unmet need for healthcare among adult primary care patients, they also discovered that uninsured adults were less likely to receive preventive and screening services (Diamant, et al., 2004). Nursing needs to work towards the promotion of preventive health for the women. Perhaps when the women have mandated testing done, prevention screening programs can be established at these sites, providing preventive care for them.

Meeting underlying needs. Another important nursing consideration is an understanding of the womens' underlying issues. For example, the findings regarding lack of disclosure and concealment also have implications for practice as nurses may fail to obtain accurate information concerning a woman's health, affecting her health status. Additionally, persons with dual diagnosis need ethical protections regarding capacity and consent. It is imperative that nurses promote this protection while also providing humanistic care within their own practice. Also, by recognizing that stigma results in shame and embarrassment (Goffman, 1963) nurses can acknowledge that individuals

need positive affirmation. Validating and legitimizing formerly incarcerated women's healthcare needs can lead to successful encounters. Healthcare professionals also need to be more culturally sensitive and understand the complex issues regarding the care of formerly incarcerated women. Nursing needs to be keenly aware of these aspects, incorporating them into a patient-specific plan of care.

Providing competent and compassionate care. The findings of these interviews also revealed that participants in the study repeatedly expressed their need for the provision of competent, compassionate, and non-judgmental care. As substantiated in the literature (Fosbinder, 1990, 1994; Dingman, Williams, Fosbinder, & Warnick, 1999), the women found that having healthcare personnel who spoke to them in a respectful manner, took time with them, and listened to them was vital. Therefore, it is essential that nurses understand the specific needs of formerly incarcerated women.

Education

Educating formerly incarcerated women. The IOM (2004) report indicated that education programs promoting health literacy, health education, and health promotion should be developed with the involvement of people who will use them such as formerly incarcerated women, promoting sensitivity to cultural and language preferences.

Educating nurses and other care providers. Education that incorporates the unique circumstances of formerly incarcerated women needs to be woven into the nursing curricula. The women in this study also wanted healthcare personnel to be culturally competent, displaying congruent behaviors, attitudes, and policies at both a system and staff level. They requested a system, agency and those professionals working in that system to be effective in cross-cultural situations, while simultaneously possessing

interpersonal competence. Meeting patients' expectations (Dingman, et al., 1999), having culturally competent (Browne & Fiske, 2001; Johnson, et al., 2004; Kirkham, 2003) and displaying interpersonal competence (Fosbinder, 1990, 1994) are also supported in literature. Nurses need to be educated in all of these aspects of care. Furthermore, nurse educators are obligated to instruct caregivers and helpful others as to the women's personal and social identity issues. Nursing education might provide students with opportunities to interact with inmates and correctional systems to heighten awareness of the issues of this high-risk group. Moreover, content related to stigma, for example, might be embedded within undergraduate and graduate nursing program curricula. Incorporating models of care that address stigma and other related-issues may provide better care to formerly incarcerated women.

Research

Nurse researchers need to study the issues surrounding healthcare encounters by performing additional quantitative and qualitative studies. These studies can potentially expand the body of knowledge related to the provision of care in this vulnerable population. First, nurse researchers need to perform additional research studies with post-incarcerated women, focusing on the characteristics of women who achieved successful encounters. Next, additional studies need to focus on the individuals who care for this vulnerable population. Qualitative studies that focus on the perceptions and point of view of providers will offer additional insights into the healthcare encounters of formerly incarcerated women. Quantitative studies can also be conducted to investigate the attitudes, beliefs, and behaviors of healthcare personnel who care for this group. Through the efforts of researchers, conditions that both facilitate and hinder healthcare needs can

be explored to find new ways for nursing to direct their efforts toward approaches that provide more seamless care.

Other areas of exploration include research directed at examining some of the underlying issues of the women. For example, recognizing the lack of disclosure or concealment issues might help providers better understand and care for in this disenfranchised group. Finally, nurse researchers might propose studies that further examine women with dual diagnoses, stigmatization, and identity issues.

Policy

Post-incarcerated women described various experiences that resulted in either positive or negative healthcare encounters. Some formerly incarcerated women had a requisite knowledge deficit. Some concealed their problems because they feared retribution and rearrest. Others dealt with embarrassment, shame, and feelings of stigmatization. Conversely, they used contingencies of self-direction and showed capacity within healthcare encounters. They enlisted helpful others to get their healthcare needs met and noted that caring providers made a positive difference in their healthcare experiences.

This study has significant implications for formerly incarcerated women. As women on probation or parole re-enter the community, their post-incarceration needs are enormous. Policies aimed at revamping the current correctional system such as revising drug court and working collaboratively with other groups to address the fragmented healthcare system need to be implemented. For example, providing public-private partnerships that attend to the women's multiple health problems, especially their dual diagnoses are needed. Perhaps, the mandated encounters where women are sent for drug

testing could become sites for primary care visits. The main goal of this proposed policy would be the timely, comprehensive, equitable, affordable, regular source of healthcare from incarceration through recovery. An example of this type of care might be the establishment of a primary care clinic within a recovery facility.

In general, nurses can advocate for strategic healthcare plans for formerly incarcerated women. The healthcare industry and the community at large will continue to grapple with the many physical and mental health problems of vulnerable groups and the contexts within which they exist. Community advisory groups could facilitate discussion and recommend available resources regarding how to implement the proposed model of care.

Conclusion

Eight individual interviews and 2 focus groups for a total of 16 interviews were conducted with formerly incarcerated women to explore their perspectives on healthcare. The findings of this study generated a substantive explanation and explanatory model of the process of “going back-and-forth” in a fragmented healthcare system. Nursing is in a unique position to address the health concerns of women, as society seeks a better understanding of the complexities of the healthcare system and this disenfranchised group. These findings are but an introduction to the broader research topic.

References

- Amnesty International (2004). *United States of America: Rights for all*. Retrieved June 17, 2004 from <http://web.amnesty.org/library/Index/engAMR510012004>
- Arrestee Drug Abuse and Monitoring Program (2003). *Drug and alcohol use and related matters among arrestees*. Chicago, IL: National Opinion Research Center.
- Beck, A. (2000). *Prisoners in 1999*. Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Bloom, B., & Covington, S. (2003). *Gender responsive strategies: Research, practice, and guiding principles for women offenders*. La Jolla, CA: Center for Gender and Justice.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice Hall.
- Bradley, R., & Davino, K. (2002). Women's perceptions of the prison environment: When prison is the safest place I've ever been. *Psychology of Women Quarterly* 26(4), 351-359.
- Browne, A., & Fiske, J. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23(2), 126-147.
- California Coalition for Women Prisoners (2003). *Women and prison*. Retrieved June 17, 2003 from <http://www.prisonactivist.org/women>
- Campbell, S., Roland, M., & Buetow, S. (2000). Defining quality of care. *Social Science and Medicine*, 5(11), 1611-1625.
- Center for Law and Social Policy (2002). Every door closed: Barriers facing parents with criminal records. *CLASP*. Philadelphia: Community Legal Services Inc.

- Chafetz, L. (1990). Withdrawal from the homeless mentally ill. *Community Mental Health Journal*, 26(5), 449-461.
- Charon, J. (2004). *Symbolic interactionism: An introduction, an interpretation, an integration*. Upper Saddle River, NJ: Pearson Prentice-Hall.
- Chesney-Lind, M. (1998). Women in prison: from partial justice to vengeful equity. *Corrections Today*, 60, 66-73.
- Cooke, C. (2002). Understanding incarcerated populations. *AORN Online*. Retrieved June 17, 2003, from OVID database.
- Covington, S. (2004). A woman's journey home: challenges for female offenders. *Prisoners once removed: The impact of incarceration and re-entry on children, families, and communities*. Retrieved April 28, 2004 from <http://www.centerforgenderandjustice.org/journey.html>
- Davis, A. (2000). The shocking plight of black women prisoners. *Ebony*. Retrieved June 16, 2003 from http://www.findarticles.com/cf_0/m1077/8_55/62685043/print.jhtml
- Denzin, N., & Lincoln, Y. (2000) *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Diamant, A., Hays, R., Morales, L., Ford, W., Calmes, D., Asch, A., Duan, N., Fielder, E., Kim, S., Fielding, J., Sumner, G., Shapiro, M., Hayes-Bautista, D., and Gelberg, L. (2004). Delays and unmet need for health care among adult primary care patients in a restructured urban public health system. *American Journal of Public Health*, 94(5), 783-789.

- Dingman, S., Williams, M., Fosbinder, D., & Warnick, M. (1999). Implementing a caring model to improve patient satisfaction. *Journal of Nursing Administration*, 29(12), 30-37.
- Dluhy, N. (1995). Mapping knowledge in chronic illness. *Journal of Advanced Nursing*, 21(6), 1051-1058.
- Enos, S. (2001). *Mothering from the inside: Parenting in a woman's prison*. New York: State University of New York.
- Fickenscher, A., Lapidus, J., Silk-Walker, P., & Becker, T. (2001). Women behind bars: Health needs of inmates in a county jail. *Public Health Reports*, 116(3), 191-196.
- Figueira-McDonough, J., & Sarri, R. (2002). *Women at the margins: Neglect, punishment, and resistance*. New York: Haworth.
- Fosbinder, D. (1990). *Nursing care through the eyes of the patient*. Unpublished doctoral dissertation. University of San Diego, San Diego, CA.
- Fosbinder, D. (1994). Patient perceptions of nursing care: An emerging theory of interpersonal competence. *Journal of Advanced Nursing*, 20, 1085-1093.
- Gelberg, L., Andersen, R., & Leake, B. (2000). The behavioral model for vulnerable populations: Application to medical care use and outcome for homeless people. *Health Sciences Research*, 34(6), 1273-1302.
- Gelberg, L., Browner, C., Lejano, E., & Arangua, L. (2004). Access to women's healthcare: A qualitative study of barriers perceived by homeless women. *Women & Health*, 40(2), 87-100.
- Gibbs, A. (1997). Focus groups. *Social Research Update*. Retrieved November 24, 2004 from <http://www.soc.surrey.ac.uk/sru/SRU19.html>

- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York: Simon & Schuster.
- Gorski, T. (2000). Post-incarceration syndrome. *The November Coalition*. Retrieved June 8, 2004 from <http://www.november.org/stayinfo/breaking/PICS.html#reference>
- Goss, J., & Leinbach, T. (1996). Focus groups as alternative research practice. *Area*, 28 (2), 115-23.
- Greer, K. (1998). *Accounts of women in prison: Relationships, emotions, and identity*. Unpublished Doctoral Dissertation. University of Southern Illinois, Springfield, IL.
- Haworth, S., & Dluhy, N. (2001). Holistic symptom management: modeling the interaction phase. *Journal of Advanced Nursing*, 36(2), 302-310.
- Herivel, T., & Wright, P. (2003). *Prison nation: The warehousing of America's poor*. New York: Routledge.
- Human Rights Watch (2004). *Human rights abuses against prisoners*. Retrieved June 18, 2004 from <http://www.hrw.org/prisons/abuses.html>
- Institute of Medicine (2004). Committee on health literacy. Board on a healthcare services. *Health literacy: A prescription to end confusion*. Washington, DC: National Academy Press.
- Jane Addams Center for Social Policy and Research (2004). *Research brief: Children, families, and the criminal justice system; Women prisoners and recidivism: Factors associated with re-arrest one year post-release*. Jane Addams College of Social Work. Chicago: University of Illinois.

- Johnson, J., Bottorff, J., Browne, A., Grewal, S., Hilton, B. & Clarke, H. (2004). Othering and being othered in the context of health care services. *Health Community, 16*(2), 255-271.
- Kirkham, S. (2003). The politics of belonging and intercultural health care. *Western Journal of Nursing Research, 25*(7), 762-780.
- Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health, 16*(1), 103-121.
- Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal, 311*, 299-302.
- Kreuger, R. (1988). *Focus groups: A practical guide for applied research*. Newbury Park, CA: Sage.
- Kvale, S. (1996). *Inter Views: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.
- Lim, Y., Andersen, R., Leake, B., Cunningham, W. & Gelberg, L. (2002). How accessible is medical care for homeless women? *Medical Care, 40*(6), 510-520.
- Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Luck, J., Andersen, R., Wenzel, S., Arangua, L., Wood, D., & Gelberg, L. (2002). Providers of primary care to homeless women in Los Angeles County. *Journal of Ambulatory Care Management, 25*(2), 53-67.
- Luke, K. (2002). Mitigating the ill effects of maternal incarceration on women in prison and their children. *Child Welfare, 81*(6), 929-948.
- Madeline, N. (1997). Understanding women with dual diagnoses. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 26*(5), 567-575.

- Maeve, M. (1999). Adjudicated health: incarcerated women and the social construction of health. *Crime, Law, and Social Change*, 31, 49-71.
- Maeve, M. (2000). Speaking unavoidable truths: Understanding early childhood sexual and physical violence among women in prison. *Issues in Mental Health Nursing*, 21, 473-498.
- Maeve, M. (2001). Waiting to be caught: The devolution of health for women newly released from jail. *Criminal Justice Review*, 26, 143-169.
- Maeve, M. (2003). Nursing care partnerships with effects on health and crime. *Journal of Psychosocial Nursing*, 41(9), 30-40.
- May, R. (1967). *Psychology and the human dilemma*. Princeton, NJ: Van Nostrand.
- Mead, G. (1934). *Mind, self, and society*. Chicago, IL: Chicago University.
- Merton R., & Kendall P. (1946). The focused interview. *American Journal of Sociology*, 51, 541-557.
- Morgan, D. (1997). *Focus groups as qualitative research*. Newbury Park, CA: Sage.
- Morse, J. & Richards, L. (2002) *Read me first: A user's guide to qualitative methods*. Thousand Oaks, CA: Sage Publications, Inc.
- National Commission on Correctional Health Care. (2002). *The health status of soon-to-be released inmates: A report to Congress. Volume 2*. Retrieved June 28, 2003 from http://ncchc.org/pubs/pubs_stbr.html
- National Institute of Corrections (2003). *Gender-responsive strategies: Research, practice, and guiding principles for women offenders*. Washington, DC: National Institute of Corrections.

- O'Brien, P. (1998). *Women in transition from prison: Making it in a free world*. Unpublished doctoral dissertation. University of Kansas, Kansas City, MO.
- O'Brien, P. (2001). *Making it in the free world: Women in transition from prison*. Albany, NY: State University New York Press.
- Office of Women's Health (2003). *Women's health issues: An overview of special populations*. Retrieved June 10, 2004 from <http://www.4women.gov/owh/pub/womhealth%20issues/special.htm>
- Office of Women's Health (2005). Retrieved April 13, 2006 from <http://www.4woman.gov/owh/>
- Parsons, M., & Warner-Robbin, C. (2002). Factors that support women's successful transition to the community following jail/prison. *Health Care for Women International*, 23(6), 6-18.
- Petersilia, J. (2001). Prisoner reentry: Public safety and reintegration challenges. *Prison Journal*, 81, 360-375.
- Pomeroy, E., Kiam, R., & Abel, E. (1998) Meeting the mental health needs of incarcerated women. *Health and Social Work*, 23(1), 71-75.
- Powell, R., Single, H., & Lloyd, K. (1996). Focus groups in mental health research: Enhancing the validity of user and provider questionnaires. *International Journal of Social Psychology*, 42(3), 193-206.
- Richie, B. (2001). Challenges incarcerated women face as they return to their communities: Findings from life history narratives. *Crime and Delinquency*, 47(4), 368-389.

- Robbins, I. (1999). Managed health care in prisons as cruel and unusual punishment. *Journal of Law and Criminology*, 90(1), 195-238.
- Safer Foundation Council of Advisors to Reduce Recidivism through Employment (CARRE) (2002). Jane Addams Center for Social Policy and Research. *Jane Addams College of Social Work, University of Illinois at Chicago*. Chicago, IL: University of Illinois.
- Siefert, K., & Pimlott, S. (2001). Improving pregnancy outcome during imprisonment: A model residential care program. *Social Work*, 46(2), 125-134.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.
- Travis, J., Solomon, A., & Wahl, M. (2001). From prison to home: The dimensions and consequences of prisoner reentry. *Urban Institute Justice Policy Center*. Washington, DC
- United Nations. *Universal declaration of human rights 1948-1998*. Retrieved April 8, 2005 from <http://www.un.org/Overview/rights.html>
- U. S. Department of Justice Bureau of Justice Statistics (2003). *Key Crime and Justice Facts: At a Glance*. Retrieved July 18, 2003, from <http://www.ojp.usdoj.gov/bjs/glance.htm>
- U.S. Department of Justice, Bureau of Justice Statistics (2004). Prison and jail inmates at midyear 2004. *Bureau of Justice Bulletin*. Retrieved April 20, 2005 from <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim04.pdf>

U. S. Department of Justice, Bureau of Justice Statistics (2005). Bureau of Justice Statistics/Justice Research and Statistics Association. *2005 National Conference*.

Retrieved November 9, 2005 from

<http://www.jrsa.org/events/conference/abstracts.html#CORRECTIONS>

Vigilante, K., Flynn, M., Affleck, P., Stunkle, J., Merriman, N., Flanigan, T., Mitty, J., & Rich, J. (1999). Reduction in recidivism of incarcerated women through primary care, peer counseling, and discharge planning. *Journal of Women's Health*, 8(3), 409-415.

Walsh, K. (1997). Encounters, endings, and temporality in psychiatric nursing. *Journal of Advanced Nursing*, 25(3), 485-491.

Young, D. (2000). Women's perceptions of health care in prison. *Health Care for Women International*, 21(3), 219-234.

APPENDICES

Appendix A

Sample Flyer – Site A

***How would you like to receive a
a \$25.00 gift certificate
to Wal-Mart?***

**A nurse researcher would like to ask you some
questions about a recent doctor's office, clinic, or
emergency department visit.**

**The purpose is to learn more about how to care
for women recently out of prison or jail.**

**You can sign up to be in a group interview or you
can be interviewed alone.**

**The meeting at the Welcome Home office will last
about 1-1 1/2 hours.**

**If you are interested, please call Sue Hoyt, RN,
USD researcher at (619) 889-7155 (cell)
to schedule a time to meet.**

Appendix B

Sample Flyer – Site B

***How would you like to receive a
a \$25.00 gift certificate
to Wal-Mart?***

A nurse researcher would like to ask you some questions about a recent doctor's office, clinic, or emergency department visit.

The purpose is to learn more about how to care for women recently out of prison or jail.

You can sign up to be in a group interview or you can be interviewed alone.

The meeting at Serenity House will last about 1-1 1/2 hours.

If you are interested, please call Sue Hoyt, RN, USD researcher at (619) 889-7155 (cell) to schedule a time to meet.

Appendix C

*Consent Form -- Individual Interviews**Purpose*

The purpose of this study is to find out what happens at a clinic or doctor's office visit between doctors, nurses, and patients that sometimes make patients happy or not happy with their doctor or nurse with their care.

Procedure/Data Use

You will be asked to fill out a one-page information form. These forms will have only a number, not your name. After you fill out the forms, they will be kept in a locked file cabinet and kept confidential. Only K. Sue Hoyt will listen to the tapes and take some notes. K. Sue Hoyt will keep this information for a minimum of 5 years before it is destroyed.

You will be given a fake name for purposes of confidentiality (i.e., Mary's name will be changed to another name of her choosing). You will be interviewed by K. Sue Hoyt for 1 to 1½ hours, at a date, time, and place that is best for you. You will be asked about a visit to a clinic or doctor's office since you left prison or jail or if you did not go to see doctor or clinic why or why not. You will also be asked what made you feel good after your visit, bad after your visit, and what you think a patient's clinic or doctor's office visit should be like, how you think your visit could have been made better, and how you feel about returning to this clinic or doctor's office. The interview questions will be written down on a piece of paper. Your answers will be tape recorded.

Risks

Everything is confidential. Your name will never be used. However, there is a risk in discussing your visit (e.g., past events may cause you emotional distress). If this happens, you are allowed to stop the audiotape and end the interview immediately. You may wish to continue your interview at a later date and time.

Rights/Benefits

You don't have to be in this study. You have the right to leave or quit the study at any time. It is important to think about what you say so that you will not regret it later. The results of this study will be made available to you if you request them from the researcher at the completion of the study. Taking part in this study will not affect your being involved with Welcome Home/Serenity House, your healthcare services, or insurance in any way. You will receive a \$25.00 gift certificate from Wal-Mart. The benefit of the study is to help nurses' better serve women out of jail or prison when they go to the clinic or doctor's office.

I have read and understand this form and I agree to be interviewed. If I have any other questions, I will contact either K. Sue Hoyt, Researcher at 619-889-7155 or Diane Hatton, Professor at the University of San Diego at 619- 260-7481.

 Name of Participant (Printed)

 Name of Researcher (Printed)

 Signature of Participant (Signed)

 Signature of Researcher (Signed)

 Date

 Date

Appendix D

Consent Form – Focus Groups

Purpose

The purpose of this study is to find out what happens at a clinic or doctor's office visit between doctors, nurses, and patients that sometimes results in patients being happy or not being happy with their doctor or nurse or their care.

Procedure/Data Use

You will be asked to fill out a one-page information form. These forms will have only a number, not your name. After you fill out the forms, they will be kept in a locked file cabinet and kept confidential. Only K. Sue Hoyt will listen to the tape recording and take some notes. K. Sue Hoyt will keep this information for a minimum of 5 years before it is destroyed.

You will be given a fake name for purposes of confidentiality (i.e., Mary's name will be changed to another name of her choosing). You will be interviewed with a group of others by K. Sue Hoyt for 1 to 1½ hours, at a date, time, and place that is best for you. You will be asked about a visit to a clinic or doctor's office since you left prison or jail or if you did not go to see doctor or clinic why or why not. You will also be asked what made you feel good after your visit, bad after your visit, and what you think a patient's clinic or doctor's office visit should be like, how you think your visit could have been made better, and how you feel about returning to this clinic or doctor's office. The interview questions will be written down on a whiteboard or a piece of paper. Your answers will be tape-recorded.

Risks

Everything you say will be kept confidential by the researcher but there is no way to guarantee that anything you say may not be kept confidential by the others in the group. Your name will never be used by the researcher. There is a risk in discussing your visit (e.g., past events may cause you emotional distress). If this happens, you are allowed to end your interview immediately.

Rights/Benefits

You don't have to be in this study. You have the right to leave or quit the study at any time. It is important to think about what you say so that you will not regret it later. The results of this study will be made available to you if you request them from the researcher at the completion of the study. Taking part in this study will not affect your being involved with Welcome Home/Serenity House, your healthcare services, or insurance in any way. You will receive a \$25.00 gift certificate from Wal-Mart. The benefit of the study is to help nurses' better serve women out of jail or prison when they go to the clinic or doctor's office.

I have read and understand this form and I agree to be interviewed. If I have any other questions, I will contact either K. Sue Hoyt, Researcher at 619-889-7155 or Diane Hatton, Professor at the University of San Diego at 619- 260-7481.

 Name of Participant (Printed)

 Name of Researcher (Printed)

 Signature of Participant (Signed)

 Signature of Researcher (Signed)

 Date

 Date

Appendix E

Demographic Form

Age_____

Marital Status

Single_____ Separated_____

Married_____ Divorced_____

Widowed_____

Children yes no_____ How Many?_____

Ages of Children (under 18 years) _____

Do you now have custody of your children? CIRCLE YES NO

Years of School Completed_____ CIRCLE 1 2 3 4 5 6 7 8 9 10 11 12

High school diploma Circle YES NO

GED Circle YES NO

Any college Circle YES NO If so, how many years_____

Current Work_____

Other Assistance

WIC Circle YES NO

TANF Circle YES NO

General Assistance Circle YES NO

SSI Circle YES NO

Other_____

Living Conditions

Shelter Circle YES NO

Home Circle YES NO

Homeless Circle YES NO

Living with Family Member/Spouse Circle YES NO

Other

Race/Ethnicity

African American _____ *Native American* _____

Asian _____ White _____

Hispanic _____ Other _____

Past Jail or Prison Time

How long have you been out of jail? _months/yr

How many other times have you been in jail or prison?

Date(s) and length of time you were in jail or prison _____

Prison or Jail Location(s) _____

Health Insurance

HMO _____

PPO _____

Medicare _____

Medical _____

Other _____

None _____

When was the last time you went to see a doctor or nurse at a hospital, doctor's office, or clinic? _____

Appendix F

Interview Questions – Individual Interviews

1. Tell me about a recent clinic or doctor's office since you left prison or jail.

Probe: What made you feel good after your visit?

Probe: What made you feel bad after your visit?

Probe: If you haven't recently gone to the doctor since you left prison or jail, please tell me why.

2. How do you feel about returning to this clinic or doctor's office?
3. Describe what you think a clinic or doctor's office visit should be like?

Probe: How do you think your visit could have been made better?

Flesch-Kincaid Reading Level 5.5

Appendix G

Interview Guide – Focus Groups

1. Tell us about a recent clinic or doctor's office since you left prison or jail.

Probe: What made you feel good after your visit?

Probe: What made you feel bad after your visit?

Probe: If you haven't recently gone to the doctor since you left prison or jail, please tell us why.

2. How do you feel about returning to this clinic or doctor's office?
3. Describe what you think a clinic or doctor's office visit should be like?

Probe: How do you think your visit could have been made better?

Flesch-Kincaid Reading Level 5.5

Human Participant Protections Education for Research Teams Completion Certificate

This is to certify that

Karen Sue Hoyt

has completed the **Human Participants Protection Education for Research Teams** online course, sponsored by the National Institutes of Health (NIH), on 06/11/2001.

This course included the following:

- key historical events and current issues that impact guidelines and legislation on human participant protection in research.
- ethical principles and guidelines that should assist in resolving the ethical issues inherent in the conduct of research with human participants.
- the use of key ethical principles and federal regulations to protect human participants at various stages in the research process.
- a description of guidelines for the protection of special populations in research.
- a definition of informed consent and components necessary for a valid consent.
- a description of the role of the IRB in the research process.
- the roles, responsibilities, and interactions of federal agencies, institutions, and researchers in conducting research with human participants.

National Institutes of Health
<http://www.nih.gov>

B.V., (B., D.V.)
Professor, Hearing
Univ. of San Diego

Appendix J: Human Participant Protections Education for
Research Completion Certificate – Research Assistant[NCI Home](#)[Cancer Topics](#)[Clinical Trials](#)[Cancer Statistics](#)[Research & Funding](#)[News](#)

Human Participant Protections Education for Research

Completion Certificate

This is to certify that

June Green

has completed the **Human Participants Protection Education for Research Teams** online course, sponsored by the National Institutes of Health (NIH), on 09/21/2005.

This course included the following:

- key historical events and current issues that impact guidelines and legislation on human participant protection in research.
- ethical principles and guidelines that should assist in resolving the ethical issues inherent in the conduct of research with human participants.
- the use of key ethical principles and federal regulations to protect human participants at various stages in the research process.
- a description of guidelines for the protection of special populations in research.
- a definition of informed consent and components necessary for a valid consent.
- a description of the role of the IRB in the research process.
- the roles, responsibilities, and interactions of federal agencies, institutions, and researchers in conducting research with human participants.

National Institutes of Health
<http://www.nih.gov>

[Home](#) | [Contact Us](#) | [Policies](#) | [Accessibility](#) | [Site Help](#) | [Site Map](#)

A Service of the National Cancer Institute

FIRSTGov

<http://cme.cancer.gov/cgi-bin/cms/cts-cert5.pl>

9/21/2005