

ASSESSING THE HEALTH NEEDS OF WOMEN REENTERING THE COMMUNITY  
AFTER INCARCERATION

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**Title**

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**DOCTOR OF NURSING PRACTICE**

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## ABSTRACT

This dissertation work, guided by the social ecological model, sought to assess the physical, mental, social, and spiritual health needs of women reentering the community after incarceration from the perspective of the women themselves. Women participating in a group substance treatment program at a residential transitional facility were recruited for voluntary participation in focus groups (n=19) and semi-structured interviews (n=12). Community-based recommendations were developed based on identified needs.

One-quarter of the interviewed women had hepatitis C, while 83% had at least one mental health diagnosis. The women described physical and mental health consequences of abuse, largely inflicted by family and significant others. Their close relationships were characterized by complexity, especially with mothers and children – sometimes inciting feelings of isolation or despair, other times, self-efficacy or heightened spirituality. Within the community, the women experienced problems accessing, and finding common ground within the healthcare system. They perceived barriers to timely and adequate mental health treatment in three categories: primary care providers were unwilling/unable to treat them; excessive wait times precluded access to specialty mental healthcare; and they generally distrusted the system. They viewed staff support within the transitional facility as a major contributor to their success or failure. They also desired exercise opportunities and healthier food choices within the transitional facility. Community activities, such as spiritual or religious meetings contributed to a sense of belonging, but they desired more opportunities for positive community involvement. On the societal level, gaining safe, affordable housing and financial stability were major hurdles. In addition, stigmatization from society was experienced on many levels.

Finally, recommendations were made to the transitional facility to promote and remove barriers to exercise and healthy foods, to develop and maintain a culture of trauma-informed care among all staff members, and to promote the development of healthy, prosocial community connections. Primary care facilities were recommended to address adverse childhood events and adult trauma, and to foster innovative strategies to provide timely and effective mental healthcare. Finally, policy-makers were recommended to consider pursuing legislation allowing expungement, and to develop and implement strategies to provide safe, affordable housing options to those with criminal records.

## **DEDICATION**

This work is dedicated to reentering women. Thank you for the great privilege of knowing you, even if only for a moment in time. This work represents the countless hours I spend thinking about how to make things better for you and for your children.

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## **CHAPTER 1. INTRODUCTION**

### **Background and Significance**

The United States imprisons more people than any other nation in the world (National Research Council, 2014). In fact, the United States imprisons at about seven times the rate of Western European democracies (National Research Council, 2014). As home to only five percent of the world's population, American prisons house 23% of the world's prisoners (National Research Council, 2014).

The incarceration of women is particularly high when compared with other countries. The United States incarcerates 100,000 more women than any other country in the world (Walmsley, 2014). Additionally, the incarceration of women has been increasing at a faster rate than that of men, and North Dakota has experienced one of the highest rate increases in the United States (Bureau of Justice Statistics, 2014). On December 31, 1978, when data were first collected, North Dakota had jurisdiction over just four female prisoners. In 2014, 204 women were imprisoned or jailed in North Dakota. Between 2014 and 2015, the United States decreased its female imprisoned population by about 1500 women while North Dakota's imprisoned population stayed about the same at 208 women (Bureau of Justice Statistics, 2014).

The literature demonstrates that traumatic histories, mental health diagnoses, and substance use disorders are particularly common in incarcerated women when compared with their male counterparts and to the general public (Binswanger et al., 2010; Colbert, Sekula, Zoucha, & Cohen, 2013; Flores & Pellico, 2011; Sutherland, 2013; Weiss, Hawkins, & Despinos, 2010). In addition, incarceration itself may exacerbate health problems with low priorities for treatment and prevention and further traumatic events occurring while incarcerated

(Colbert et al., 2013; Kelly, Cheng, Spencer-Carver, & Ramaswamy, 2013). Furthermore, health needs during the time immediately post-incarceration can be overwhelming.

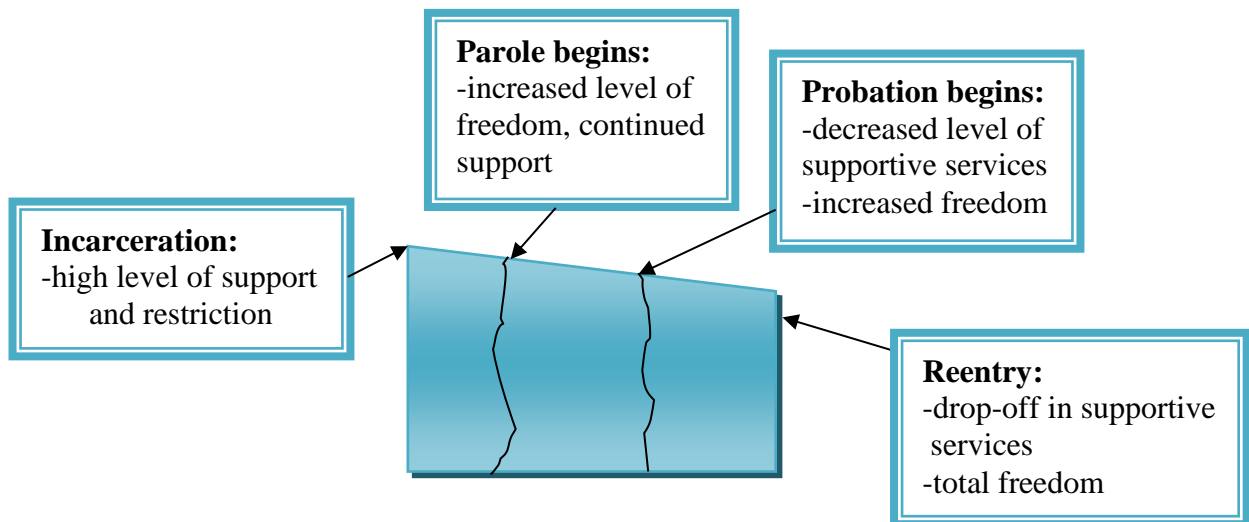
Data exist focusing on strategies for decreasing recidivism for both genders, yet few works were found that focus on health status and barriers to achieving a healthier state for this population. However, the World Health Organization, Centers for Disease Control, the Robert Wood Johnson Foundation, and others report that healthcare providers' focus on social determinants of health and health promotion from a social perspective may be the most important way to begin to address health disparities (Oregon Primary Care Association, n.d.; Robert Wood Johnson Foundation Commission to Build a Healthier America, 2014). From the perspective of the healthcare provider, health states and barriers to health may be more important than recidivism data.

Limited empirical data exist related to the health needs of incarcerated or recently-incarcerated women in North Dakota. In one study, the needs of women recently released from prison in North Dakota were surveyed from the perspective of service providers in the area (Bergseth, Richardson Jens, Bergeron-Vigesaa, & McDonald, 2011). The topics assessed included mental health and substance abuse, but excluded other health topics. To the author's knowledge, no needs assessments have been performed focusing specifically on the health needs and barriers to health for this population in North Dakota, especially from the perspective of the women themselves. Therefore, the purpose of this dissertation was to perform a health needs assessment of women who are reentering the Fargo community after incarceration and to develop recommendations for community organizations, healthcare providers, and policy-makers to meet the identified health needs.

## Problem Statement

A small, informal needs assessment and literature review was performed in prior coursework regarding the needs of post-incarceration women of Fargo, North Dakota. A semi-structured interview of one key informant revealed several priority needs including safe housing, employment and financial concerns, medical and mental health and chemical dependency treatment opportunities, continued supportive services, and social and community reintegration.

The key informant also identified poor continuity of care. Case managers, probation and parole officers, and other supportive personnel often build strong prosocial constructs with women that move them toward positive lifestyles. But after release from these programs, case management and other formal supports abruptly end. This break in continuity of care repeats the isolation that the women experienced when they were first incarcerated (See Figure 1).



*Figure 1.* Justice system continuum.

Comprehensive community programs in Fargo strive to meet needs in each of these areas. However, data are lacking that could be used to prioritize and characterize the needs of justice-involved women being served by these programs. A needs assessment provides the opportunity to improve outcomes for the reentering women in the community.

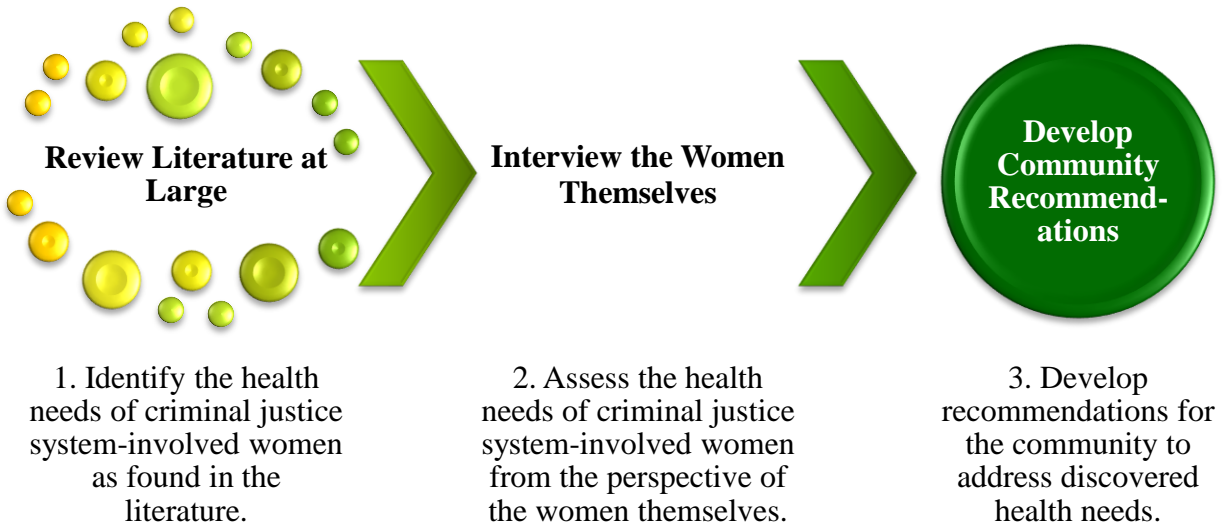
One residential facility serving women during the immediate reentry period expressed the desire for a more thorough and client-centered needs assessment to be performed with the women to guide program planning. The residential, transitional facility serves women during parole, probation, or immediately post-incarceration. Women are referred to the facility by state or federal corrections departments, by probation or parole officers, or other entities. Women live in the facility, work in the community, and fulfill a variety of group and individual programs such as substance abuse treatment, and other programs that focus on developing coping skills and practical life skills. Although the facility currently collects data regarding how programming affects recidivism, they currently have no constructs for assessing the health needs of the women. Because the women are referred to the transitional facility at different points within the corrections system from areas all over the state, the demographics of the women in this facility resemble the female incarcerated population in the state (H. Brandt, personal communication, March 15, 2017). A health needs assessment is the first step in revising policy and programming to better meet the health needs of reentering women in the community.

### **Project Description with Purpose and Objectives**

The purpose of this project was to assess the health needs for women reentering the Fargo community after incarceration, from the perspective of the women themselves. Health was interpreted holistically as defined by the World Health Organization (1946) to include physical, mental, social, and spiritual wellbeing. Findings were used to inform recommendations for community-based organizations, healthcare providers, and policy-makers. The social ecological model was used to guide each part of the project.

The direction of the project moved from general to specific. That is, the project began with a broad view of the health of justice-involved women as found in the literature and moved

toward the specific health needs of the same population in the Fargo area. Project findings were used to develop recommendations for community-based programs, healthcare providers, and policy-makers to address the needs articulated through this assessment.



*Figure 2.* Project objectives and approach.

## **CHAPTER 2. LITERATURE REVIEW AND THEORETICAL FRAMEWORK**

### **Literature Review**

#### **Incarcerated Women: Who Are They?**

A diverse group of women share incarceration experiences, but frequently recurring characteristics of such women are found in the literature, as described by Scroggins and Malley.

Female offenders are often young, poor mothers who lack education, job skills, or a stable employment history, and whose lives have been characterized by patterns of abuse and addiction. Upon their release from prison, most women are still young, still poor, still parents, still uneducated, still unemployed, still deal with substance abuse problems, and still traumatized by experiences of abuse ... (Scroggins & Malley, 2010, p. 148).

In addition, minorities are overrepresented when compared to the general public, especially Black and Hispanic women (Covington, 2007; Flores & Pellico, 2011; Gilham, 2012; Weiss et al., 2010). Women's pathways to crime are not typically violent. Instead, crimes are often income-generating with the purpose of providing for loved ones or for substance acquisition (Covington, 2007; Heidemann, Cederbaum, & Martinez, 2014; Kelly, Paralez-Dieckmann, Cheng, & Collins, 2010).

#### **Health Needs Prior to Incarceration**

Criminal justice system-involved women experience worse health states when compared to the general population in terms of physical, mental, and social health (Binswanger et al., 2010; Colbert et al., 2013; Flores & Pellico, 2011; Green et al., 2016; Harner, Budescu, Gillihan, Riley, & Foa, 2015; Lynch, DeHart, Belknap, & Green, 2013; Sutherland, 2013; Tripodi & Pettus-Davis, 2013; Weiss et al., 2010). Specifically, traumatic events during childhood and adulthood, substance use disorders, and mental health problems occur at disproportionately higher rates. As

Harner et al. (2015) summarize, “Trauma exposure has been identified as a pathway to prison for many female trauma survivors, because their coping mechanisms are often criminalized” (p. 59).

**Trauma.** “Traumatic events...overwhelm the ordinary human adaptations to life” and “generally involve threats to life or bodily integrity, or a close personal encounter with violence and death” (Herman, 2015, p. 33). Trauma is a close companion to the criminal justice system-involved woman (Covington, 2014; Green et al., 2016; Harner et al., 2015; Kelly et al., 2013; Tripodi & Pettus-Davis, 2013). In one urban Midwestern study, 65% of women in city jails had experienced physical or sexual abuse as children (Kelly et al., 2013). Just under half had experienced intimate partner violence in the year prior to incarceration (Kelly et al., 2013).

The Adverse Childhood Experiences (ACE) study (Center for Disease Control and Prevention, 2016; Felitti & Anda, 2010) focuses on the long-term health effects of trauma occurring in childhood. Researchers from Kaiser Permanente and the Center for Disease Control and Prevention (CDC) assessed the presence or absence of childhood trauma in categories of abuse, neglect, and family household dysfunction (e.g. sexual abuse, physical abuse, a household member being incarcerated and a household member using drugs constitute four categories; see Appendix A). Over 17,000 patients whose childhood trauma experiences were assessed and recorded in 1995 are continuing to be followed to gather information about mortality and other health outcomes. Thus far, researchers have found that adverse childhood experiences are *highly* associated with mental illness, substance abuse, fibromyalgia or chronic fatigue syndrome, and even biomedical diseases such as chronic obstructive pulmonary disease, liver disease, and coronary artery disease, even when corrected for other known risk factors (CDC, 2016; Felitti & Anda, 2010; Glowa, Olson, & Johnson, 2016). Further, as patients experienced multiple categories of adverse childhood experiences, the prevalence of each health problem increased. In



fact, individuals who experienced three categories of adverse childhood experiences are 60% more likely to have an autoimmune disease that requires hospitalization (Nakazawa, 2016). Those who experienced four categories are two times more likely to have cancer and depression diagnoses (Nakazawa, 2016). Individuals who experienced six or more categories of adverse childhood experiences died *two decades earlier* and are 46 times more likely to abuse intravenous drugs when compared with those without adverse childhood experiences (Prewitt, 2014). The risk of suicide attempt increased by 50% each time the ACE score increased by one (Glowa et al., 2016). As the ACE study suggests, not only mental illness, but also biomedical diseases can be correlated with traumatic early life experience; however, they are rarely included in assessment of patients by primary care providers (CDC, 2016; Felitti & Anda, 2010; Glowa et al., 2016). However, there is limited documentation of the feasibility and utility of the use ACE scores in primary care.

**Substance use disorders.** Patients with substance use disorders battle with the biggest public health problem we currently face in this nation (U.S. Department of Health and Human Services, 2016). Substance use disorders usually begin as a coping mechanism for the physical or psychological pain from traumatic events that exhaust healthy coping mechanisms (Covington, 2014; Felitti & Anda, 2010; Harner et al., 2015; Herman, 2015). The substance abuse then leads to a path of further destruction and problems (Covington, 2014; Felitti & Anda, 2010; Harner et al., 2015; Herman, 2015). Conviction associated with substance use is often the main event leading to incarceration for women (Covington, 2014; Felitti & Anda, 2010, Fleming, LeBlanc, & Reid, 2013; Gilham, 2012). Around 60-80% of incarcerated women have histories involving substance use (Binswanger et al., 2010; Green et al., 2016; Lynch et al., 2013; Tripodi & Pettus-Davis, 2013). For North Dakotan imprisoned women, about 50% are incarcerated for drug-

related crimes, and another 20% for property crimes, typically committed for drug acquisition (Grueskin, 2016).

In the Executive Summary of the “Surgeon General’s Report on Alcohol, Drugs, and Health” (US Department of Health and Human Services, 2016), authors discuss the current problem of substance use disorders in our nation:

Our healthcare system has not given the same level of attention to substance use disorders as it has to other health concerns that affect similar numbers of people. Substance use disorder treatment in the United States remains largely segregated from the rest of healthcare and serves only a fraction of those in need of treatment...Many factors contribute to this “treatment gap,” including the inability to access or afford care, fear of shame and discrimination, and lack of screening for substance misuse and substance use disorders in general healthcare settings (US Department of Health and Human Services, 2016).

**Mental illness.** Prison has been dubbed “the mental health provider of last resort for trauma survivors” (Harner et al., 2015). Histories of trauma, substance abuse, and mental illnesses are related to and compound the complexity of one another (Covington, 2014; Green et al., 2016; Tripodi & Pettus-Davis, 2013). Several studies demonstrate the higher prevalence of mental illnesses in the population of incarcerated women when compared to other populations such as male incarcerated individuals, non-incarcerated women, or the general public. In one study, interviewers from the United States Census Bureau spoke person-to-person with 6,982 inmates of jails. A higher percentage of women than men reported medical conditions including cancer, diabetes, hypertension, asthma, and hepatitis. In addition, women reported a higher prevalence of mental health disorders such as bipolar disorders, depression, posttraumatic stress

disorder, anxiety, and personality disorders than their male counterparts (Binswanger et al., 2010). Flores and Pellico (2011) discussed the higher percentage of women reporting anxiety and personality disorders than their male counterparts. In a mixed-methods study by Colbert et al. (2013), the sample of 34 women who had been recently incarcerated were functioning well below the national average in mental health domains. For Green et al.'s (2016) sample of 464 jailed women from six states across the nation, 67% of women reported at least one lifetime mental disorder. Posttraumatic stress disorder (PTSD) is four to ten times more prevalent among incarcerated women compared to the general population (Green et al., 2016). Harner et al. (2015) further delineated the higher prevalence of PTSD in incarcerated women (17-48%) compared to non-incarcerated women (10.4%). Traumatic events and PTSD are also associated with poor physical health conditions (CDC, 2016; Felitti & Anda, 2010; Green et al., 2016; Harner et al., 2015).

### **Health Needs During Incarceration**

**Inadequate health provision.** Although some emphasize the opportunity incarceration affords for “catching up” on routine health screening (Binswanger et al., 2010; Nijhawan, Salloway, Nunn, Poshkus, & Clarke, 2010), existing health problems are likely to worsen during incarceration (Colbert et al., 2013). Provision of care is limited to the most urgent physical health needs (Colbert et al., 2013; Kelly et al., 2013). The prison system often “provides far less medical care and rehabilitative programming than is needed” (National Research Council, 2014, p. 6). Medications that patients have long been prescribed may be abruptly discontinued on admission to jail or prison due to expense or institution policy (Colbert et al., 2013; Kelly et al., 2013). Overcrowded prisons are very common and are correlated with worse health conditions and increased suicide risk (National Research Council, 2014).

Foods provided in prisons and jails are typically especially high in fat and caloric content (National Research Council, 2014). One study revealed that women gained over one pound weekly during early incarceration (Clarke & Waring, 2012). Special accommodations may be very difficult to obtain for those with diabetes (Colbert et al., 2013) or for pregnant women (Sutherland, 2013).

Although largely comprised of a male sample (92%), Patterson (2013) demonstrated incarceration's impact on mortality. She summarizes, "Each additional year in prison produced a 15.6% increase in the odds of death for parolees, which translated to a two-year decline in life expectancy for each year served in prison...Incarceration reduces life span" (p. 523).

**Traumatic triggers and new abuse.** Events within the walls of the prison such as victimization or standard institutional operating practices can be further damaging to women's already damaged psychological health (Heidemann et al., 2014; National Research Council, 2014). Ordinary practices in the justice system such as restraint use, isolation, and body searches can result in flashbacks of prior trauma. Yelling or cursing by staff can also trigger a trauma response. The officers' response to these gut-reactions may further actualize trauma. The prevalence of traumatic history of women makes them particularly vulnerable for re-traumatization or triggering prior abusive memories (Covington, 2014).

**Mother-child dyad.** Approximately 60% of women in state prisons are mothers and 6-10% of women are pregnant when incarcerated (Goshin, Byrne, & Henninger, 2013; Kristof, 2016). As previously discussed, parental incarceration is categorized as an adverse childhood experience by the ACE study, and about one in 28 children has an incarcerated parent (Keays, 2015). Incarceration of a parent is "a traumatic experience in childhood that alters the structure of the developing brain in a manner that exposes them to greater risk for a multitude of short and

long term poor health outcomes” (Keays, 2015, p.5). Children with incarcerated mothers are more likely to experience mental health problems such as depression, anxiety, grief, eating/sleeping changes, learning disabilities, and aggressive or withdrawn behavior (Diamond, 2012; Gilham, 2012; Goshin, Byrne, & Blanchard-Lewis, 2014; Stringer & Barnes, 2012; Turney, 2014). Children of incarcerated parents are also more likely to experience physical health conditions such as asthma, obesity, speech/language problems, and seizure disorders (Turney, 2014). Further, they are more likely than their peers to become criminal justice system-involved themselves, which reflects the possibility that incarcerated women may come from a line of other incarcerated women (Goshin et al., 2014). However, frequent contact with children throughout the incarceration process has been shown to reduce maternal anxiety, depression, and physical distress (Diamond, 2012; Gilham, 2012; Stringer & Barnes, 2012). In fact, frequent visitation is the best predictor of restored family health post-incarceration (Gilham, 2012; Huang, Atlas, & Parvez, 2012).

Prison nursery programs may offer hope. Eight states in the United States have programs that allow mothers to remain primary caregivers of their infants during incarceration, including Illinois, Indiana, Ohio, Nebraska, New York, South Dakota, Washington, and West Virginia (Associated Press, 2016). In prison nursery programs, mothers can live with and care for their newborns for a specific amount of time, typically over one year. The dyad is supported with medical care and typically resides separately from the general prison population. Supportive measures are provided such as parenting and child development education (Brown & Valiente, 2014; Diamond, 2012; Goshin et al., 2013; Goshin et al., 2014).

Prison nursery programs can be beneficial for mother and child alike. When matched for socioeconomic and cultural backgrounds, mother-infant attachment was found to be more secure

for dyads in these prison nurseries compared to their non-criminally involved counterparts (Byrne, Goshin, & Joestl, 2010; Goshin et al., 2014). Preschool aged children who participated in prison nursery programs as babies may experience less anxiety and depression than their separated counterparts (Goshin et al., 2014). Mothers also benefit from the prison nursery programs as recidivism is sharply reduced (Diamond, 2012; Gilham, 2012; Stringer & Barnes, 2012). Authors of one study found that recidivism rates within three years of discharge dropped from the area norm of 38% to just 14% for the prison-based nursery program (Goshin et al., 2013). Ohio's recidivism rates dropped to 3%, compared to 33% overall; Nebraska, 9% versus 33.3%; New York, 13% versus 26% (Associated Press, 2016). These recidivism data are difficult to find in association with other types of programs. Further, the cost of running such a program is far outweighed by the cost savings ascertained by decreased recidivism (Brown & Valiente, 2014; Diamond, 2012).

**Human immunodeficiency virus and hepatitis C virus.** There is a high prevalence of human immunodeficiency virus (HIV) in jails and prisons (Catz et al., 2012; Farel, 2012; Fleming et al., 2013). Although the rate of infection of HIV is five times higher in the incarcerated population, 90% of these cases are male (CDC, 2015). Coinfection hepatitis C virus with HIV is also common in the incarcerated population (Fleming et al., 2013). For this reason, the CDC has targeted the incarcerated population for risk-reduction efforts (Catz et al., 2012; CDC, 2015). Fears about safety, isolation, and stigmatization may prevent partner disclosure of HIV status, information-seeking, and transmission reduction behaviors (Catz et al., 2012). Substance use may preclude readiness to undergo anti-retroviral treatment (Haley et al., 2014). Initiatives aimed at prevention of HIV are also needed according to several studies (Catz et al., 2012; Farel, 2012; Fleming et al., 2013; Haley et al., 2014). Individuals may not anticipate

barriers to risk prevention after release such as stigmatization precluding employment, social acceptance, and adherence problems related to substance abuse (Haley et al., 2014).

There are many barriers to reducing transmission risk including unmet information needs and social/personal motivational barriers. Initiating condom use with a partner when they were not previously used may be difficult. In addition, it was common in the literature for HIV positive individuals to report being well-informed regarding HIV, but specific assessment questions demonstrated the contrary, especially regarding disease transmission. For these reasons, it may be wise for the healthcare provider to focus on patient-centered education starting with a detailed assessment of the patient's knowledge base. This may begin with inquiries regarding plans for initiating condom use or needle sharing immediately post-incarceration. (Catz et al., 2012).

Patient navigators have also shown some benefit for the population of HIV-infected individuals during reentry. Navigators may be nurses or social workers or even peer navigators. Their roles may vary, but often include escorts to and/or coordinating of medical or court appointments and support in special circumstances. In one study, patients reported being able to complete tasks that would have been impossible for them alone. Peer navigators seemed to be especially capable of building rapport, providing advice patients can receive, and overcoming trust barriers with which medical and other service providers struggle. They acted as a bridge between the patient and service providers, helping both navigate each other (Koester et al., 2014).

### **Health Needs Post-Incarceration**

After exiting the justice system, women have no extra skills in terms of psychological or technical training (Flores & Pellico, 2011). Further, a new criminal tag strips her of the tools she

once possessed (Flores & Pellico, 2011). Even after paying off the debt of her crime by serving the sentenced time, she continues to be penalized. For example, a drug felony excludes her from accessing welfare benefits (Flores & Pellico, 2011). She is excluded from some opportunities in several professional fields such as law enforcement, healthcare, or childcare (Flores & Pellico, 2011; Lynch et al., 2013; Scroggins & Malley, 2010; Weiss et al., 2010). Even the constitutional right to vote can be lost while imprisoned, and beyond in some states (Flores & Pellico, 2011).

Without these basic tools, the most fundamental necessities of life may present particular difficulties for the post-incarceration woman (Flores & Pellico, 2011; Weiss et al., 2010).

Barriers to safe, affordable housing pervade. A criminal background may make women ineligible for the safest housing. Paying rent requires income, but even many low-income positions require a clean criminal background (Flores & Pellico, 2011).

Many post-incarceration individuals have further demands placed on them with requirements to meet with probation officers, undergo mandatory drug testing, participate in programming, etc. (Flores & Pellico, 2011; Wu et al., 2012). If these obligations are unfulfilled, consequences may include returning to prison/jail (Flores & Pellico, 2011; Wu et al., 2012) as one woman discusses:

I start my day running to drop my urine [drug testing]. Then I go see my children, show up for my training program, look for a job, go to a meeting [Alcoholics Anonymous] and show up at my part-time job. I have to take the bus everywhere, sometimes eight buses for four hours a day . . . If I fail any one of these things and my PO [probation officer] finds out, I am revoked. I am so tired that I sometimes fall asleep on my way home from work at 2 a.m. and that's dangerous given where I live. And then the next day I have to



start over again. I don't mind being busy and working hard . . . that's part of my recovery. But this is a situation that is setting me up to fail (Flores & Pellico, 2011, p. 492).

**Poor access to healthcare.** Acquisition of health insurance takes time and mental faculties that some are not prepared to invest. Qualms about paying for healthcare services and medications, in addition to confusion about gaining health insurance have been cited as barriers to accessing healthcare for post-incarcerated women (Colbert et al., 2013; Wu et al., 2012). Navigating and prioritizing health needs in the midst of the plethora of other immediate needs can be challenging and sometimes impossible (Wu et al., 2012). For example, HIV risk reduction may not rank among the highest priorities for women during immediate reentry transitions (Catz et al., 2012). Probation/parole requirements may be a barrier to accessing healthcare as many healthcare providers do not have availability past normal business hours, which women often spend working, undergoing treatment programs, or meeting other requirements of parole or probation (Wu et al., 2012). Limitations on driving abilities and depending on public transportation may further impair access to care (Wu et al., 2012).

**Allured to previous ways.** Acquisition of financial security can present utmost difficulty. The overwhelming reentry transition burden may leave women feeling that they have little choice but to reacquaint with negative social networks, relapse as a coping mechanism, or trade drugs or sex for money or housing (Catz et al., 2012; Flores & Pellico; Haley et al., 2014). In a meta-synthesis of ten narrative studies on the experience of post-incarceration, one woman's voice characterized the justification for returning to illegal activities in the name of survival.

Well, to me, prostituting was too demeaning and I was raped too many times, so I stopped doing it. Right? So I started selling drugs . . . It's not like I sold drugs to become a rich person or anything. I sold drugs to pay my rent (Flores & Pellico, 2011, p. 492).

**Criminal for life.** The criminal stamp hampers already depleted resources, leaving women in a worse state than before incarceration in terms of stigmatization and its associated lack of social capital and poor life satisfaction (Cobbina, 2010; Flores & Pellico, 2011; Heidemann et al., 2014; McNeill, 2014). The punishment experience remains long after a sentence has been served with a type of alienation that Fergus McNeill (2014) calls prisoner disenfranchisement. He describes America as the most extreme nation on the spectrum of poor treatment of ex-convicts as follows:

The extent of felon disenfranchisement...is a kind of civil death. There are limitations on voting rights... public assistance, public housing, access to the labor market, access to particular social places and spaces. So all of these forms of disengagement, disenfranchisement, [and] alienation remove people from the capacity to develop the sense of belonging which is critical to desistance (McNeill, 2014).

The isolation afforded by the status of felon may be a severe detriment to health and wellbeing and instill fear in those who must face it (Doherty, Forrester, Brazil, & Matheson, 2014; Flores & Pellico, 2011). Some may face stigmatization on multiple, intersecting levels, including minority status, HIV-infection, mental illness, and addiction (Haley et al., 2014).

### **North Dakota Needs According to Service Providers**

Bergseth et al. (2011) published a work that prioritized needs for recently incarcerated women in North Dakota from the perspective of community-based service providers. Not surprisingly, housing, mental health, interpersonal functioning, employment, family-related needs, acceptance/support, and substance abuse were found to be the most urgent needs. However, each item was also rated by service providers in accordance with their perception of how well the need was being addressed in the community. The area of need perceived to be

addressed most poorly was that of acceptance and support. In fact, 100% of those who felt that acceptance and support were a great need also expressed that the need was not being addressed *at all*. Acceptance and support deficits are discussed as those supports which assume a level of acceptance into the community as a neighbor, a coworker, or other fellow community member. Acceptance and support in those roles may enable employment, housing, and other resources. Bergseth et al., further provide guidance for priority of program refinement and development.

### **Theoretical Framework**

Urie Bronfenbrenner (1979) developed a theoretical framework for human development which describes the interconnectedness, and inter-influential nature between a person and their environment on multiple levels and throughout time:

The ecology of human development involves the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded (Bronfenbrenner, 1979, p. 21).

Bronfenbrenner (1979) describes a person's ecological environment, that is, the relationships between humans and their relationship to their surroundings, as resembling a set of nesting Russian dolls. The first and smallest doll, the microsystem, is that which most immediately houses the person, "a pattern of activities, roles, and interpersonal relationships experienced by the developing person in a given setting with particular physical and material characteristics" (p. 22). Taking one step further, Bronfenbrenner discusses the interactions between those environments. This is called the mesosystem, "a system of microsystems" (p. 24), which focuses on interactions of elements in the milieu in which the individual has direct

contact, for example, how the home might support or hinder what is happening at school, or work and social life. The third level of Bronfenbrenner's ecological environment is the exosystem, settings into which the person never steps, but which can affect development. His example is the way a parent's workplace can have enormous effects on a child, though the child is not directly present in the parent's workplace. The outermost nesting doll represents societal, political, and cultural conditions, the macrosystem. "The macrosystem refers to consistencies... that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies" (p. 26).

Through time, that is, the chronosystem, a person's understanding of their environment expands. For example, a young child mostly knows and changes the microsystem only, but an adult is typically aware of, and interacts with, the policies within their macrosystem in mutual influence. Further, role changes and life transitions incite new patterns of thought and behavior, for example, adopting the new role of mother, buying a home, or getting sick (Bronfenbrenner, 1979).

Bronfenbrenner's theory alludes to the complexity of the human experience. "A relation obtains whenever one person in a setting pays attention to or participates in the activities of another" (Bronfenbrenner, 1979, p. 56). These dyads are characterized by reciprocity; each interactive element dynamically impacts the other, "as in a ping-pong game in which the exchanges tend to become more rapid and intricate as the game proceeds" (p. 57). Furthermore, these reciprocal interactions become more complex through the duration of the relationship. Later in life, one tends to exchange roles, that is, behave in the way the other first behaved toward them. Therefore, though these interactions may seem simple or commonplace, they are developing a concrete foundation which shapes future behaviors. These interactions are also

characterized, according to Bronfenbrenner, by a certain balance of power. That is, one of the actors may make a greater influence on the other (Bronfenbrenner, 1979).

Bronfenbrenner's environmental levels were adapted to guide the assessment of the women's health from the beginning stages of developing of the data collection tools, to data analysis and organization, through the development of recommendations. Bronfenbrenner's microsystem was adapted to the women's individual level of environment, such as physical and mental health diagnoses, personal approaches to relationships, and how they identified themselves spiritually and within society. The next level of environment for the project was that of family and close relationships and how these relationships affected their health. Relationships included those of their immediate families, their significant others, and other close relationships which they considered family. The next outer level of environment was that of the community. The community was defined, for the purposes of this project, as the environments the women encountered on a regular basis which required interactions with people in paid positions, yet in which the women maintained some influence over the decisions made within the environment. These include interactions with professional or community organizations and their personnel. Examples include interactions with probation and parole officers, healthcare providers, and the environment and relationships within the transitional facility, places of employment, or organized religious meetings. The outermost level of environment was the societal/structural level, which could be compared with Bronfenbrenner's macrosystem, or the societal, cultural, political, and legislative environments.

The individual, family and relationships, community, and societal/structural levels were addressed in relationship to the four realms of health: physical, mental, social, and spiritual. Analysis and organization of the data also followed Bronfenbrenner's general model for clear

reporting of qualitative data in a logical and meaningful pattern. Finally, Bronfenbrenner's ideas regarding the complex interconnectedness of the women with their surroundings on multiple levels influenced the author's thinking throughout the process of developing, implementing, and analyzing the data. Namely, in order to improve the health states of the women, change must occur on many levels – within the individual, within the family and close relationships, within the community, and within the societal/structural environment in policy and legislative changes. Recommendations were made based on the women's reports of contributing factors to health and health needs on the community and societal/structural levels of environment. Evidence-based approaches were sought to support recommendations.

## **CHAPTER 3. PROJECT DESIGN**

### **Project Implementation and Data Collection**

A small, informal needs assessment was carried out as part of prior coursework with a women's transitional facility in Fargo. One primary key stakeholder expressed interest in a more thorough health needs assessment of the women within one residential transitional facility. The facility's desire was to assess the women's needs from their own voices and to receive recommendations to guide programming.

The purpose of this project was to assess the health needs for women reentering the Fargo community after incarceration. Health was interpreted holistically as defined by the World Health Organization (1946) to include physical, mental, social, and spiritual wellbeing. Three objectives guided this project:

1. To identify the health needs of reentering women as found in the literature.
2. To assess the health needs of reentering women from the perspective of the women themselves.
3. To develop recommendations for community-based organizations, healthcare providers, and policy-makers to address identified health needs.

### **Literature Review**

The first step in this project was to conduct a review of current literature regarding the health needs of incarcerated and reentering women. Two databases were used as described in Chapter 4. Findings from the literature review, as reported in Chapter 2, in addition to the social ecological model, were used to guide the development of the focus group and interview guides.

## **Assessing Health Needs**

Focus groups and individual interviews were used to assess the health needs for women reentering the community from the perspective of the women themselves. In addition, a short questionnaire was used to collect demographic information. Interview data collection focused on the health needs of reentering women in physical, mental, social, and spiritual realms of health on individual, family and close relationships, community, and societal/structural levels when applicable.

### **Focus Groups**

Two separate focus groups were carried out at the partnering facility in Fargo. Women were recruited from a previously scheduled, mandatory group session they attended at the facility as part of their transitional program. First, an informational meeting was held in order to introduce the co-investigator, explain the project, and review the consent. For the first informational session, 11/11 women expressed interest in participating in the focus group, signed consents, and participated in questionnaires. A focus group session took place two days after the informational session. For the second informational session, 2/10 women were excluded due to federal jurisdiction. The remaining 8/10 women expressed interest, signed consents, and participated in questionnaires and the subsequent focus group session for a grand total of 19 focus group participants. Focus groups were conducted during the regularly scheduled group time and lasted 94 and 86 minutes, respectively. Group sessions were audio recorded, transcribed, and coded in the same manner as personal interviews, as described in detail below. The transitional facility provided \$10 gift cards to area stores for each participant.

During each focus group, participants were asked as a group to discuss health needs and barriers to health for them and/or for women who shared their experiences using a focus group



interview guide (See Appendix C). The main purpose of the focus groups was to develop rapport between the participants and the co-investigator. Additionally, they served as an opportunity to recruit participants for subsequent individual interviews. Data collected during the focus groups were also used to support data collected during the individual interviews.

### **Semi-structured Individual Interviews**

Following each focus group, participants were invited to participate in an individual, semi-structured interview. Interviews were scheduled at the participants' convenience and were conducted at the transitional facility in a private location. A semi-structured interview guide was used that focused on the women's health experiences, needs, and barriers to health in areas of physical, mental, social, and spiritual health (See Appendix D). The interview sessions ranged from 42 to 85 minutes. Each interview was digitally recorded and transcribed verbatim. Each interview participant was given a second \$10 gift card to an area store. Interviews were audio-recorded. The audio device holding focus group and interview sessions was kept confidential and inaccessible to anyone other than the co-investigator via a locked file box when not in use. The sessions were transcribed verbatim excluding identifying data into password-protected Microsoft OneNote documents. After transcription, the audio recordings were deleted.

### **Demographic information**

Each participant was also asked to complete a paper demographic information questionnaire. The questionnaire was read aloud (See Appendix A) to procure better completion rates. Questionnaire items included age, race/ethnicity, highest education completed, incarceration history, current employment status, wage rates, and how many children the women had. Hard copies of the demographic questionnaires were anonymous and kept in a secure,

locked location until they were entered into a secure password-protected Microsoft Excel document. Hard copies were then destroyed.

### **Community-Based Recommendations**

Following primary data collection and informed by current literature, the final step of this project was to make recommendations based on community and societal/structural level needs as identified by the women themselves. State and city policies were explored through the internet and interactions with community members. Further evidence-based approaches to meeting those needs were gathered, discussed, and will be, as an extension of this project, disseminated to community-based organizations fit to make changes to existing programs, or to develop new methods for meeting those needs.

### **NDSU Institutional Review Board Approval**

North Dakota State University (NDSU) Institutional Review Board documents were submitted for expedited review July 1<sup>st</sup>, 2016 (See Appendix E). Because participants included incarcerated women, a vulnerable population, a full review occurred July 15<sup>th</sup>, 2016. After appropriate revisions were made, the project was approved July 25<sup>th</sup>, 2016. NDSU Documents were forwarded to the transitional facility and subsequently approved.

### **Benefits and Risk to Subjects**

Participants benefitted by receiving up to \$20 in gift cards to area stores. Additionally, participants potentially benefitted from sharing their personal health needs in an interpersonal interaction and through an outlet for the desire to give back (O’Gorman et al., 2012).

Implementation of change after dissemination of findings may also benefit participants, and/or the population as a whole, through new or improved programming for reentering women. As the public becomes more aware of the incarceration problem, women may find themselves more

readily accepted by the community. Finally, it is the hope of the co-investigator that the women will become healthier in areas of physical, mental, social, and spiritual health as a long-term result of this preliminary step towards change.

It was deemed possible that emotional and/or psychological distress could occur when sharing or recalling prior negative health experiences or outcomes. In order to safeguard against any harm in this regard, participants were reminded they could stop at any time without consequence. The participant could choose to follow up with the transitional facility for further counseling or referrals as needed.

To safeguard against the loss of privacy, participants were reminded that all responses were voluntary. Safeguards against loss of hard copies of questionnaires and audio recordings were taken. Hard copies of questionnaires were anonymous and kept in a secure, locked location until they were entered into a secure password-protected Excel document. Hard copies were then destroyed. The audio device used was kept confidential and inaccessible to anyone other than the researcher via a locked file box when not in use. After transcription, the audio recordings were deleted.

## **CHAPTER 4. EVALUATION**

### **Literature Review**

In January, 2016, two databases were used to uncover appropriate literature. Boolean format was used to search for keywords “health AND incarceration AND women” in the EBSCOhost MEDLINE database. Limiters were placed for those articles published 2010-2016, full text availability through the university’s access, those written in the English language, and those pertaining to adults 19 years and older. Forty-one articles met this criterion. Fourteen were excluded due to irrelevant topics, irrelevant populations, or duplication of articles for a total of 27 articles reviewed. ProQuest Sociological Abstracts was used to search for keywords “women AND incarceration AND (reentry or reintegration)”.

Limiters placed in the ProQuest Sociological Abstracts database were for those articles which were peer reviewed, scholarly journals published 2010-2015. Fourteen additional articles were used after the above-stated exclusions. Articles discovered using this process were combed through multiple times for themes related to the topic of health needs. Reference lists were used to identify further pertinent literature. Other searches for information gaps were also sought as needed through 2017. Results of the literature review are discussed in Chapter 2.

### **Data Collection Tools**

The focus group guide was developed based on Krueger and Casey’s work (2000), findings regarding women’s needs as identified in the literature, and the adaptation of Bronfenbrenner’s social ecological model. After the co-investigator introduced herself and verified that each participant had signed a consent, a simple opening was used to encourage each participant to introduce themselves and begin speaking at the beginning of the focus group. A subsequent question was used to encourage the women to think and speak further about the

general topic of their health. Next, the women were asked the key questions about what they needed to be healthier, and barriers to their health in each of the four realms of health: physical, mental, social, and spiritual. Cues followed each question to elicit more information about how their health was affected on different environmental levels. Open-ended probes such as, “Tell me more about that,” or “What else?” were used to elicit more complete answers or for clarification as needed. The women were also gently redirected back to the topic of health when the conversation veered. See Appendix C for the focus group guide.

The semi-structured interview guide was designed to capture each woman’s personal and complex experiences with contributing factors to health, health needs, and barriers to health in each of the environmental levels. The semi-structured format allowed the co-investigator the freedom to clarify or further explore topics that seemed to be of significance to the participant, in addition to pausing to respond with the purpose of building rapport and trust (See Appendix D).

### **Data Analysis**

Demographic data were entered into an Excel spreadsheet and descriptive statistics (e.g. sums, means, ranges, percentages, etc.) were calculated to describe the demographic characteristics of the study participants. These data are presented in Chapter 5. Descriptive content analysis was used to analyze the focus group and individual interview data as described by Granaheim and Lundman (2004). First, each transcript was read and reread line by line and condensed into codes with the purpose of retaining the interviewee’s meaning, as understood by the co-investigator, while shortening the text into usable codes (Granaheim & Lundman, 2004). Within each transcript, the applicable codes were designated and additional codes were generated as needed. Each interviewee’s codes were electronically assigned a unique electronic highlighter color and pasted into a Microsoft Excel document. The unique color for each

interviewee was retained within the Excel document. The use of the Excel document allowed the co-investigator to move, arrange, and group codes with similar meanings. Next, the codes were organized into categories using the a priori organizational structure of the interview guide to reflect the social ecological model. Finally, the data was further organized into physical, mental, social, and spiritual health realms. Some codes, which did not fit into the a priori organizational structure were grouped into similar themes from specific lived experiences including using substances, and the incarceration experience. An outside qualitative expert was consulted periodically not only to discuss and make decisions regarding discrepancies within the coding system, but also to debrief throughout the intense process of data collection, transcription, and analysis. The organized compilation of codes also allowed the co-investigator to recognize redundancy of the data when no new information or themes emerged from the data and theoretical saturation was achieved (Walker, 2012).

## CHAPTER 5. RESULTS

### Participants

The final sample included 19 racially diverse women who ranged in age from 20-58 years (mean age 30.6 years). The highest level of education ranged from 9<sup>th</sup> grade to some college. All the women had been to either jail or prison, with six women experiencing both jail and prison. The average number of times each woman had been incarcerated (either jailed or imprisoned) was about three times. All the women except one had been to jail at least once, for a collective total of 93 jail visits. One woman denoted more than ten visits to jail, and one woman had only been to prison and not jail. The shortest jail visit lasted 10 days, and the longest lasted 26 months. The average jail stay lasted six months. Seven of the 19 women had been to prison at least once with the shortest stay, one month, and the longest stay, 120 months. The average prison stay lasted just over 27 months.

Seven women worked 40 hours or more weekly. Five women worked 21-39 hours. Two women worked less than 20 hours weekly. One woman did not report how many hours she worked weekly, but stated she was employed. Four women were not employed. The average hourly wage was \$10.18, ranging from \$8.75 to \$13 per hour. Eleven of the fifteen working women made less than \$11/hour. With these data, speculative annual salary calculations were made as seen in Table 3. The 2015 United States poverty guidelines are provided for comparison (US Department of Health & Human Services, 2015).

The 19 women were mothers of 42 total children. Four women had no children. One woman had nine children. On average, the women had 2.2 children, or between two and three children, each. Questionnaire data are reported in Tables 1-6. Comparisons to 2016 state inmate data were made when available.

Table 1

*Participants' ages versus state inmate ages*

<b>Measure</b>	<b>Participant Age</b>	<b>State Inmate Age</b>
Range	20-58	18.7-62
Average	30.6	33.4

Table 2

*Participants' highest grade completion*

<b>Grade</b>	<b>Frequency</b>
College Degree	2
Some College	6
GED	2
12.0	5
11.0	1
10.0	2
9.0	1

Table 3

*Participants' employment*

<b>Hours and Wages</b>	
Hours/week average	33.3 hours
Hours/week range	0-41 hours
\$/hour range	\$8.75-13
\$/hour average	\$10.18
Annual average salary (\$10.18/hr x 33.3 hours weekly x 52 weeks)	\$17,627.69
Annual average salary at full time (\$10.18 x 40 hours weekly x 52 weeks)	\$21,174.40
<b>United States Poverty Guideline</b>	
Household of 1	\$11,770
Household of 2	\$15,930
Household of 3	\$20,090
Household of 4	\$24,250



Table 4

*Participants' races/ethnicities versus state inmate races*

<b>Participant Race/Ethnicity</b>	<b>n</b>	<b>Percent</b>	<b>State Inmate Race</b>	<b>Percent</b>
Hispanic or Latino	0	0%	Hispanic	4%
American Indian/Alaska Native	4	21%	Native American/Alaskan Native	33%
White	8	42%	Caucasian	60%
Black or African American	1	5%	Black	1%
			Other	2%
≥2 Races/Ethnicities	6	32%	Not measured	

Table 5

*Participants' incarceration histories*

<b>Incarceration Measure</b>	
Jail visits average	5.5 visits
Jail visits cumulative	93.0 visits
Jail length of stay range	0-26 months
Jail length of stay average	6.0 months
Jail length of stay cumulative	113.8 months
Prison visits average	0.8 visits
Prison visits cumulative	16.0 visits
Prison length of stay range	0-120 months
Prison length of stay average	13.7 months
Prison length of stay cumulative	260.0 months
Cumulative visits jail + prison	109.0 visits

Table 6

*Participants' children*

<b>Number of Children</b>	
Cumulative	42
Per woman range	0-9 children
Per woman average	2.2 children
Per woman median	1 child

### **Health Experiences and Needs: Social Ecological Model**

The qualitative data were derived mainly from personal interviews (n=12), but data from two focus groups (n=19) were used to supplement the data where appropriate. The women were identified by number to retain privacy. Data used from focus groups were denoted by “FG1” or “FG2”. The women discussed their needs a priori, according to the design of the interview guide, which addressed their health and health needs in realms of physical, mental, social, and spiritual health. The health realms were further explored on multiple environmental levels: individual, family and close relationships, community, and societal/structural. The data are organized according to levels of environment and health realms.

Other themes emerged from the data and were discussed as lived experiences. These relate to Bronfenbrenner’s social ecological system as the chronosystem, that is how events throughout time affected the health of the women. Elements discussed as lived experiences include using substances and the prison experience.

Contributing factors to health were organized according to the social ecological model based on what the women said about their health (see Figure 3). Health needs were also organized according to the social ecological model based on what the women said they needed and inferred at times, based on stated contributing factors. Health needs were summarized in Figure 4 at the end of Chapter 5. Both contributing factors to health and health needs are discussed in the narrative found below.

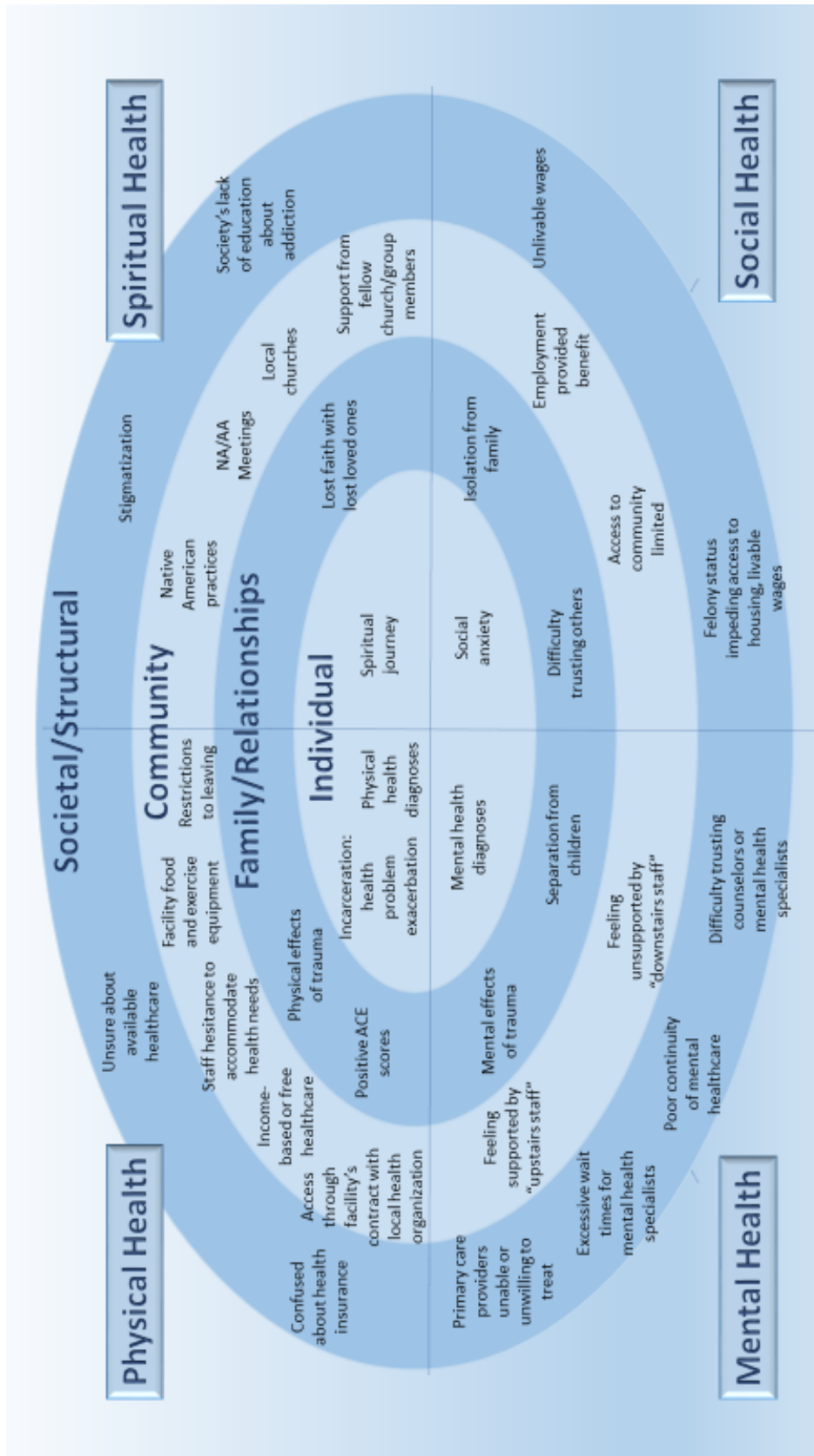


Figure 3. Contributing factors to health according to the social ecological model.

## **Individual**

Contributing factors to health and health needs were discussed on the individual level of environment in each of the four realms of health. The women discussed their individual physical and mental health states, diagnoses, and priorities. Their personal approaches to relationships were also described. Finally, the women discussed how they identified themselves spiritually and within society.

**Physical health.** During the personal interviews (n=12), women rated their overall health status on a scale of 0-10, with 0 being the worst health they have ever been in, and ten, the best health they have ever been in. Scores ranged from 4-10/10. The average rating was 6.5/10.

The women were also asked about their past medical history. Four women noted being diagnosed with hepatitis C. One woman relayed that she lacked information about hepatitis C after being diagnosed recently. She wondered about treatment and transmission of the disease, and implications of the disease on her health. One woman's top health priority was to undergo treatment for hepatitis C. Another described having problems with her teeth. Another listed diagnoses of fibromyalgia, carpal tunnel syndrome, and asthma.

Many women mentioned that regular health checkups had not been a priority due to a lifestyle of using drugs. They described sobriety as a time of discovering and seeking treatment for what may have been going on in their bodies when drugs kept them from noticing. One woman described experiencing numbness since incarceration. When asked about when the numbness started, she responded: "In jail. But I don't know. That's the first time I was straight for a long time; I wasn't on drugs or anything. So maybe the problem was always there, but I never noticed" (1).

**Mental health.** Almost all of the women self-reported having one or more mental health problems. The most common problems mentioned were anxiety, depression, attention deficit hyperactivity disorder (ADHD), and PTSD (See Table 7). Women also listed bipolar disorder, obsessive compulsive disorder, and personality or mood disorders. Two-thirds listed more than one problem. Some were currently being treated for their mental health problems, while others experienced poor continuity of mental health care, such as breaks in taking their medications due to changing corrections institutions and their provider’s orders and prescriptions not following them, inability to pay for medications, or changing healthcare providers.

Table 7

*Mental health problems*

Identifier	Anxiety	Depression	Attention Problems	PTSD	Bipolar	Other	Breaks in Medication
1							
2							
3	+	+	+				
4	+		+			+	
5		+		+		+	+
6	+	+					+
7	+	+	+	+	+	+	+
8	+						
9		+					
10	+	+		+			+
11	+	+	+	+			
12	+	+	+	+	+	+	+

**Social health.** Social health on an individual level refers to “that dimension of an individual’s well-being that concerns how he gets along with other people, how other people react to him, and how he interacts with social institutions and societal mores” (Russell, 1973, p. 75). Some women described automatically distrusting (4, 3), or disliking people (8, 12) or being more guarded because of the way they grew up. “I don’t like meeting new people. I hate new

people, because I've just been screwed over so much. So, you know. I like to stick with what I know” (8). One woman even disclosed her skepticism about the interview; underlined portions represent the words of the co-investigator and are included when they provide clarity or insight.

Yeah. I'm a lot more guarded, and I'm like skeptical about a lot of different things, like...

\*pause\*

Probably even me.

Yeah. Kinda. Like why?...I tend to run when things get hard which I'm not trying to do anymore...But yeah. I know it carries into my life now, like the relationships I've been in (4).

One described experiencing social anxiety as a barrier to developing new relationships:

My anxiety- I don't get to do anything that I want to do. So, like, if I want to go somewhere, I probably won't go, because I'll worry about all the wrong things...Like somebody sees me, and I look weird...Or like, what if I fall? Or what if it's cold? Or, you know, just like, all the wrong things. Like, what if I have something on my face? During this whole thing right now, I'm thinking, “What if I have something on my face?” (11).

**Spiritual health.** Half the women expressed spirituality to be a major factor in their overall health. Some women even described spiritual health as the most important aspect of their recovery. Some women described their spirituality as a journey with times of running from God, or feeling God had wronged them because of their difficult problems, and times of coming back to God, or gaining new understanding.

Many women also discussed their own need to be ready to make healthy changes. Some felt ready to walk away from old lifestyles: “I don't even want to be high anymore. I'm just done doing that” (4). Some described taking responsibility for their past mistakes. Others knew they

were not ready, “Ain’t nothing's going to change until I'm ready myself for it. Yeah. Someone can force me to do something, but doesn't mean anything is going to change when I'm done doing what they want me to do” (12).

One woman described feeling that it was too difficult to have hopes and dreams about the future:

I've tried so hard for so many years trying to do things [voice broke momentarily], and it was never good enough for people. So I'm just like fuck it. I don't want to dream big and then never achieve those dreams to be let down even more. That's why I try not to think too much about the future (12).

However, one women described needing hope for the future: “You have to have hope or else, what are you gonna do? Go insane? Probably” (11). Most women had dreams of giving back and being active citizens in the community. Some wanted to be substance abuse counselors, feeling that their experiences would enable them to relate with their clients on a more helpful level than some of their own counselors. Many had dreams of going back to school or pursuing a new career. See Table 8.

Table 8

*Dreams for the future*

<b>Identifier</b>	<b>Dreams</b>
1	Open a homeless shelter
2	Get a good job
3	Go back to school, maybe be a nurse
4	Be a counselor
5	Go back to school, maybe be an addiction counselor
6	Go back to school, inspire others
7	Go back to school, become a dentist
8	Become an addiction counselor
9	Did not discuss
10	Get a metal refabrication job
11	Go back to school
12	I don't want to dream big

**Family and Close Relationships**

Bronfenbrenner (1979) discussed the complexity of the human experience, especially in regards to how relationships affect healthy development. Jean Miller (1990) further discussed that healthy relationships are paramount for women's psychological health. When the women were asked about how their closest relationships affected their health, they demonstrated the complex intermingling between the quality and characteristics of their relationships with their health.

They bore the physical effects of abuse from family and significant others. They experienced dichotomous relationships with both their mothers and their children which affected mental health. They experienced isolation and hesitance to reconnect with loved ones as contributing factors to social health. Finally, they experienced both a building of and a loss of spirituality and hope, because of their family and close relationships.

**Physical health.** Adverse childhood experiences are the best-known predictor of poor health outcomes (Prewitt, 2014). Experiencing childhood and adulthood trauma was an over-



arching theme for the women. The women discussed that the trauma they endured affected their health in many ways. Women mentioned physical scars, residual musculoskeletal aches and pains, difficulty in their ability to relate to and trust others, low self-esteem, blurred memory, and feeling stuck in their past trauma. Most of the abuse the women reported was at the hands of family members or significant others.

Although the ACE Questionnaire (See Appendix A) was not presented to the women, many women listed and/or discussed their specific childhood and adult traumatic experiences when they were asked about whether trauma was ever addressed by a healthcare provider. Collectively, the women reported experiencing nine of ten categories of adverse childhood experiences. Two women, without being asked, discussed five different categories of adverse childhood experiences during the interview; another three named four categories. The ACE mentioned by the women are tabulated in Table 9, but likely under-represent actual ACE scores, since the questionnaire was not physically or verbally administered.

Table 9

*Adverse childhood experiences and adult abuse reported by women*

<b>Adverse Childhood Experiences (See Appendix A)</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>	<b>(8)</b>	<b>(9)</b>	<b>(10)</b>	<b>(11)</b>	<b>(12)</b>
Verbal abuse				+								
Physical abuse				+	+							+
Sexual abuse							+			+		+
Poor support	+											+
Neglect	+		+		+							
Parents separated/divorced			+	+	+			+		+	+	+
Domestic violence	+		+	+								
Household substance abuse	+		+		+							
Household mental illness			+		+							
Family member incarcerated												
<b>Adult abuse</b>			+	+	+		+		+	+		+

Seven of twelve women also reported physical, emotional, and/or sexual abuse in adulthood, all by a significant other. Three women reported that the father of one of their children tried to kill them. “He was really abusive. He went to federal prison for trying to kill me...I have scars on my head from getting hit in the head with a bat. And just, the list goes on and on” (10). One of them described the nature of her traumatic relationship in detail:

...that man beat the fuck out of me for six years. Like terribly. Beat me up all the time. Just like, I don't want to say brainwashed, but basically brainwashed me into thinking I was this horrible person, and this horrible mother, and I deserved to die, and that, you know, just all these horrible things about myself all the time...he put me on his phone plan, so he could control turning my phone on or off...he got me pregnant, so he knew he had me. And then he talked me into quitting my job to stay home with my kids, so I did. And he talked me into thinking that I can't have friends in order to be a good mom, and then he made my family think, you know, that I didn't need them...they had resentment

towards me. And then he made me believe that I was crazy because I was bipolar. And I couldn't control those feelings inside of me, and my mind was just, *lost*. I had nothing. It had all been stripped from my being (7).

She went on to describe an episode of severe physical abuse that precipitated her drug addiction:

And he just got so pissed off at me, started freaking out...he goes and reaches down and grabs my son, cause my son was crying. And I went to go calm him down as well...and he turned around and back-handed me so hard across the face that he dislocated my jaw. And I fell to the ground, and I got back up five more times. And each time, I didn't even get to stand up straight, and he closed-fist punched me in the face. And the last time he hit me, he hit me so hard. I fell and I hit my head on the corner of the bed frame, and I lost consciousness. And I just remember waking up to his uncle slapping me in the face trying to get me to wake up. I had like, big black eyes, like the bear on the Jungle Book. Just big...Just... I had a concussion, broken nose, dislocated jaw. I had hand prints all around my neck. I had a fat lip, just cut open, like bruises just covering my whole body. I immediately just hopped in my car, and I drove home drunk. And I went to my ex-boyfriend's house. And he's a heroin addict. And that was the first time I ever tried heroin in a needle. And I was just like, so dead and numb and just like, lost inside. I just didn't understand why someone who loved me could do that to me. And the heroin just numbed the pain, and made it go away. That's where I started my addiction (7).

One woman described how childhood sexual abuse affected poor decisions she made later in life:

I was raped when I was 12 twice by [a close family member] who was like, 18 at the time. That was never really looked into, like a family, something you just, you know, nobody ever heard that it happened. So I never really dealt with that. So, I think, like, after that I have these issues with men, like controlling...I had really low self-esteem, because I continued to stay with this guy. I started having kids when I was 19 and...after a while I noticed there was a pattern...he kept me trapped by having me have kids (10).

**Mental health.** In general, the women discussed their relationships with their mothers and their children more than any other relationships. Both dyads were characterized by contrasting feelings and effects on mental health. Half of the women described unhealthy relationships with their mothers. They also discussed how relationships with significant others affected their health.

Specifically, four of the women's mothers used drugs or alcohol (1, 3, 5, 8), enabled drug use (1, 5), or abused or allowed abuse of the women as children (4, 12). Despite this, some women stated strong loyalty to their mothers. "She was an enabler for me to keep using," and later, "I loved her so much. I'd do anything for her" (5). One woman discussed several ways in which her mom's mental illness and addiction affected her negatively. Yet, she still felt a strong bond.

I used to be [on medications for ADHD] when I was younger...but then my mom would take them for her own personal use, so my dad just took us all off our medications...My mom drowned in her addiction. She'd like walk around town with no shoes, no jacket in the middle of winter, not knowing where she was...My mom, before she passed away, she would always say, 'Well, at least I did something right.' So, I'm living my life for her (3).

Other women discussed family conditions early in life characterized by neglect and drug or alcohol abuse, but then later in life, sobriety and strong support. One woman discussed this dichotomy.

So, how did those close relationships affect your health?

I don't know. They didn't do nothing good for me. Cause they just gave me drugs. My mom's always like, trying to make me stay sober and shit. She still does. She went to treatment and got cured, I guess.

So she's sober now.

Yeah. She's been sober for a long time. Probably 10-12 years.

Is she a positive influence on you now, or is there still a lot of –

No. She's a positive influence. She's good. We get along. I talk to her every day...She sobered up. Just one day, she went to treatment and sobered up and started sun-dancing, and I can barely remember her being this big old drunk anymore (1).

The women demonstrated strong connections with their children. Nine of the 12 women told about their children within the first two minutes of the interview when asked, "Tell me a little bit about yourself." Half of the women discussed their children as their strongest motivation to become healthier, but this relationship and its effect on health was also complex. One woman discussed the dichotomy between her daughter being her strongest motivation to do better, yet feeling the stress of being responsible for her daughter:

When I get out, I am going to be having to pay for her, and feeding her, taking care of her...And that's kind of overwhelming, too, but not too overwhelming, but – it's just um; she's my first daughter, my first child ever, so I don't know how well things are gonna go

when I have her on my own. So, it just gets kind of overwhelming, and sometimes I don't want to do it, but I just gotta breathe and know that it will be okay (11).

Another woman (12) described making choices that made her mentally less healthy so that her daughter could be in a healthier environment:

Oh, don't get me wrong, I miss my kids with all my heart, but they're in a place where they have more than I could ever give them. And I know that. And I'm not just going to try and yank them from that, because that will cause more problems...It's like I know I'm in and out, in and out, in and out, and she doesn't understand. But I can't see her cry like that. My heart melts! And then, when I leave that, it hurts. So, that's what makes me want to go use, too. Because I know I'm not just going to pull her out of what she knows. It wouldn't be fair to her. Period.

She further described needing to keep a connection with her daughter, though limited, as a motivator to stay alive:

I'm still alive, though...If it weren't for my kid, I really wouldn't have anything left. ... All I want, all I ask is that they still know me, know who I am. And know that I love them. And I did what I did for reasons. And that, you know, I wouldn't change anything about them...You know, I wish I could have my kids, but I know mentally I'm not at that state, and I don't know if I ever will be, to fully be there the way I know I should be (12).

Relationships with significant others were also representative of the complex nature of human relationships and their effects on health and development. Over half of the women experienced severe abuse and/or used substances with past significant others. Yet three women still had hope that their current relationship would be different, even though both she and her partner had histories of addiction and/or imprisonment. The women felt that their boyfriends

understood, because they had been through the same experiences. “Cause he's a recovering addict, too, so we both know how it is, kinda like, we're not looking down on each other” (11). “He does have a history of drugs. And he went through the same treatment as me, and it's - we're both on the same page, and he wants to stay sober and be sober and live a good life” (7). “He makes me feel like I’m not doing it alone...we push each other to grow” (3).

**Social health.** According to Jean Miller (1976), healthy female psychological development depends on building healthy connections with others. Miller defines characteristics of healthy relationships as growth-fostering: mutual, empathic, and empowering. Mutuality refers to the ability of both parties to convey personal thoughts, feelings, and perceptions to another. Empathy refers to the ability of both parties to relate to the other without losing their sense of self. Finally, each person empowers the other – sharing power in an upward fashion, not in a pattern of exerting authority over one another. Growth-fostering relationships result in increased zest and vitality, the empowerment to act, an increased knowledge of self and others, increased self-worth, and a desire for more connection (Miller, 1986). Disconnected relationships can be equally devastating to health. Miller discusses that broken relationships result in 1) diminished zest or vitality, 2) disempowerment, 3) unclarity or confusion, 4) diminished self-worth, and 5) a turning away from relationships (Miller, 1990).

Mutually positive relationships were described to the women. Then the co-investigator asked the women whether they had experienced this type of relationship. One woman could not think of anyone with whom she had a mutually positive relationship. Three women could name one person while three more could only name their recent boyfriends. Five women could name several people. Two women summarized their closest relationship circles by saying, “All my friends are in jail,” (8) or “Everyone I know uses” (7).

Five women described having broken relationships with family and wishing to restore them, but feeling unable to for various reasons. One woman was asked whether she wished to reconnect with her estranged children, “Oh yeah. But what stops me? I’m not sure. I think a little bit of my pride. I think a little bit here, I don't want to connect while I’m here, because I'd have to tell them” (9). Some felt powerless to reconnect. One woman described a no-contact order separating her from her son. “I would pursue something, but I can't. There's nothing I can do. Like, I mean, I have tried, and I get in trouble. Like, even for trying. Like, doing it in the right way. So, I just say, ‘Fuck it’ (2).” Some described feeling isolated from their family members because of their own choices. One woman made choices to stay in an abusive relationship. “I would end up taking him back, and I was just – [My family] really kind of gave up on me. They're like, you must like this, or you know, you continue taking him back” (10).

One woman described how her family and close relationships have affected how she is prone to distance herself from others. “It has me really guarded now... When I meet people, I'm like, even the simplest similarity, I'm like, oh my God - no. Even though that person could be completely different, but like, just a similarity, it's just like, no” (4).

**Spiritual health.** The women described how their family and close relationships affected their spirituality, in terms of affecting their relationship with God, or in terms of building or destroying a sense of hope. Several women described losing faith or hope after losing loved ones or being separated from their children. “I lost so much. I was angry with God for a long time, but I think I'm starting to realize he does everything in his own way, and it's getting better” (5).

Like when I was using, I believed in God, and then He took everything from me, and I used to blame him. Like okay, why do you keep taking everything from me? And then you're still not here. What am I supposed to do? But then I realized I make the choices I



make...then I got back into God. And then um, I lost faith again when I lost um, that person close to me (11).

One woman described how being placed in a healthy foster family made her feel proud of her own productivity. She described her first experience of what she called a normal family:

Yeah. Like me and my friend were driving one day and we parked. ... this family had their windows wide open, and it was them sitting at the table, a son and a daughter and a mom and dad, and they were just like, having a meal and it's like, "Damn." Like, that is what a normal family is supposed to look like. Like, that's so cool! And then, after that, that's when I went into a foster home, and just, to finally feel like I was in a normal setting. Like, they pushed me to my limit with academics...I graduated high school a half a year early...It felt good (3)!

She went on to describe how her daughter brought her a strong sense of hope. "And now, my daughter, she... just looking at her, like, I'm - I know that I can become somebody better than I became" (3).

### **Community**

The community was defined, for the purposes of this project, as the environments the women encountered on a regular basis which required interactions with people in paid or official positions, yet in which the women maintained some influence over the decisions made within the environment. These include interactions with professional or community organizations and their personnel. Examples include interactions with probation and parole officers, healthcare providers, and the environment and relationships within the transitional facility, places of employment, or organized religious meetings.

**Physical health.** The women's community interactions with both the transitional residential facility and the local healthcare facility affected their physical health. They discussed having priorities during healthcare visits that were different from their healthcare provider's priorities and problems accessing needed healthcare. They also discussed the desire for better access to exercise and better food choices within the transitional facility.

Upon being admitted to the transitional facility, the women were required to undergo a basic physical exam at a local healthcare facility which was paid for by the transitional facility. The purpose of the exam was to address chronic health problems, resume chronic health medications when medically necessary, and to test for infectious diseases such as hepatitis B and C, HIV, syphilis, and others. Some described feeling frustrated that healthcare providers were unwilling to address their own health priorities during these visits; however, the women noted that they were invited by the healthcare provider to follow up with other health concerns. These subsequent visits were to be paid for by the patient, but provisions were made by the healthcare facility for an income-based payment model. While living at the residential facility, the women also qualified for free services at the healthcare facility through a homeless health program.

Women were asked whether a healthcare provider ever asked about their history with trauma. Four stated they generally do not, and four thought they should. One expressed feeling trauma is unimportant in regards to health. When one woman was asked whether a healthcare provider ever asked about her history with trauma, she began listing her adult trauma:

I continued being married to a man who used to beat me. My ex and I used to physically fight all the time. I've been in relationships that are physical. This last one was more mental than anything. He beat me down in my head for 10 years or more. I felt like a piece of shit.

Do you wish a healthcare provider would ask you about that, or is it something that isn't applicable?

I think it is applicable, because it has a lot to do with why we use, I think. You know? So much. Like PTSD, I get scared of um, when a man raises his voice, you know. That stuff...it'll never go away. It's always going to be there. You just gotta learn how to cope with it. That's hard. Lots of different factors, you know (5).

When further discussing access to healthcare, some women described some staff at the transitional facility being hesitant to help them access needed healthcare. They described having trouble getting transportation to get their medications or transportation to healthcare facilities when needed. Their medications were held and distributed by staff upon request, but some women noted the staff did not always tell them that their medications were nearly gone in time for them to obtain more, which caused disruptions in physical and mental health treatments.

When discussing opportunities for exercise, some women noted that the transitional facility was close to a walking path and rentable bicycles, but most desired more opportunities for exercising. In fact, half of the women said the most important thing they needed for better physical health was to exercise. The women noted poor opportunities for exercising indoors. They knew about the availability of some simple exercise equipment within the transitional facility, such as an exercise ball, yoga mat, and videos for yoga, but they also experienced barriers to using the equipment, such as the lack of a private place to exercise. They were told one multi-purpose room could be used for exercising, but it was also a room used for family visitation, meetings with staff, and other purposes. The room was also under video surveillance, which made some women feel uncomfortable. They also noted that other women lived in their quarters, so lack of privacy and wanting to respect others' time and space prevented them from

exercising in their rooms. Some wished for an on-site elliptical machine and weights, or an outdoor handball or basketball court. At times, the women were placed on restrictions by staff which prevented them from leaving the building to go to the gym. They noted feeling that it was difficult to obtain permission because of disciplinary actions for things like not keeping their rooms up to facility standards or having food or drinks outside of designated areas. These restrictions prevented them from obtaining or using gym memberships. Paying for a gym membership was also a barrier to exercise. Yet, with all these barriers, one woman prioritized exercising in her room daily, but discussed feeling self-conscious making this choice in front of others. She noted her decision to prioritize exercising positively affected her health.

I force myself to wake up in the morning just to go to treatment. I force myself to go to work. I force myself to do things...[but] when I'm working out, I feel proactive. I feel energized. I feel good inside (3).

The foods provided at the transitional facility were described as unhealthy, high in carbohydrates, with little provision of fresh vegetables or fruits. However, women who had experienced prison noted that the food was far superior to prison food. Some women had gained weight since being at the transitional facility, but some admitted that sobriety from methamphetamines likely played a role in their weight gain.

**Mental health.** The women described how the environment within the transitional facility affected their mental health both negatively and positively. They discussed generally feeling unsupported by the staff they encountered most regularly. Others offered support that bolstered their sense of self-efficacy.

In general, they felt they were treated poorly by staff that were “downstairs”, or in closest proximity to their living quarters. These staff members were responsible for checking the women

in and out of the facility, enforcing facility rules, passing on the women's concerns to their case workers or other licensed staff as needed, passing medications, and at times, giving rides to the women. The women described feeling that "nit-picky" rules and their consequences, namely being put on status that prevents them from going into the community or having other privileges taken away, were sometimes enforced in ways that made them feel disrespected or demeaned:

Another rule: You gotta have your beds made every day, or you get written up. That doesn't bother me. Whatever. But it's more nit-picky stuff. It's like, I'm not here to make a mess in my room. I'm here to work, do treatments. Follow the rules? Yeah! But come on! What are you thinking? Why do you have to be so...I've got bigger fish to fry. We got a lot on our plates...or people start using again or whatever...These small things add up (6).

They described that even one staff member treating them with a disrespectful attitude could make life tasks more difficult. One woman relayed difficulty getting permission to go to job service:

The first thing out of somebody's mouth when you say, "I'm going to sign out to go to job service," [is] "No." ...This isn't even funny. There's nothing funny about this. Don't smirk at me or give me some kind of attitude. [She says,] "You don't have time to go. It's 4:00. You have to be back at 5:00." I said, "Yeah I do. I have an application that I'm saving...I'm going to go finish it and submit it." "No. You don't have time." I could be there in ten minutes. But the first thing out of this one gal's mouth is no. Right away, before she even knows the situation. It's no. And she gets a kick out of that. She really does (6).

One noted feeling an “us and them complex” from downstairs staff (FG1). Another woman described feeling that downstairs staff lacked understanding and belief in the women’s ability to be successful. Another noted the staff’s expectation that she would test positive on a urine drug screen affected her negatively:

They say this is supposed to be a transition place, transition so we can be able to be better people. But we get so much hate from them downstairs. Even like, they mess with me and be like, “What do you want? Get out of here.” I just, I’ve lived with so much hate with just the staff alone, towards these ladies here who is trying to be better people. And like...we ain’t got time for that. We not here for that. They be saying, “I know you gonna drop dirty.” It’s like they be waiting for us or something...Where’s the support? Even the littlest support from the staff would help us a lot (FG1).

They also described that one person showing care made a difference for them.

Cause there are some that will come beside you...“Are you ok? You don’t look okay today.” You know, and that kind of means a lot. [One staff member] sat up in our group, and she said, “I honestly don’t think I could ever do what you guys do.” She’s like, “I would run instantly if I was put in your situation.”...That’s all I expect staff to do. Put yourself in our shoes once, whether or not you could try and grasp that, and think of yourself being in trouble, whatever it may be – big, small, whatever. Like, if you could for once second, like, kind of put yourself in our shoes. It’s the principle. If you just, have a little bit of a care (FG1).

While many felt frustrated with treatment of one or two staff members, the majority felt a few individual “downstairs” staff members, and the licensed “upstairs” staff, in general, demonstrated professionalism, genuine care, and enabled them to become healthier. “There are

some very good staff here – the upper staff upstairs...they're more professional...They actually care for you...[Names a staff member], she'll bend over backwards for you to go on the computer to look up job service or something like that” (6). Many named specific case managers or other licensed staff providing counseling, help becoming employed, access to healthcare, or help navigating the criminal justice system. One even noted about a supportive staff member, “She knows that I'm never going to fail a [drug test]. I'm not about that. You know? I got my head on straight. This place saved my life” (5).

**Social health.** According to several authors (Bergseth et al., 2011; Doherty et al., 2014; Giordano, Cernkovich, & Rudolph, 2002; Heidemann et al., 2014), women need to develop new, prosocial relationships, as a part of a change in identity transformation. Often, women develop a prosocial relationship with someone that has come into their lives because of incarceration – a staff member, case manager, or fellow participant in treatment (Heidemann et al., 2014). Heidemann and colleagues (2014) suggest that these most supportive prosocial relationships most often occur outside of the woman’s usual social circles, that is, outside the realm of family and friends.

When the participants were asked about their ability to interact with others in the community or whether they felt the need to develop new community relationships, some women could relate to this need, but others could not. Five women expressed the desire for more opportunities for social interaction, such as more frequent access to go shopping for basic supplies, or being taken on outings in the community, such as to the library or the movies. Some perceived barriers to developing new relationships, including distrusting people, social anxiety, or difficulty getting permission from the transitional facility to be out in the community.

Some woman described feeling the need to cut ties with old social circles. “I know if I want to stay sober that I can't hang around with the same people that I hung out with before. If I want to stay sober, I have to find sober people in my life” (7).

There were a couple girls ... that when I go back there, I will not be calling them, because we drank. ... So, the ties have been severed for many years. But if they're still living in the same place, you know, I wouldn't go there. That kind of thing. You know, I wouldn't do that (6).

The women discussed how their work contributed to more positive social health. All the women who had jobs at the time of the interview (75%) expressed feeling good about working. The women viewed working as a privilege that built their self-efficacy and helped them make prosocial connections with others in the community. “Working, it feels productive: getting paid, having money left over...It's nice being productive, and the people like me at work” (9). One described women at the transitional facility generally having a good reputation with employers, “And she likes everybody from [the transitional facility], because everybody just comes to work, and all we want to do is work. Cause we can't do nothing but work” (10). Two women discussed their places of employment making exceptions to company policies by hiring them even though they had a criminal record. Favorable work histories and a hard-working reputation changed the supervisors' minds. One participant described:

And I go, “Are you hiring for this [position]?” “Yeah.” “Do you think I could apply for it?” “Not while you're at [residential transitional facility], honey.” ... She called me back down, and she said, “I talked to my bosses, and they said they were going to, you know, take a chance, make an exception, and we'll try you out” (9).



**Spiritual health.** Many women found a sense of community, belonging, and self-efficacy at local Narcotics/Alcoholics Anonymous meetings and churches:

My spirituality is a lot stronger than it was. I mean, I always believed. And I always pray. And, but now, I'm active in [a local church], Celebrate Recovery, and I do a step study...What keeps me going there is when I was in the hospital, [people from church] came up to see me...People don't do that. They hardly know me, and it's like, wow (9). ...I went to an NA meeting last night...I'm all new to it...and I could kinda catch the vibe, and I actually really do want to go back to NA, because it makes me feel like I can do this. Cause look around at all the people surrounding me that are doing the same thing, whatever it be, from drugs or alcohol, or whatever. It's nice to know that people really do care (FG1).

Many took part in spiritual Native American practices within the community such as smudging and going to sweat. Those individuals felt worshipping at Christian churches was synonymous with their Native American ways of worshipping. As one participant described,

I go to church. I go to sweat. That's helped a lot...You send your prayers up, and when you smudge, you pray and everything. And you go to sweat, it's like you do four rounds, and it's like, hot stones, like hot, hot, hot. If you touch them, you're gonna get burned. You sing and you pray, and you're giving yourself to the Creator (4).

She described feeling clean and closer to God as a result of her practices.

Some women expressed barriers getting to church or spiritual places of worship due to lack of transportation or strenuous schedules at work, treatment, or other responsibilities. They

described getting rides as helpful to their spiritual health. One woman discussed wishing that spirituality and inspiration were built into treatment programs more.

Spirituality is important, and we don't get that. All of our treatments and stuff - there's not a lot of spirituality in it, and I wish there was. Cause that's huge... If you don't know how to get it yourself - here or in prison or something - you're not going to find it. You have to find it, anyway. You have to. But you know what? People need to suggest that. "Why aren't you in college? Let's get that FAFSA form going," and stuff like that. Case workers here are too: "That's not my job". They need... somebody to suggest things like that, and to bring that aura around. "There's this out there. Have you been to Disney Land? Rockefeller to go ice skating?" That's living (6).

### **Societal and Structural**

Societal and structural levels of the environment include societal, cultural, legislative, and policy elements within the women's environment, over which the women had little control or influence. The women described how confusion about health insurance policies and healthcare access affected their physical health. They felt failed by the mental healthcare system, to which they had poor access. They also discussed facing stigmatization on many levels.

**Physical health.** The women discussed how policies about health insurance affected their access to healthcare. In general, the women expressed confusion about health insurance. In particular, they were confused about Medicaid and Medicare eligibility and status, to which healthcare provisions they had access, and how to access them.

Well, not having insurance, not having the resources or the information: where to go, how to get it, where to get it. I think that's a big thing. Like when I gone here, they only sent me with so much medication. Then I went through severe withdrawals from it. I

couldn't pay for it. It was kind of expensive. And then I was jumping through hoops. I suppose I could've went to [receive care from the local homeless health facility], but nobody told me...education, pretty much, you know? (10).

**Mental health.** The women described structural and cultural barriers to mental healthcare. Although the provision of physical healthcare is discussed on the community level of environment, the provision of mental healthcare is discussed in detail here, within the societal and structural level of environment. The definition of the community environment, for the purposes of this paper, involves interactions on a regular basis and women's influence over decisions made within the environment. The women generally described experiencing neither of these. Instead, the women described experiencing barriers in three main categories. They felt primary care providers were unwilling or unable to treat them for their mental health problems, experienced excessive wait times for specialty mental healthcare, and felt a general lack of trust in the system.

Many women shared the opinion that their primary healthcare providers were unwilling or unable to help them with their mental health problems like depression, anxiety, ADHD, and other mental health problems:

She didn't want to listen to me...I kept telling her, I need help. I need help with my anxiety and my panic attacks. She wouldn't help me. ...She doesn't want to help me. It's like, I have to suffer through this, because I have a background. I'm not a pill seeker. My drug of choice is meth (5).

One woman described feeling no one would help her with her mental health problems because of her history of drug abuse.

I went to an appointment ... and they see [we're from the transitional facility]. They say, "Okay. This is this. You're an addict. You're just going to try and get this out of me, so I'm just not even going to try and acknowledge your concerns" (7).

Many women discussed that primary healthcare providers were unwilling or unable to treat their complex mental health problems such as ADHD in the presence of substance use disorders. In these cases, the women were referred to mental health specialists. However, the structure of the mental health system was a set-up for failure with wait times exceeding the time frame in which the women could receive help. "The waiting list for the mental health - it's ridiculous. I feel like by the time...I mean, we'll be put on the waiting list, but by the time it's time for us to go, like, it's already too late" (FG1). During one focus group of 11 women, three women chimed in about waiting two months, three months, and six months to be seen for their mental health problems. While waiting for their appointments, all three relapsed. One woman was referred to be seen by a mental health specialist while at the transitional facility. While waiting, she relapsed, was sent back to prison, was re-released into the transitional facility on parole, and was *still waiting* for her original appointment. She estimated she had been waiting "at least six months" (5). One woman wondered out loud if her entire course to prison could have been avoided if she could have received effective mental healthcare as a young adult. "...back home, when I was just trying to get some anxiety medication, I was getting the run-around. I think back then, if they would've helped me some, my life...wouldn't have ever gotten as bad as it was" (10).

One stated that one of her major goals at the beginning of treatment was to get medical help for her mental health problems. However, she found her referral appointment was so far in the future that she would complete her entire substance treatment course and leave the

transitional facility before the appointment came. She discussed how lack of timely and effective treatment kept her from reaching her goals on many levels:

They won't even give me anything for my ADHD. They tell me, "Oh, you need to go to a professional for this." And it's going to be a month or two before I get in. I have been tested, and I've done all the big exams and all this and that. And I have the paperwork that's ten pages long that says I'm bipolar, manic-depressive. I have ADHD. I have anxiety. I have PTSD. I have all of this stuff, and that I need something for it...I can't even hold a job without being able to concentrate! I want to go back to school. I can't do that without being able to concentrate. I can't even pay attention to my kids the way I need to if I cannot concentrate. You know? It's like, it's not just a little thing. It's a big thing. And I don't want to use. I really don't want to. And I'm not saying it's an excuse to use. I'm just saying that after trying so hard for so long, I'm not gonna tell people I'm gonna go use. I'm just going to end up doing it, because it's my only option. And I hate that. When you go to treatment, that's where you try to get your help and your stabilization. And they still don't stabilize you...And any place I try to get into, it's too long (7).

Two thirds of the women described having a hard time finding a counselor or mental healthcare provider they trusted.

Therapists...but I don't really open up to them. Cause if you don't understand it, then why should I try to explain myself, when all they're doing is looking at the clock, wondering when it's going to be over? If you're just going to sit there and get paid for it, then I'm not going to open up myself to you (3).

Two more women described not being honest with counselors. They feared that telling the truth about their traumatic histories or their true mental health state might negatively affect their sentences. “There's things I could maybe be more open about, but I'm not going to, because I figure that it's not in my best interest as far as getting out of here and getting to someplace else”

(6). One described feeling a “weird vibe” from a therapist that made her never go back:

A long time ago, there was a program. But this guy that I checked out, I didn't go back.

Because he just wanted me to repeat the incident over and over and over and over. So, it felt weird. He was weird. I thought he was weird. And so, I didn't ever go back to that

(9).

Two women described finally finding therapists they liked. Then they lost these therapists due to moving or needing more specialized care. They felt going through the work of finding a new one might not be worth the trouble. They knew that the relationships they built with counselors and case managers within the transitional facility would likely be severed after being released from the transitional facility. In fact, professionals within the transitional facility are, according to their policy, to have none but incidental contact with those released from the facility for up to one year after the women fulfill probation terms. The women hoped for better continuity of care, even though they knew this was not a usual occurrence:

She was one of the first counselors I was actually ever able to open up to, and I've been in counseling since I was little. So, I really liked her, and [she moved]. Now I'm seeing [a case manager] upstairs, and I'm slowly starting to like her. And now that I'm almost done, I asked her if I could possibly still see her after I leave. Because I'm not going to go out there to try and find someone new. And it's - it's not going to happen (12).

I remember getting back from treatment, going to go see my therapist that I seen before I relapsed. She's like, "I can't help you anymore." And she was the one person after 20 years trying to find a good therapist, cause I had a lot of therapy needs in my younger years. She was the one person that I felt I really clicked with. And she really helped me, and I was really good about seeing her...I felt like I gained something from it. And then I go into see her, and she tells me, "You use. You've done this. You've done that. Blah, blah, blah. The situation's different. And I can't help you anymore"...And that kind of really really hit me hard...It just...makes you feel like I'm not worth helping...Like I'm unable to be helped, or...made better...I kind of fell off the deep end after a lot of the outside factors gave up on me, in a way. They didn't want to help me. Cause they, you know, they couldn't do anything for me, they said. So, it's like, you know, what are my only options to do for myself (7)?

**Social health.** Societal and structural factors affected the women's prosocial opportunities. The women expressed difficulty finding ways to meet their most basic needs such as finding work with livable wages. Further, finding a safe, affordable place to live presented particular challenges.

**Livability.** The women were asked whether they could make it on their own financially. Nearly half stated they would not be able to financially make it on their own. "By myself, it would be hard...I would try to room with somebody else, and try to get my rent cheaper or something like that" (9). One woman's monthly child support bill was ~\$700 monthly, after which, her take home pay was ~\$800. Another's child support had accrued to \$21,000 owed since being incarcerated. "I just turn my checks in. I'm like, have it then. Child support takes the other half? Well, here, you can have the other half" (10).

Several expressed difficulties in getting jobs with a felony on their records. One woman discussed feeling frustrated that past mistakes still haunt her.

In all honestly, I've made these mistakes in the past, when you've got that felony on your record. And you don't think about it. You're a kid! And that affects you the rest of your whole life. And you struggle with yourself. It's tough” (FG1).

One woman further discussed how she feels disadvantaged every time she fills out an application that requires reporting about criminal history:

But it's embarrassing right away for me when I'm doing an application. I'm qualified for the job and so forth, but yeah, I gotta check that. And they don't ask me if I'm diabetic or you know, whatever it is. But they do ask about that...That's frustrating, because I don't want to feel any less than anybody else I'm going to work with. But right away, I feel like I have a check against me. I have to prove myself more than somebody else on the same level (6).

**Housing.** Obtaining safe, affordable housing is critical to successful reentry (Kanovsky, 2016), yet the women faced structural barriers to obtaining it. “Being a felon, you know, makes it harder, yes. Trying to get on housing being a felon does not work. They won't touch you. So, it's really hard” (12). One woman discussed that places accessible to felons may mean proximity to others with a similar past. “I actually looked into felon housing. And before you know it, like, I was living next to a drug dealer, and then, like a couple months after that, I was already using again” (FG1).

It's so hard. I've been looking for a place. You can't find a place. Cause my felonies...Finding someone to rent from - that is really hard. Once they see felony, they're like, “No, no.” They don't even ask what kind. It's just automatically, you're a bad



person, or you're not taken seriously, or you're not treated with respect or something. Like anywhere, it's like this (1).

**Spiritual health.** The women described a lack of acceptance from society on multiple levels. Some women described experiencing trouble with stigmatization at work, in the criminal justice system, and from the general community. Three described fellow employees assuming they would steal, or not being allowed to work the till because of their residence at the transitional facility. One woman described getting into a car accident, and the police arriving on the scene accused her of using drugs:

...judgmental. I mean, even for [the transitional facility], there's a stereotype for all of us, 'cause we come from parole or probation or whatever it is. Like, I was in a car accident last week, and the cop, the first thing that came out of his mouth was, "I'm assuming you're high" (FG1).

Half of the women expressed feeling judged by society, especially in regards to being an addict or being at the transitional facility. They felt that people viewed them as immoral because of their addiction problems. "They automatically judge or automatically think you're a bad person" (1). "Education needs to be out there for everybody across the board that doesn't understand that...It is a disease. It's incurable. People die from this kind of thing" (6).

I'm an addict. That makes me a bad person. That makes me a horrible mother. And that just means that I'm a liar and a thief, and everything I do is to hurt somebody else. Which isn't true. ... I feel like that keeps me, or holds me back from moving forward and stuff. I don't like that. I just wish people could see me for who I am and not for the bad habits that I have (7).

## The Lived Experience

### Using

The women interviewed reported the drug(s) to which they lost control, their drug(s) of choice (See Table 10). Drug use began as early as age 13 years. The women discussed experiencing a transition from controlled use to uncontrolled use, in addition to using substances in order to treat mental health problems.

Table 10

#### *Drug(s) of choice*

<b>Drug(s) of choice</b>	<b>Number of women (n=12)</b>
Methamphetamines	5
Methamphetamines and Marijuana	2
Opiates	2
“Everything”	1
Alcohol	1
Heroin	1

**Motivation and control.** The women noted a transition from an ability to control their drug use until, eventually, they became addicted and lost control. Eleven of 12 women described using in order to cope with the loss of a loved one, the loss of a job, or separation from a child or children. Four women used the words “fell off the deep end” or mentioned a “cliff” when describing the event that for them, marked the transition from controlled use to uncontrolled use. Nine women described feeling they lost everything because of uncontrolled use, as described by one woman when she was separated from her children:

When I have my kids, I have everything...It was just us all the time. I had them. I worked my ass off...and then I lost [my children], and I was like, ‘Ok, now I have no one.’ So, I didn’t want to feel. I stayed high, so I didn’t have to feel...I went really off the deep end there (8).

**Self-treating mental health problems.** Five women described using substances in order to cope with physical or mental health problems such as ADHD, anxiety, depression, PTSD, or physical pain:

...So when the gun went off, like, it was loud. So, like anything that is loud, bothers me. [When people say,] ‘That blows my mind.’ That bothers me...Anything and everything bothers me, because of my PTSD, and so I didn't really know how to deal with that. And I still don't. I really can't do anything, really. So, that's why I use, because I don't have to worry about any of that. When I use, my ADHD, I remember everything. I organize everything. When I use, my anxiety, I don't care what people think about me. My depression, I'm happy when I use. My PTSD, I don't have to feel. So, it takes care of all four things that's wrong with me. And it's just easier, I suppose. So, my mental health, it plays a big part (11).

Many women experienced using drugs as a means for escaping reality: “I didn’t feel nothing at all. That was why I used it. Like it didn’t allow me to feel ... I didn’t want to feel the pain. I didn’t want to feel. It would numb me” (10). “So I didn't have to live in the reality that I was living in. So I didn't have to feel alone, so I didn't have to feel depressed or... I didn't have a lot of anxiety” (3).

### **Prison Experience**

Five of the twelve women had been to prison. While most of the women described the prison experience as a contributor to poor health, two women admitted that prison probably saved their lives. One went to prison when she was deep in her lifestyle of using and selling: “If I wasn't locked up or anything, I probably, at some point in time, would've killed my- you know, just kept going and going and going” (10). The other went to prison after her mother died. “That

was probably a good thing that I went, because I was already getting high. That probably saved my life that I was locked away, cause I would've lost it" (5).

One described good access in prison to routine preventive health measures, but poor access for any other medical need:

Out there? No...you pretty much have to be on your death bed out there before they even do anything. So, you gotta like, pretty much, eat right, stay fit...They don't do shit for you out there, really. But...I had a pap done, and it came back abnormal. I didn't think it was serious, but then they were like, "No. You really need to take care of this." So, I followed through with it, because I was there and I was forced to (10).

One described her teeth getting worse while in prison. "I haven't been able to take care of my teeth like I want to. It's hard to come by dental floss. I mean, that's a big thing for me. My teeth have gotten really bad" (5). She continued, "Mentally, it's screwed me up a lot. I mean, it's taken my kids away from me...I don't blame the system, but this last time I went back...I needed treatment. ...has made me feel pretty crappy about myself" (5). Others shared opinions about needing treatment instead of prison. "I feel like they should a try different options before... I mean, when you send a bunch of addicts together... like, I got high in jail. And you meet new connections...They should be more treatment-oriented, and longer treatment" (8).

I mean there's a lot of people that need treatment, and there's a lot of people that need to be here [in the transitional facility], instead of the prison's over crowdedness. But I think people are getting better, because the amount of incarceration nowadays has skyrocketed, especially in North Dakota. And people know somebody, or themselves or... So many people have been incarcerated for things that, you know, it should have been a

treatment situation. And people get locked up. And what does that do? Now we don't have any money. We can't work. What is this costing the state (6)?

In regards to obtaining or continuing medications for mental health problems, the women described facing difficulty. "If you don't come in with it, it's hard to go with it. You know, because you gotta see the health care provider" (5).

When you're incarcerated, they take you off your medication – can just disappear – and make you just sit here for many, many, many days. They lost my medications. I was in New England, and on the 7th or 9th day I was there, they had to take me to the infirmary, because I was crying and stuff. None of my medication followed me. It was very severe (6).

She continued later, "And there's nobody to talk to when you have situations, especially. It's a traumatic time, and there's nobody to talk to. There's no mental health counselors or any therapy" (6).

Some questioned out loud about the fairness of drug laws. "I feel they're too harsh... My friend right now, he sat for 25 months on a paraphernalia charge. There's chomos that sit three months in jail." The co-investigator responded, "What's a chomo?" "Child molester."

Well, when I got caught, I was a confidential informant for selling five Xanax pills for \$20, and I got five years. Or you could be a child molester or murderer and get... a little more time, or even less. It depends. You know what I mean? I think it's very harsh.

They're very harsh on people. It's too... I don't know. I think they need to look at it like, "Do they need help? What's really going on?" (5).

One woman described experiencing major negative health consequences related to poor access to healthcare while in prison. She first experienced severe low back pain after a fall in jail.

“I slipped and fell in the jail and told them. And they said, ‘Well, you're up and walking, so you're fine’” (9). After a short jail stay, she was sent to prison, where her back pain grew worse. She was then transferred to two subsequent facilities over the next few months, where she was able to access some physical therapy.

My movement's better probably because of the stretches I was doing, but um, they didn't look any further. And that's why I kept putting papers in [requesting medical attention]. I need something else done on my back. It's hurting. This is ridiculous. It's hard to sit in class with a pillow and an ice pack, and I was doing ice packs all day long, because of the heat (9).

It was intended for her to complete substance use treatment while there. Her back pain, at that time, was “flaring really bad”. A nurse practitioner at the facility ordered magnetic resonance imaging (MRI) for her, and she was subsequently sent back to prison. She described wondering if she had been taken out of treatment and sent back to prison because of her need for costly diagnostic imaging. She noted that the transfer out of treatment may have lengthened her total time incarcerated. “Everyone who's been on this 18-month sentence, pretty much along with me, have already gone” (9).

Why did I get kicked out? I don't know. Then I started writing the DOC [Department of Corrections] saying, "I'm sitting here with no write-up, no reason why I'm back. This is interfering with my parole. I've already been denied parole because I didn't complete treatment. And why didn't I complete treatment?" I mean, if DOC was to look over my record...I have no write-ups...No write-ups whatsoever. I'm not a problem child. And they don't know what happened at [the facility from which she was sent back to prison].

They don't just send you back for nothing! Then where's my write-up? Write me up! At least let me know what I'm fighting! Right now, I have nothing (9).

When transferred to the transitional facility, staff members took note of the severity of her back pain, which at that point was debilitating. “When I was lying in bed, I couldn't even use my feet to scoop myself up. It would hurt so bad. I couldn't go to the bathroom by myself” (9). They made accommodations for her to be hospitalized. Shortly after her stay there, she was diagnosed with metastatic cancer and given a one-year prognosis. During the interview, she wondered whether more could have been done early on. She discussed her frustration with poor access to healthcare while in the system:

And they found that the thing in my back has a lot of activity. Obviously, it's moving, or it's hot or whatever. When I walk a little bit, you can feel my lower back. It's just hot on the outside, as touch, and it hurts and aches. And so whatever it is, it's growing. And so obviously, there were signs of it a few months ago that might've been looked at a little more seriously. And so, it wasn't. It was just constant pain there...Once I have gotten to you [healthcare providers], everything starts getting better. But it's the system here, that doesn't let us get to you...It's the DOC that doesn't let us get to you. And that's what's bad. One of the nurse practitioners, whoever she is, in the prison is really good, too. But her hands are tied when she says, “I need an MRI for this person.” Well, it takes like six months to get it. And since I'm going to be out the door in 30 days to another institution, let them worry about it (9).

In sum, the prison experienced offered stability for some women by way of extracting them from their dangerous cycles of using. Prison also provided access to some routine screening measures. However, access to health diagnosis and treatment was limited for acute or chronic

conditions. For one woman, the poor access could potentially have had a substantial impact on her prognosis, in addition to potentially impacting her course within the justice system.



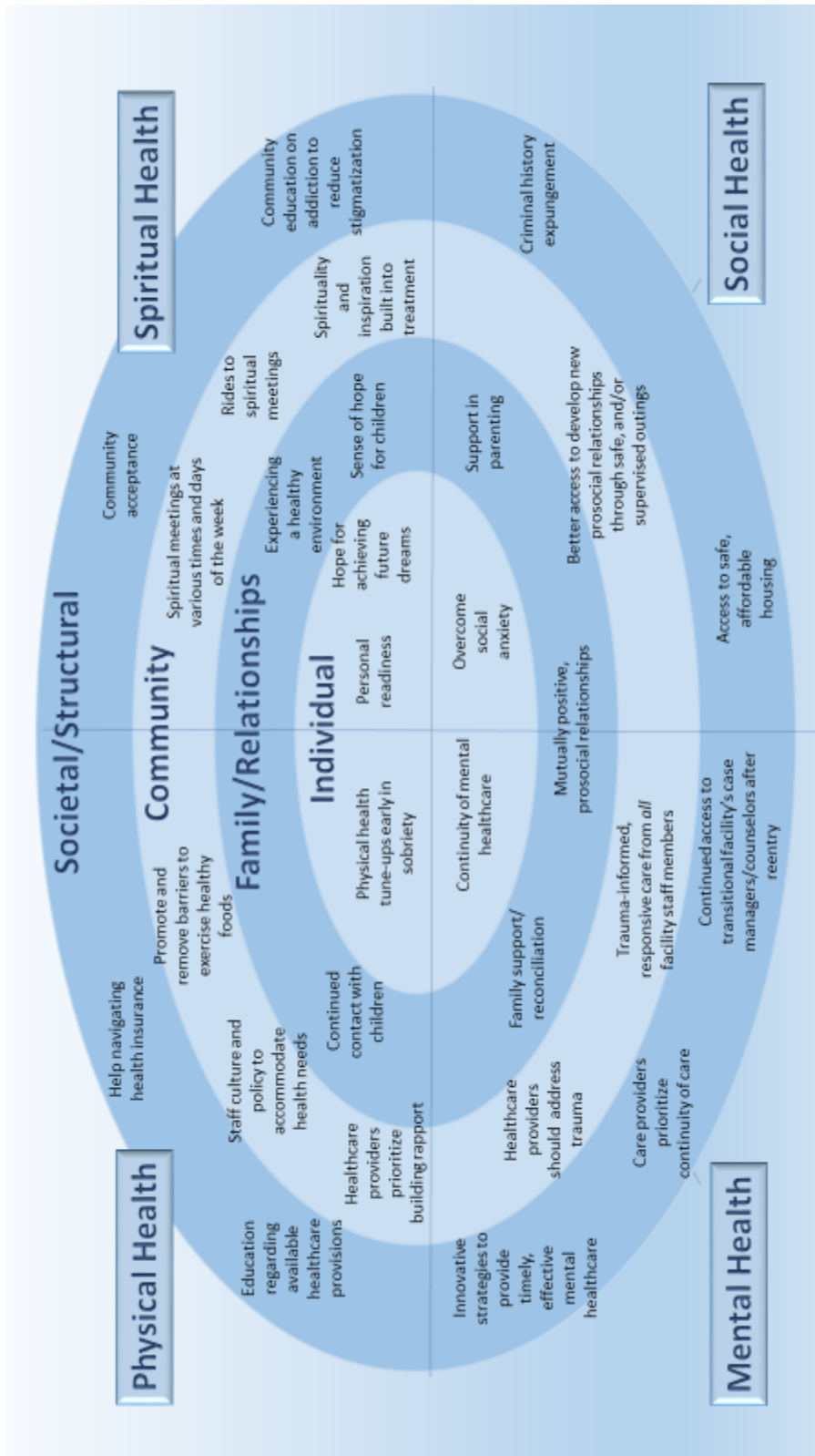


Figure 4. Health needs according to the social ecological model.

## CHAPTER 6. DISCUSSION AND RECOMMENDATIONS

### Recommendations for the Transitional Facility

Table 11

*Recommendations for the transitional facility*

<b>Primary Recommendation</b>	<b>Discussion and Examples</b>
Promote and remove barriers to exercise and healthy foods.	<ul style="list-style-type: none"><li>-Designate a place solely for exercise.</li><li>-Consider asking and/or surveying women to see what kinds of equipment they would be most likely to use (e.g. elliptical machine, free weights, adjustable exercise bike, video or even a live on site class).</li><li>-Incorporate safe, ergonomic exercise equipment use into facility orientation in order to promote use.</li><li>-Reconsider facility policy regarding restrictions' effect of participating in gym memberships and health.</li><li>-Consider nutrition budget's allowance for salad bar options at least several times weekly.</li></ul>
Develop and maintain a culture of trauma-informed care among <i>all</i> staff members.	<ul style="list-style-type: none"><li>-Provide education for trauma-informed care of staff.</li><li>-Staff members who repeatedly do not demonstrate this culture are hindering the mission and may need to be let go.</li><li>-Develop or revise policy for staff's response to residents' healthcare needs; err on the side of caution.</li><li>-Consider prioritizing continuity of mental health care through continued support of facility case managers and counselors after release.</li></ul>
Promote the development of healthy and prosocial connections within the community.	<ul style="list-style-type: none"><li>-Consider designating one staff member whose sole role is to accommodate transportation to healthcare-related needs such as visits, medication acquisition, or laboratory draws, and community outings such as trips to the local gym, library, or stores during high traffic times of the week and/or particularly cold months.</li></ul>

### **Exercise and Healthy Foods**

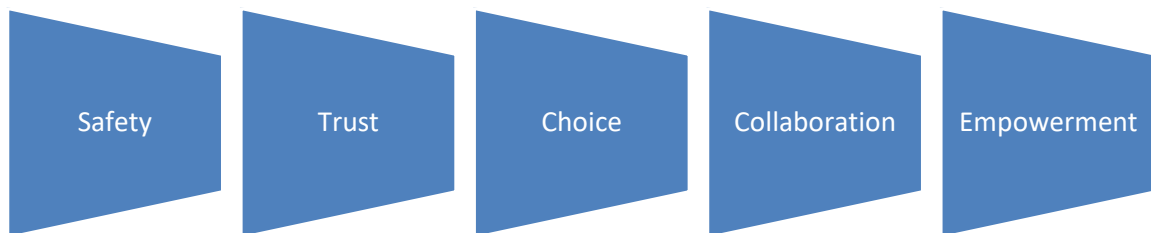
The physical health benefits of exercise, such as decreasing the risk for cardiovascular events, diabetes, and other diseases, are widely known, but exercise also promotes mental health.

Regular exercise has been shown to decrease depressive symptoms in ways comparable to

antidepressant therapy, and can decrease anxiety (Weir, 2011). Individuals who exercise regularly are also likely to experience memory, thinking, sleep, and mood improvements (Godman, 2014). Expanding the opportunity and access to exercise at the transitional facility may not only improve physical health, but may also help the women think more clearly during treatment programs, and respond more positively to the various stressors during reentry.

### **Trauma-informed Care Models**

Organizations who employ a trauma-informed care model have staff who recognize the long-term health effects of adverse childhood experiences and ongoing trauma. They also recognize when individuals display manifestations of trauma and implement their knowledge into all levels of interactions including organizational structure and policies, daily practices, and staff culture. The trauma-informed care transitional facility would be characterized by empowering women, and creating an environment where the women can be involved in making some decisions about their treatment plans. In addition, ensuring women feel physically and emotionally safe is a priority that guides policies, daily activities, and all staff interactions. One example of ensuring physical and emotional safety would be staff taking women's health complaints seriously, erring on the side of safety and caution in regards to staff facilitating access to a healthcare provisions or obtaining medications when needed (Menschner & Maul, 2016).



*Figure 5.* Trauma-informed practice principles. Adapted from Benedict, 2014.

Transitioning from trauma-informed care, even on an institutional level in a corrections setting was shown to decrease violent reactions by about 50%, suicide attempts by 60%, and

decreased incidents of self-injury at the Rhode Island Department of Corrections Women's Facilities. Disciplinary measures from a trauma-informed approach prioritize accountability, have firm and consistent boundaries, and enact reasonable, timely, and predictable disciplinary measures. These practices promote safety (Benedict, 2014).

Changing the culture of an organization to one of trauma-informed care may require changes on all levels including revising mission and vision statements, treatment plans, policies, budgets, and staffing changes. For example, staff that continually fail to demonstrate trauma-informed care principles may be causing re-traumatization and placing undue stress on the individual at a time of increased vulnerability, indirectly driving women back toward their prior unhealthy coping mechanisms and relationship patterns such as usurping authority or using substances. Instead, staff should be hired, not only based on experience and training, but also on personal qualities such as being empathic, non-judgmental, and a natural team player (Benedict, 2014). Many evidence-based resources are now available concerning making the shift toward being organizationally trauma-informed and can be consulted for more information (Menschner & Maul, 2016).

### **Promote Prosocial Relationships**

As the women transition from fully incarcerated to fully independent, supports must change from providing everything to supporting some independence with women obtaining their own personal provisions. During the early transition phases, providing transportation to locations that can help women develop prosocial relationships within the community and develop connections with community organizations can ease the dramatic change in independence after completing their stay at the transitional facility.

## Recommendations for Primary Care Facilities

Table 12

### *Recommendations for primary care facilities*

<b>Primary Recommendation</b>	<b>Discussion and Examples</b>
Address trauma within primary care.	<ul style="list-style-type: none"> <li>-Implement provider training on ACE’s relationship to health.</li> <li>-Incorporate trauma-informed care principles into the primary care setting.</li> <li>-Consider implementing ACE screening tool into primary care visits.</li> <li>-Prioritize developing rapport, and physical and emotional safety while following evidence-based practices.</li> <li>-Prioritize continuity of care throughout the reentry period and beyond.</li> </ul>
Develop innovative strategies to provide timely and effective mental healthcare.	<ul style="list-style-type: none"> <li>-Consider Telepsychiatry Collaborative Care Model and other evidence-based models that provide greater access to specialized mental healthcare than the current referral model.</li> <li>-Obtain further education and resources for collaboration for evidence-based diagnosis and treatment of the most common mental health problems encountered in the practice.</li> </ul>

### **Address Trauma within Primary Care**

**Trauma-informed care in primary care.** About adverse childhood events, Jeffrey Brenner notes, “It’s the best predictor we’ve found for healthcare spending, healthcare utilization, poorly controlled chronic illness, obesity, substance abuse, smoking, out of wedlock teen birth, probably homelessness and incarceration... That’s a pretty stunning correlation. We get obsessed with very small correlations in healthcare... Here’s a huge relationship that has good, solid scientific evidence for it, and we’re not doing anything about it” (Levins, 2015).

Becoming trauma-informed in the primary care setting involves the same principles as trauma-informed care in other settings, as discussed above. The American Academy of

Pediatricians (AAP) developed a guide for beginning to address trauma in primary care as a facility-wide approach. The four-step process of implementation is outlined with four questions beginning with, “Why are we looking at this issue?” Understanding the health implications and scientific basis for addressing trauma is a first step. Further, healthcare personnel can be reminded that patients often feel relieved just for being asked the question about whether they experienced trauma as children. This realization may put healthcare providers at ease regarding fears about causing harm. A small group within the practice that has buy-in in the beginning may pilot the implementation of screening and reveal their findings about feasibility with the rest of the group (AAP, 2014).

Once buy-in is achieved, and the facility has decided to move forward with addressing trauma, the next question to explore is, “What are we looking for?” This begins to address the topic of the target population for screening measures. Some ideas about target populations include parents of infants. The tool could be used to identify parents who may need more support in parenting skills, and education regarding fostering resilience factors for their children. Adults visiting for routine chronic disease appointments or medication review may also be considered as a target population for a one-time screening (AAP, 2014).

The third question is, “How do we find it?” This determines the logistics about asking about trauma. Examples included using a pre-visit questionnaire administered by nursing staff and addressed by the provider or provider interviews. Ideas about how to maintain privacy, how to avoid stigmatization, and how to maintain safety are also addressed in this stage (AAP, 2014).

The last question addressed is, perhaps, of most concern to the care provider, “What do we do once we have found it?” First, a list can be compiled of possible community resources when needs are identified. A focus group or other assessment tool can be used to discover the

patient's own desires and referral needs, which may further guide this step. Employing the principles of empowerment may also help guide this process. Providing information to patients about the likely connection of some of their health problems to their trauma may be enough to empower them to seek out the resources they feel they need most. The role of the provider may be to help the patient connect the dots, just as we do with other health problems. For example, healthcare providers educate patients with allergies about trigger avoidance to reduce symptoms. Connecting the dots for them about what lifestyle changes they can make can be an important first step in their own efforts to reduce their poor health experience and outcomes (AAP, 2014).

In the setting of patients with co-existing substance use disorders, it may be important to note that the healthcare provider can create an environment that is trauma-informed while maintaining firm boundaries regarding following evidence-based policies of prescribing, such as avoiding inappropriate use of stimulants, benzodiazepines, and opioids. Patients who have a history of drug abuse often feel judged on multiple levels, including from providers within the healthcare system. When patients perceive that a provider assumes they are drug-seeking, or develop the perception that the provider thinks they do not deserve to be treated appropriately because of their histories, they are less likely to feel welcomed by the healthcare community in the future. Instead, healthcare providers can prioritize building rapport and physical and emotional safety as a long-term approach to getting patients to come back again, thus building continuity of care (Salvalaggio, McKim, Tayler, & Wild, 2013).

One example of unintentionally compromising a foundation of physical and emotional safety is to begin the healthcare visit with questions regarding drug use, or the reason for incarceration, that may be perceived as accusatory. Although drug history is an important part of taking a full health history, the history-taking process can begin with principles of developing,

rather than compromising safety. For example, the visit can begin with interviewing about past medical history, surgical history, or current medications instead of illicit drug history (Salvalaggio, McKim, Tayler, & Wild, 2013).

**ACE screening.** Incorporating an ACE screening tool into an already busy office visit can seem daunting, but can help identify high-risk patients, connect patients with health-promoting and preventative interventions, and can, itself, be an intervention which reduces a patient's overall frequency of health facility utilization (AAP, 2014; Felitti & Anda, 2010; Glowa et al., 2016). Further, incorporating ACE concepts into primary care settings may be the best way to assess risk factors for the greatest number of people, as about 90% of the population visits a primary care provider (Prewitt, 2014). Studies regarding the decreased frequency of healthcare visits as a result of incorporating ACE principles into primary care, and feasibility of implementation are further discussed.

One medical institution developed a pre-visit questionnaire addressing adverse childhood experiences for patients to fill out at home. To any "yes" questions, the provider would respond, "I see that you have ... Tell me how that has affected you later in your life?" (p. 85). The facility found that *simply asking the question* within the healthcare visit produced a 35% reduction in doctor visits, an 11% reduction in emergency department visits, and a 3% reduction in hospitalizations when compared to the year previous to discussing past trauma during visits. This study's results were compared with an earlier approach where the traumatic experiences screening was performed, but instead of addressing the issue in the primary care provider's office, the patient was referred when warranted. See the results presented in a Table 13 below (Felitti & Anda, 2010).



Table 13

*Reduction in doctor’s visits by addressing ACE in different settings*

	<b>Percent reduction when addressed in primary care</b>	<b>Percent reduction when addressed by referral</b>
<b>Doctor Visits</b>	35%	11%

Providers may feel hesitant to incorporate one more screening tool into an already busy visit. Barriers can include poor provider acceptance, worries about changing an already established visit routine, and worries about increased visit length. Authors Glowa et al. (2016) explored the feasibility of incorporating an ACE screening tool into well and routine chronic health visits. In three rural primary care practices, seven providers implemented the ACE screening tool to an average of 21 patients each. Nurses who roomed patients gave the ACE questionnaire to patients, and providers reviewed the results during the visit. The clinicians overwhelmingly felt that incorporating the questionnaire did not disrupt the visit, that patients found the incorporation acceptable, and that providers gained new, helpful information about the patient. The patient’s treatment plan did not change for five out of six visits, and added five or less minutes to the visit (Glowa et al., 2016). Additionally, qualms about re-traumatization of patients when asked about previous trauma have been shown to be unwarranted in the 440,000 patients screened at Kaiser Permanente without any reported patient crises (Prewitt, 2014).

**Mental Healthcare in Primary Care**

Although needs were not prioritized by the women, codes related to needing timely and effective mental healthcare were more frequent than any other code. According to the Health Resources and Services Administration, only 44% of the need for mental healthcare providers is met in North Dakota. Twelve more psychiatrists are needed statewide to overcome designation of being a health professional shortage area (Kaiser Family Foundation, 2017).

The extreme mental health provider shortage calls for primary care providers to educate themselves and employ innovative strategies to develop a network of collaboration to provide the best care to the most patients. A team-based approach extends the care a psychiatrist is able to provide to more patients. Additionally, a team-based approach has the potential, over time, to help the primary care provider develop the skills to appropriately treat more and more complex patients with less frequent consultations (Olson, 2014).

Dr. John Fortney, a medical professor at the University of Washington Medical Center, discussed in an internet-broadcast presentation, that poor access to mental healthcare is a nationwide problem. Of all of those with mental health problems, only 40% receive care of any kind, 22% see a mental healthcare specialist, while only 12% ever see a psychiatrist. He presents models of care that employ telepsychiatry and multi-disciplinary collaboration in order to broaden the limited reach of psychiatrists (Fortney, 2015).

Telepsychiatry uses computer and internet technology to provide online consultations to care providers, patients, or others within the healthcare team at the point of care. The first patient-to-service link in the Telepsychiatry Collaborative Care Model is the healthcare provider who identifies the need for a patient to receive more specialized care than the provider feels comfortable offering within an office visit. The provider has several options to step-up mental healthcare including an immediate, online telepsychiatry provider-to-psychiatrist consult, or patient-to-psychiatrist consult in the primary care provider's office. Other options include connecting with a psychiatric/mental health nurse practitioner, pharmacists, or psychologists. A behavioral health nurse care manager may also be utilized, whose role is to maintain an ongoing teaching and monitoring relationship with the patient. In this model, the electronic health record is further used for providers from several specialties to communicate collaboratively and make

changes to the benefit of the specific patient. This type of care model resulted in better medication adherence, increased medication responses, and increased remission rates, when compared to the usual care model of referral only. This type of innovative model could be modified to meet the need for more timely and effective mental healthcare (Fortney, 2015).

The team approach to mental healthcare can look different for different settings, but has been found to improve clinical outcomes by 200%. Although implementing these models may be more expensive up front, they produce cost savings over time. In one study, after four years of implementation, the per patient savings was \$3,400 (Olson, 2014).

## Recommendations for Community Religious or Spiritual Organizations

Table 14

*Recommendations for community religious or spiritual organizations*

<b>Primary Recommendation</b>	<b>Discussion and Examples</b>
Expand access to meetings and interactions.	<ul style="list-style-type: none"> <li>-Collaborate with transitional facility to provide transportation to meetings.</li> <li>-Offer meetings during various times of the week, at various times of the day to accommodate varied work schedules.</li> </ul>
Combat stigmatization in the community: begin with church members.	<ul style="list-style-type: none"> <li>-Invite community stakeholders to speak to members and other members of the community about the reentering population, health needs, barriers to health, and the physiological effects of trauma and addiction as an effort to reduce stigmatization within the community, and to promote prosocial relationships as members seek out opportunities to promote change.</li> </ul>
Consider incorporating culturally competent Native American practices.	<ul style="list-style-type: none"> <li>-Pursue education regarding Native American spiritual practices, such as smudging and sweats, and consider whether offering such practices within the organization coincides with already existing beliefs, mission, and vision.</li> <li>-The co-investigator has only had exposure to these practices from the perspective of a few interview participants. Determining appropriateness of incorporation of these practices is solely at the discretion of the organization.</li> </ul>

## Recommendations for Societal and Structural Level of Environment

Table 15

*Recommendations for societal/structural level of environment*

<b>Primary Recommendation</b>	
Pursue legislating expungement.	-Especially in relationship to drug charges, in order to facilitate gainful employment and expand access to safe and affordable housing.
Develop and implement strategies to provide safe, affordable housing options to those with criminal records.	-Navigating and overcoming the barriers to the women’s access to safe and affordable housing, except for recommending pursuing expungement legislation, is beyond the scope of this project.
Implement state prison nursery program.	-Sharply reduced recidivism rates and cost-effectiveness are discussed at length within the literature review. Please see pages 11-13 for more details.

### **Expungement**

Currently, only three states do not offer any expungement of criminal offenses or limitations on public access to criminal records. Currently, North Dakota has no mode of clearing criminal records for adults except in rare circumstances. Specifically, a minor state felony, when associated with a sentence of one year or less, may be reduced to a misdemeanor, after the sentence and terms of probation have been completed. However, the records are not subsequently sealed or expunged. Similarly, for an individual pleading guilty for possession of one ounce or less of marijuana, the court can motion to seal the record if no other criminal offenses occur for two years. There also is one provision of pardon of punishment (but not guilt), which is granted by the state governor for two individuals per year, on average. The pardon is only granted rarely, when the offense prevents the granting of a licensure or certification that is required for employment, or other rare circumstances. In 2015, 50 applications were reviewed by the North Dakota Pardon Advisory Board, but only two pardons were granted (Love, 2015).

North Dakota does have a nondiscrimination provision of the law, which states that someone cannot be disqualified from being granted state-issued licenses or certificates, solely because of a criminal offense. However, the granting body has the right to deny employment or authority to practice if the individual is deemed not to have been rehabilitated, or if the offense directly inhibits the ability to serve in the position. The provision offers broad advice for deeming “sufficient rehabilitation”, including considering how much time has passed since conviction. The provision does specify that five years after release, an individual “shall be deemed prima facie evidence of sufficient rehabilitation,” or accepted as rehabilitated until proven otherwise (Love, 2015). However, according to the women, several employing bodies still have it within their policies not to allow individuals with felon records to be employed in certain positions. Some organizations have recently changed these laws in our area, but there is still a long way to go.

Other states like Indiana, have recently incorporated expanded expungement laws into legislation, with the purpose of restoring employment access and other rights to reentering individuals. In fact, all criminal offenses, except those involving serious violence, public corruption, or sexual offenses, are eligible for expungement after waiting one to ten years, based on the gravity of the offense. After an expungement order, misdemeanors and minor felonies are sealed and may not be accessed without a court order. There are limitations to this. For example, one can be granted some types of expungement only once. The recent passing of these laws in Indiana was received well by the public (Love, 2014).

## **Housing**

Interviewed women desiring to obtain access to safe, affordable housing with prior felony convictions faced considerable difficulty, yet it is critical to effective reentry. Further, minorities

are over-represented in the incarcerated population. As reentrants face poor access to socioeconomically advantaged neighborhoods, poor social determinants of health for minorities may be perpetuated (Kanovsky, 2016).

Assessing the contributing factors to this need and developing recommendations to address the need is beyond the scope of this project as it delves into the interpretation and enforcement of laws, such as the Fair Housing Act, and others, to which the co-investigator has no prior training nor exposure. However, the greater provision of expungement, as previously discussed, has the potential to drastically alleviate poor access to employment opportunities in addition to expanding access to safe and affordable housing. The co-investigator recommends that the community further investigates contributing factors to the housing needs experienced by the women.

A brief and necessarily simplistic discussion of the Fair Housing Act follows in order to demonstrate the complexity of the housing situation. The Fair Housing Act “prohibits discrimination in the sale, rental, or financing of dwellings...on the basis of race, color, religion, sex, disability, familial status, or national origin” (Kanovsky, 2016, p.1). Further, “a housing provider violates the Fair Housing Act when the provider’s policy or practice has an unjustified discriminatory effect, even when the provider had no intent to discriminate” (p. 2). Because of this, housing providers face possible litigation for policies that may unintentionally affect a certain race more than another race. For example, in a community where one race is disproportionately convicted of crimes more than another race, prohibiting housing to anyone with a criminal conviction may unintentionally discriminate against that race (Kanovsky, 2016).

Similarly, housing providers may face litigation if they make exceptions to their own policies. As an illustration, two women of different races both have felonies on their records and

apply separately to a landlord for an apartment. The landlord's typical policy is not to rent to felons. If the landlord makes an exception to that rule for one woman, and not to the other, the landlord could be prosecuted for discrimination (Kanovsky, 2016).

A consequence of the Fair Housing Act is that a housing provider may feel liable whether they decide to rent to felons or not. Meanwhile, housing providers who accept those with certain criminal records develop a reputation within the community for doing so, and consequently become inundated and burnt out with requests for accommodation (personal communication, H. Brandt, March 15, 2017). Additionally, those living in felon-friendly housing are surrounded by other felons who were also accepted, decreasing their chances to develop prosocial relationships with socioeconomically advantaged neighbors.

As demonstrated, the housing problem is a complex one, and many community stakeholders expressed difficulty in arriving at solutions to the problem (personal communication, H. Brandt & C. Schuler, March 15, 2017). For this reason, a multi-disciplinary, collaborative approach is recommended. The conversation should include experts in the law, legislators, those with experience in the barriers to housing for the population, and the women themselves. Perhaps this approach may be useful to develop innovative solutions to the housing problem.

### **Prison Nursery**

The complexity of the mother-child dyad was discussed in the literature review, and by the women. As discussed previously, half the women described unhealthy relationships with their mothers. In addition, the women demonstrated that their children were an innate and strong motivator to pursue healthy lifestyles, but limited resources hindered their success. Separation from children was devastating to women's health, and the best predictor of family health was continued, close contact with children. Further, incarcerated women often have children who



become incarcerated, as discussed in Chapter 2. Jean Miller's (1990) concepts regarding the health benefits of mutually positive relationships may be best enacted within the mother-child dyad. It follows that prison nurseries offer the parental and overall health support women need to break the cycle of trauma, addiction, and incarceration for the next generation. Cost-effectiveness was also discussed in Chapter 2.

### **Limitations**

Qualitative data, both in the collection and analysis process, are subject to various interpretations (Granaheim & Lundman, 2004). Although the process heavily involved a qualitative data expert from start to finish, a large majority of the data were collected and interpreted by one co-investigator new to qualitative data. For these reasons, researcher bias is inevitable. Additionally, due to the scope of the project, the convenience sample consisted of reentering women undergoing a substance treatment program. While data were cited regarding the high prevalence of substance use in the population of incarcerated women in North Dakota, the convenience sample may have overrepresented substance use problems in the population, to the possible exclusion of other incarceration experiences. Sample size was also small, and while generalizability is limited, it should be noted that the entire incarcerated population of women in North Dakota was only 208 (Bureau of Justice Statistics, 2014).

### **Interpretation of Results, Implications for Practice, and DNP Roles**

While the women shared their journeys one by one, I, the co-investigator had a journey of my own that I would like to share here in first-person. Upon learning of the increasing rate of women's incarceration in North Dakota, I was, honestly, a little disinterested. However, I moved forward in investigating the problem as a necessary step in completing a class project. The women's common story arc emerged from the literature and captured my attention. Severe

childhood and/or adult trauma resulted in addictions as coping mechanisms. Mental health problems further complicated their stories. Each factor was intertwined with justice-system involvement. My thoughts migrated from disinterestedly thinking incarcerated women may or may not deserve their sentences, to considering their bigger health picture, specifically trauma, addiction, and incarceration's effects on the brain and the body, and my role within it, as a healthcare provider in the doctor of nursing practice (DNP) role. I dove in deeper.

Suddenly, after the first focus group, these women were not words on a page, or statistics that made me gasp. They had faces and voices and laughs. They had tears. They trusted me with their secrets. They had something to teach me. Only twelve women were interviewed, but their stories repeatedly involved severe, enduring trauma, which some described in detail. Others only alluded. Addiction behaviors trumped their rational thinking and overpowered their deepest desires. The interviews were heavy, but transcribing, coding, and analyzing the data was heavier, leaving me in tears many times. Certainly, these women were strong pillars, survivors.

I noticed that I used to unknowingly be part of the group from whom they felt judged and stigmatized, from whom they felt they could never be helped, but I could never go back. That means, within my own practice, I will build rapport as a priority, not as an afterthought – even when I cannot give patients what they are asking for. It means I will do my best to learn to treat my population's most common health problems. It means I will invite others to experience a piece of my own transformation through education. It means I will be a leader in advocating for evidence-based change for the sake of my patient.

It also means I will step away sometimes. At the end of each focus group, I led the women through a short guided imagery exercise, "Picture yourself five or ten years in the future in a beautiful place, doing something beautiful. You look older, but you look healthy, alive, and

at peace. What is the most important thing you need to get there?” One woman shared where she was in her mind: “Waking up in the morning to my daughter just being there, seeing her smile and laugh and saying, ‘I love you! I’m hungry!’ And cooking her breakfast. And just laughing and being happy” (3). The next day, I woke up to my own child smiling, saying, “I’m hungry.” We made breakfast. I cherished the contrast of being a player in my own healthy home environment, building resilience factors within my own family, and in doing so, promoting my own sustainability in the practice. To help my patients be healthy, I have to be healthy myself.

In essence, we need each other. I need reentering women to help me see a bigger world and to be relevant as a healthcare professional, especially to a socioeconomically disadvantaged population. They need me to show them health, to be the voice that tells them it was not their fault, and that they are worth fighting for until they believe it. I still do not have the answers to all my questions, but I do believe that one answer is to prioritize principles of building rapport for the purpose of promoting continuity of care and to practice trauma-informed care principles within primary healthcare visits – first in my own practice, and then educating others to do the same.

### **Implications for Future Research**

Further research can be done, especially regarding evidence-based methods to improve physical, mental, social, and spiritual health outcomes for women. Specifically, research can be done on health outcomes, organizational feasibility, and economic implications of implementing recommendations. For example, one practice improvement project could focus solely on implementing and evaluating the effectiveness of implementing an ACE screening tool into primary care. The project may serve to inform facilities on implementation strategies regarding a topic that is relatively young in healthcare, but gaining ground nationally. Additionally, doing the

groundwork of research on evidence-based approaches to implementing a Telepsychiatry Collaborative Care Model or similar care model in primary care may also serve as a solution for our state's mental health provider shortage, and possibly provide guidance to the nation as these types of models spring up around the country.

### **Conclusion**

Contributing factors to health and the health needs of Fargo's reentering women were assessed using the women's own voices. The women discussed their individual physical health states and priorities, which included education and treatment of hepatitis C. Early sobriety was a time of discovering and seeking treatment for health problems about which using substances kept them unaware. Over 80% of the women reported mental health diagnoses, with anxiety, depression, ADHD, and PTSD being the most common. Some women discussed distrust, dislike, or being guarded in their personal approaches to relationships as a result of their childhood experiences. Some discussed spirituality as the most important factor to their health. They discussed experiencing a journey with God, with times of being close and times of running away. They also had hopes and dreams for the future, and discussed readiness as a factor of recovery.

The women collectively described or listed experiencing nine of ten categories of adverse childhood experiences, in addition to adult abuse. They bore the physical effects of abuse, largely inflicted by family and significant others. They discussed relationships with their mothers and children more than any other relationship. They viewed their children as part of their identity, and described "falling off the deep end" when separated from them. They described experiencing isolation and hesitance in reconnecting with loved ones, and experienced both a building of, and a loss of, spirituality and hope, because of their family and close relationships.

On the community level of environment, women discussed how living within the transitional facility and using community-based healthcare provisions affected their mental and physical health both negatively and positively. They discussed having priorities during healthcare visits that were different from their healthcare provider's priorities and problems accessing healthcare. Largely, they felt that healthcare providers addressing trauma was important to their health. Recommendations were made for community-based healthcare organizations to address trauma within primary care, including implementation of trauma-informed care principles and ACE screening tools.

Within the transitional facility, the women described wanting better access to indoor exercise opportunities and healthy food choices. Recommendations were made to promote and remove barriers to exercise and healthy foods. The women also generally experienced poor support from "downstairs staff" and felt supported by licensed staff. They wished for greater ability to interact with and develop new prosocial relationships within the community. Recommendations were made to implement trauma-informed care principles with all staff members, and to consider designating a staff member to provide transportation for health-related needs and for community outings.

The women faced barriers to health in the societal/structural level of environment including confusion about health insurance and health access. They faced barriers to timely and adequate mental health treatment in three main categories. They felt primary care providers were unwilling or unable to treat them for their mental health problems, experienced excessive wait times for specialty mental healthcare, and felt a general lack of trust in the system. Healthcare systems can respond by developing innovative strategies to collaboratively provide mental healthcare. Additionally, women felt they would not be able to make it on their own financially,

and had poor access to safe, affordable housing. They described experiencing stigmatization within the society on many levels. Policy-makers can combat some of these problems by pursuing legislation for expungement.

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## APPENDIX A. ADVERSE CHILDHOOD EXPERIENCES QUESTIONNAIRE

Adverse Childhood Experience (ACE) Questionnaire  
(National Council of Juvenile and Family Court Judges, n.d.)  
Finding your ACE Score

### While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...  
Swear at you, insult you, put you down, or humiliate you?  
**or**  
Act in a way that made you afraid that you might be physically hurt?  
Yes    No                      If yes enter 1 \_\_\_\_\_
2. Did a parent or other adult in the household **often** ...  
Push, grab, slap, or throw something at you?  
**or**  
**Ever** hit you so hard that you had marks or were injured?  
Yes    No                      If yes enter 1 \_\_\_\_\_
3. Did an adult or person at least 5 years older than you **ever**...  
Touch or fondle you or have you touch their body in a sexual way?  
**or**  
Try to or actually have oral, anal, or vaginal sex with you?  
Yes    No                      If yes enter 1 \_\_\_\_\_
4. Did you **often** feel that ...  
No one in your family loved you or thought you were important or special?  
**or**  
Your family didn't look out for each other, feel close to each other, or support each other?  
Yes    No                      If yes enter 1 \_\_\_\_\_
5. Did you **often** feel that ...  
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?  
**or**  
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  
Yes    No                      If yes enter 1 \_\_\_\_\_
6. Were your parents **ever** separated or divorced?  
Yes    No                      If yes enter 1 \_\_\_\_\_

7. Was your mother or stepmother:  
**Often** pushed, grabbed, slapped, or had something thrown at her?  
**or**  
**Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?  
**or**  
**Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?  
Yes No If yes enter 1 \_\_\_\_\_
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?  
Yes No If yes enter 1 \_\_\_\_\_
9. Was a household member depressed or mentally ill or did a household member attempt suicide?  
Yes No If yes enter 1 \_\_\_\_\_
10. Did a household member go to prison?  
Yes No If yes enter 1 \_\_\_\_\_
- Now add up your “Yes” answers: \_\_\_\_\_ This is your ACE Score**

## APPENDIX B. DEMOGRAPHIC QUESTIONNAIRE

What is your age? \_\_\_\_\_

What is your race/ethnicity? Circle all that apply.

American Indian or Alaska Native

Asian or Pacific Islander

Black or African American

Hispanic or Latino

White

Some other race or ethnicity \_\_\_\_\_

How long have you lived in the United States?

Your whole life

5 or more years

1-5 years

<1 year

What is the highest grade you've completed?

Less than 9<sup>th</sup> grade

9<sup>th</sup>

10<sup>th</sup>

11<sup>th</sup>

12<sup>th</sup>

Completed GED

Some college

College degree

How many times have you been to jail? \_\_\_\_\_

How many total months or years have you spent in jail? \_\_\_\_\_ months \_\_\_\_\_ years

How many times have you been in prison? \_\_\_\_\_

How many total months or years have you spent in prison? \_\_\_\_\_ months \_\_\_\_\_ years

When was the last time you were in jail or prison? Month \_\_\_\_\_ Year \_\_\_\_\_

If you are employed right now, how many hours are you working each week? \_\_\_\_\_

If you are employed right now, how much are you making each week? \_\_\_\_\_

OR

How much are you making each hour? \_\_\_\_\_

## APPENDIX C. FOCUS GROUP GUIDE

Begin by introducing self and purpose of focus group.

“I have spent time learning all I can about the health needs of women who have been involved in incarceration. The first step of this process was to research things written by researchers in the field. But I want to know more about this from you.

“The purpose of this group is to discover what your health needs are and what might be keeping you from better health. I am not talking just about your physical health needs like illnesses or the need for housing, but also what you need in order to be a healthier version of you. First, we’ll talk about broad, general health needs. Then we’ll discuss more specific needs. Let’s get started.”

### Opener

(purpose to encourage participants to speak early in the process [Krueger & Casey, 2000])

Tell me who you are, how long you’ve been here at Centre, and what you enjoy doing when you’re not here.

### Introductory Questions

What’s the first thing that comes to mind when I say, “What do you need in order to be a healthier version of you?”

What makes it harder for you (or women who share your experiences) to become healthier?

Cues after initial discussion: something inside yourself like being tired, or something outside yourself like poor access

### Key Questions

What is the most important thing you need to be a physically healthier person?

Cues after initial discussion: exercise, nutrition, access to doctors, medications, education about medical problems

What stops you (or women who share your experiences) from being physically healthier?

What is the most important thing you (or women who share your experiences) need to be healthier mentally or emotionally?

Cues after initial discussion: talking about past trauma with someone who accepts you, chemical dependency treatment, someone to talk to, help coping with daily life, access to mental health treatment

What stops you (or women who share your experiences) from being mentally healthier?

What is the most important thing you need in order to be healthier in your relationships?

Cues after initial discussion: friends/family; with supervisors/probation/parole officers; communities: work, church groups, other support groups; with the law or in society as a whole?

What stops you from having healthy relationships? Or What do you need in order to be healthier in these relationships?

Cues after initial discussion: friends/family; with supervisors/probation/parole officers; communities: work, church groups, other support groups; with the law or in society as a whole?

Any need to break ties with old friends/groups?

How does your spirituality affect your health?

What is the most important thing you need in order to be spiritually healthier?

What stops you from being spiritually healthier?

### Closing

I want you to imagine a version of you that is the healthiest version of your future self. Picture yourself five or ten years in the future, in a beautiful place, doing something beautiful. You notice that you look older, but you also look healthy, alive, and at peace. What is the most important thing you need right now in order to get there?

What is stopping you from getting there?

Considering everything that's been said so far, is there anything else you wish for me or other healthcare providers to know about how to help you become healthier?

### Additional Questions Time Permitting

What do you think about how history with trauma like abuse might affect someone's health?

Would you feel comfortable discussing things like history of traumatic events with your primary care provider?

If no, what makes you feel uncomfortable about it?

Are there things you think your primary care provider should know about you?

What are your thoughts about how incarceration has affected your health?

How have your relationships with others affected your health positively?

Family, friends, peers, service workers, other acquaintances

How have your relationships with others affected your health negatively?

Has anyone in your life helped you think you might be able to become healthier?

How did they help you?

What else do you want me to know about your health?

What else do you want me to know about what makes it harder for you to become healthier?

## APPENDIX D. SEMI-STRUCTURED INTERVIEW GUIDE

Introduce self. Remind participant about purpose of interview and terms of the consent. Ensure consent agreement prior to data collection

Tell me a little bit about yourself.

On a scale of 0-10, how healthy are you?

(0 being the worst health you have ever been in and 10 being the best health you have ever been in)

Physical health problems

Mental health problems

What's your history with drugs and alcohol?

Cue drug of choice

Are you on a lot of medications?

Provider Relationships

When is the last time you saw a healthcare provider?

Where did you go?

How did you get there?

How well do you feel that your problems were addressed?

If poorly, do you feel you can choose to see a different provider?

Were you told to follow up? Did you, or do you intend to do that?

Why or why not?

Do you typically see a healthcare provider regularly?

Like for annual checkups, pap smears, and other preventive health screenings?

If no, why not? What keeps you from doing that?

Has any healthcare provider ever asked you about a traumatic event or situation in your past?

If no, do you wish they would?

If yes, how did it make you feel or what did you think about that?

If yes, did they help you make a connection to any help you might've needed like counseling or seeing a therapist?

Do you feel any past traumatic events are important things for your healthcare provider to know about you? Does past trauma impact your health?

Let's talk about your family and the people you consider your family.

How does your family affect your health?

Do you feel supported by the people who are closest to you?

Are you able to give them the support they need from you?

Discuss mutually positive relationships – have you experienced any relationships like that in your past or present?

What is unhealthy for you in regards to your family?

What do you need in order to be healthier?

What keeps you from being healthier in your family?

Other prompts time permitting:

Children

Who is caring for them?  
Are they healthy?  
In a healthy place?  
What is your relationship like with them?  
How do your kids help you?  
How do you help your kids?

Significant other

Positive relationship?  
What about this relationship helps you? Or hurts you?

Parents

Close friends

What do you need in these relationships in order for them to be healthier?  
What about these relationships keep you from being healthy?

Think about your most recent job. Do you have a healthy work environment?

Healthy relationship with supervisors/other employees?  
Do you make enough money at your job to live?  
Wage? How many hours? Health insurance? Other benefits?  
What is healthy about your work environment?  
What is unhealthy about your work environment?  
How could your work environment be healthier?  
What keeps you from having a healthy work environment?

Who do you like to hang out with or spend most of your time with?

Any groups of people outside of your family?  
What groups?  
How does each group affect your health?  
What about these groups is healthy for you?  
What about these groups is unhealthy?  
What keeps you in this group?  
What keeps you from being part of a group that may be healthier for you?

Imagine a group of people that would join with you on your road to becoming healthier.

Who are these people?  
What do they look like? Where are they?  
Can this kind of group exist?  
What would need to happen for you to become part of a group like this?  
What kind of group would make you feel accepted?  
What kind of group can you see yourself being a part of?  
What keeps you from engaging in that kind of group?

Are there any laws or policies that keep you from becoming healthy?



As you know, I will be a healthcare provider. What should healthcare providers like me know about caring for you or women like you?

## APPENDIX E. NDSU IRB APPROVAL



July 25, 2016

Dr. Molly Secor-Turner  
Department of Nursing/Public Health

IRB Approval of Protocol #PH17004, "Assessing the Health Needs of Women Reentering the Community After Incarceration"

Co-investigator(s) and research team: Katie Banley

Approval period: 6/25/2016 to 6/24/2017 Continuing Review Report Due: 5/1/2017

Research site(s): Centre, Inc. Funding agency: n/a

Review Type: Full Board, meeting date – 7/15/2016

Risk Level: No more than minimal risk

IRB approval is based on original submission, with revised: protocol materials (received 7/25/2016).

Additional approval is required:

- o prior to implementation of any proposed changes to the protocol (Protocol Amendment Request Form).
- o for continuation of the project beyond the approval period (Continuing Review/Completion Report Form). A reminder is typically sent two months prior to the expiration date; timely submission of the report is your responsibility. To avoid a lapse in approval, suspension of recruitment, and/or data collection, a report must be received, and the protocol reviewed and approved prior to the expiration date.

A report is required for:

- o any research-related injuries, adverse events, or other unanticipated problems involving risks to participants or others within 72 hours of known occurrence (Report of Unanticipated Problem or Serious Adverse Event Form).
- o any significant new findings that may affect risks to participants.
- o closure of the project (Continuing Review/Completion Report Form).

Research records are subject to random or directed audits at any time to verify compliance with IRB regulations and NDSU policies.

Thank you for cooperating with NDSU IRB procedures, and best wishes for a successful study.

Sincerely,

A handwritten signature in black ink that reads "Kristy Shirley".

Digitally signed by Kristy Shirley  
DN: cn=Kristy Shirley, o=NDSU,  
ou=Institutional Review Board,  
email=kristy.shirley@ndsu.edu, c=US  
Date: 2016.07.25 15:38:29 -0500

Kristy Shirley, CIP  
Research Compliance Administrator

For more information regarding IRB Office submissions and guidelines, please consult [www.ndsu.edu/irb](http://www.ndsu.edu/irb). This Institution has an approved FederalWide Assurance with the Department of Health and Human Services: FWA00002439.

### INSTITUTIONAL REVIEW BOARD

NDSU Dept 4000 | PO Box 6050 | Fargo ND 58108-6050 | 701.231.8995 | Fax 701.231.8098 | [ndsu.edu/irb](http://ndsu.edu/irb)

Shipping address: Research 1, 1735 NDSU Research Park Drive, Fargo ND 58102

NDSU is an EO/AA university.

## **APPENDIX F. EXECUTIVE SUMMARY FOR THE TRANSITIONAL FACILITY**

### **Project Summary**

This dissertation work sought to assess the health needs of women reentering the Fargo community after incarceration, using a client-based approach. The assessment sought to capture the needs of the women from the perspective of the women themselves. Health needs were assessed using focus groups (n=19) and semi-structured interviews (n=12) of a group of women residing within a community-based transitional facility which focused on comprehensively assisting women in the immediate reentry period. Evidence-based recommendations were developed based on needs identified.

### **Background**

A local transitional residential facility in which women reside during incarceration, probation, parole, or for substance use treatment or other programming, expressed interest in improving their policies and practices to better serve reentering women. One Doctor of Nursing Practice (DNP) student from North Dakota State University partnered with the transitional facility in order to carry out the needs assessment and develop recommendations for the facility, and for the greater community, to meet needs as identified. Abbreviated findings and recommendations specifically applicable to the transitional facility are discussed here. The greater work can be provided upon request for more details.

### **Process**

Questionnaires collected demographic data for all participants. Two focus groups, involving a total of 19 women who were part of a substance treatment group, were used to introduce the co-investigator to the women, develop rapport, collect data about the health needs as expressed in a group setting, and to recruit women for interviews. Twelve women were

subsequently interviewed. The focus groups and interviews were audio recorded, transcribed, coded, analyzed, and organized into themes.

## **Findings**

### **Physical Health**

The women noted and appreciated the transitional facility's proximity to a walking path and rentable bicycles, but most desired more opportunities for exercising, especially via indoor opportunities within the facility. In fact, half of the women said the most important thing they needed for better physical health was to exercise. Some wished for an on-site elliptical machine and weights, or an outdoor handball or basketball court. The women also described that being placed on restrictions prevented them from leaving the building to go to the gym and wished outings to the gym could either be incorporated into programming, or participation in gym memberships could be allowed within the same privilege level as Narcotics/Alcoholics Anonymous or Celebrate Recovery meetings.

The foods provided at the transitional facility were described as unhealthy and high in carbohydrates. Some expressed desiring more provision of fresh vegetables and fruits. However, women who had experienced prison noted that the food was far superior to prison food.

One third of the interviewees had hepatitis C. Most of these desired more information about their disease. They wanted to know more, especially, about transmission, treatment eligibility and options, and the health implications of the disease.

### **Mental Health**

The women described how the environment within the transitional facility affected their mental health both negatively and positively. They discussed generally feeling unsupported by the staff they encountered most regularly, whom they called "downstairs staff". They also noted

many staff members offered support that bolstered their sense of self-efficacy and wellbeing, especially those they called “upstairs staff”.

In general, the women described feeling that “nit-picky” rules and their consequences, namely being put on status that prevents them from going into the community or having other privileges taken away, were sometimes enforced in ways that made them feel disrespected or demeaned. They described that even one staff member treating them with a disrespectful attitude could make life tasks more difficult. One noted feeling an “us and them complex” from downstairs staff. Another woman described feeling that downstairs staff lacked understanding and belief in the women’s ability to be successful. Another noted the staff’s expectation that she would test positive on a urine drug screen affected her negatively.

While many described feeling frustrated by the treatment of one or two staff members, the majority felt a few individual “downstairs” staff members, and the licensed “upstairs” staff, in general, demonstrated professionalism, genuine care, and enabled them to become healthier. Many named specific case managers or other licensed staff providing counseling, help with getting jobs, access to healthcare, or help navigating the criminal justice system. One even noted about a supportive staff member, “She knows that I’m never going to fail a [drug test]. I’m not about that. You know? I got my head on straight. This place saved my life”.

The poor access within the community to timely, effective mental healthcare, was sometimes off-set by the provision of counselors and case managers within the transitional facility. Some noted wishing they could continue seeing their counselors or case managers, with whom they were developing a sense of trust and rapport. They dreaded thinking about trying to start over in re-developing that kind of therapeutic relationship out in the community after release.

## **Social Health**

The women described viewing the opportunity to work as a privilege that built their self-efficacy and helped them make prosocial connections with others in the community. They expressed frustration to having limited access to the community for purposes such as social interaction. They desired more frequent access to go shopping for basic supplies, or being taken on outings in the community, such as to the library or to the movies.

## **Spiritual Health**

Many women found a sense of community, belonging, and self-efficacy at local Narcotics/Alcoholics Anonymous meetings, churches, and participating in smudges or sweat. Some even described spirituality to be the most important factor in their health. Some women expressed barriers getting to church or spiritual places of worship due to lack of transportation or strenuous schedules at work, treatment, or other responsibilities. They described getting rides as helpful to their spiritual health. One woman discussed wishing that spirituality and inspiration were built into treatment programs more.

## Recommendations

Table F1

*Recommendations for further action*

<b>Primary Recommendation</b>	<b>Discussion and Examples</b>
Promote and remove barriers to exercise and healthy foods.	<ul style="list-style-type: none"> <li>-Designate a place solely for exercise.</li> <li>-Consider asking and/or surveying women to see what kinds of equipment they would be most likely to use (e.g. elliptical machine, free weights, adjustable exercise bike, video or even a live on site class).</li> <li>-Incorporate safe, ergonomic exercise equipment use into facility orientation in order to promote use.</li> <li>-Reconsider facility policy regarding restrictions' effect of participating in gym memberships and health.</li> <li>-Consider nutrition budget's allowance for salad bar options at least several times weekly.</li> </ul>
Provide basic information about hepatitis C.	<ul style="list-style-type: none"> <li>-Gather and display patient-centered information about hepatitis C, including transmission, treatment, and health implications</li> </ul>
Develop and maintain a culture of trauma-informed care among <i>all</i> staff members.	<ul style="list-style-type: none"> <li>-Provide staff education to promote trauma-informed care principles.</li> <li>-Staff members who repeatedly do not demonstrate this culture are hindering the mission and may need to be let go.</li> <li>-Develop or revise policy for staff's response to residents' healthcare needs; err on the side of caution.</li> <li>-Consider prioritizing continuity of mental health care through continued support of facility case managers and counselors after release.</li> </ul>
Promote the development of healthy and prosocial connections within the community.	<ul style="list-style-type: none"> <li>-Consider designating one staff member whose sole role is to accommodate transportation to healthcare-related need such as visits, medication acquisition, or laboratory draws, and community outings such as trips to the local gym, library, or stores during high traffic times of the week and/or particularly cold months.</li> </ul>

### Conclusion

The transitional facility plays a pivotal role in coming alongside women to help them meet their needs during the reentry period. Health needs were assessed from the perspective of

the women themselves, and recommendations were based on their responses. Because of this, some recommendations may not be feasible, for example, due to financial or structural limitations. However, the health needs assessment offers insight for improving programming from a client-centered approach. For more detailed information on findings from the health assessment, the evidence-basis for recommendations and implementation strategies, please see the entire dissertation work.