HEALTH AND EVIDENCE-INFORMED PROGRAMMING

WHO WE ARE

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LISA JAMES

STEPHEN INRIG

Women in Transition Re-entry Project Inc.

Mount Saint Mary's University
LOS ANGELES

WHO WE ARE – LISA JAMES

- **EXECUTIVE DIRECTOR • WOMEN IN TRANSITION REENTRY PROJECT**
  - **2009 – PRESENT**

- **REENTRY/SOBRIETY CONSULTANT, ORGANIZER, PROGRAM MANAGER**
  - **2008 – PRESENT**

WHO WE ARE – STEPHEN INRIG

- PhD, Duke University

- MSCS, University of Texas

- Director interdisciplinary healthcare research at Mount Saint Mary's University

- Leads the Healthy Reentry Working Group at Mount Saint Mary's University

- Has volunteered with and studied reentry programs for over a decade.

WHERE WE ARE GOING TODAY

THE EVIDENCE

METHODS

- This presentation reports the preliminary findings of the Mount Saint Mary's Working Group's work with Women in Transition Reentry Project on the health needs of formerly incarcerated women in Southern California.

- Preliminary overview of the mixed-methods research the Working Group and WIT are presently conducting with community service workers and formerly incarcerated women who have recently transitioned, or who are presently transitioning, from incarceration to civilian life.

- The ongoing qualitative research methods include documentary analysis, individual interviews, and focus groups among care providers, present clients and former clients of reentry organizations in Los Angeles County.

SETTING

- The Mount Saint Mary's Working Group is conducting all study activities with homeless and reentry service providers, along with associated health providers, in Southern California (San Luis Obispo, Los Angeles, Orange, and Ventura Counties).

- In this paper, we focus on qualitative evaluation of care provided by key reentry organizations meeting the reentry needs of formerly incarcerated women.*

- The preliminary findings explored in this paper are drawing from a convenience sample of staff and voluntary participants of our participating organizations (that is, a sample of people at those institutions willing to talk with us), as well as the extant literature on the health needs of formerly incarcerated women reentering civil society.

- Sinding C. Using institutional ethnography to understand the production of health care disparities. Qualitative Health Research. 2010;20(12):1656-1663

DATA COLLECTION

- Study involves various mixed methods in its overarching analysis:

  1. document analysis of policies, protocols, training materials, and deidentified client communications with service providers;

  2. semi-structured interviews with organizational leaders, care team members and clients (present and past) at reentry organizations, and

  3. focus group interviews with organizational leaders, care team members and clients (present and past) at reentry organizations.*

- Triangulating qualitative methods in this way strengthens data quality by revealing greater complexity and understanding than could be achieved by one method alone.*

- Mixed-method triangulation is particularly useful for understanding sequential dimensions of effective teamwork in the complex environment of delivering primary care.*

- Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. Health Services Research. 2007;42(4):1758-1772 endnotes MARCH 2018 8
- Simons L, Lathlean J, Squire C. Shifting the focus: sequential methods of analysis with qualitative data. Qualitative Health Research. 2008;18(1):120-132; Farmer T, Robinson K, Elliott SJ, Eyles J. Developing and implementing a triangulation protocol for qualitative health research. Qualitative Health Research. 2006;16(3):377-394; Thurmond VA. The point of triangulation. Journal of Nursing Scholarship. 2001;33(3):253-258
- Brown JB, Ryan BL, Thorpe C, Markle EK, Hutchison B, Glazier RH. Measuring Teamwork in Primary Care: Triangulation of Qualitative and Quantitative Data. Families, systems & health: the journal of collaborative family healthcare. 2015.

SURVEY AND INTERVIEW DEVELOPMENT

- With respect to document analysis, the group is compiling and analyzing numerous materials that describe policies and procedures affecting the reentry process, which provides an evidence base for best-practice interventions, and documents from local organizations relevant to or descriptive of the health issues and reentry experiences of female releasees.

- Where possible, we are digitally recording or photocopying documents and transforming them into text using Optical Character Recognition software (or recreated through transcribed notes) and then analyzing them along with other qualitative data.*

- We used some of the analysis from the initial materials to develop the interview and focus group guides for organizational leaders, care team members, health providers, and formerly incarcerated clients.

- Based on preliminary document analysis, we are conducting semi-structured interviews with care team members and focus groups with care team members and clients at several reentry support organizations that address the needs of women (that is, we combine pre-determined sets of qualitative and quantitative questions with the freedom to ask open-ended questions relevant to the topic or discussion).

- Our interview and focus group questions are probing staff and clients' understanding of the reentry experience and processes, and the health challenges clients experience throughout, as well as the care drop-offs, delays in care, collateral consequences, and multi-level factors that may account for recidivism risks. Interviews and focus groups last 45-60 minutes, over one or two sessions, and we audio-record and transcribe them. Participants receive a $15 honorarium.

- Meyen M. Document Analysis. International Encyclopedia of Communication. Blackwell Publishing; 2008.

DATA ANALYSIS

- We are collating and conducting statistical analysis on quantitative analysis using SAS.*

- We are collating and conducting thematic analysis on qualitative data using NVivo 11.0 (QSR International, Melbourne AUS). Through iterative coding and interpretation, the project team is using NVivo software to code actual quotes, expressions, and concepts against participant characteristics, organization documents and location codes to identify themes and relationships.*

- The team is then analyzing the codes and themes to develop theories and an evidence base for the health-related issues women releasees experience.

- SAS Institute Inc., SAS Campus Drive, Cary, North Carolina 27513, USA
- Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. International Journal of Qualitative Methods. 2006;5:1-11; Mays N, Pope C. Rigour and qualitative research. British Medical Journal. 1995;311(6997):109-112.
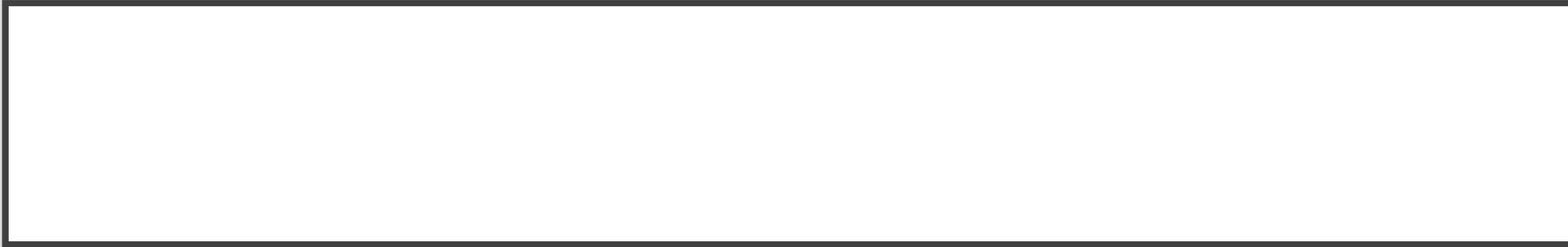
FINDINGS

MENTAL AND PHYSICAL HEALTH NEEDS ARE SUBSTANTIVE AND OFTEN UNADDRESSED

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- Female releasees have a number of mental and physical health problems during the reentry process. Some of these are long-standing and some of them developed during jail/prison, but all of them are difficult to manage upon release.

- Women often forego care owing to
  - Lack of insurance
    - Do not know eligibility for state programs
  - Cost of care,
  - Lack transportation, or
  - Lack a regular source of care.

- Immediate health needs include:
  - Asthma,
  - Depression,
  - Dental care,
  - Heart disease,
  - Mental health,
  - Stress/insomnia,
  - Women's health, and
  - Diabetes management.

- Our preliminary findings seem to be consistent with the limited literature exploring health needs of returning female prisoners.

  - One study found that women report different and more health needs (mental and physical) than men.*

  - Another study found that 95% of women reported at least one physical symptom and an average of three symptoms, post-release.*

  - Indeed, the presence of a physical illness among female releasees makes them:

    - More likely than male releasees to use illicit substances (39% vs. 28%),

    - More likely to engage in criminal behavior (53% vs. 38%), and

    - More likely to be re-incarcerated within one year (23% vs. 17%).*

- Mallik-Kane K, Visher C. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Washington DC: Urban Institute; 2008.
- Mignon S, "Health issues of incarcerated women in the United States." Cien Saude Colet. 2016 Jun;21(7):2051-60; Young D. Health status and service use among incarcerated women. Family and Community Health 1998; 21(3):16-31.
- Mallik-Kane K, Visher C. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Washington DC: Urban Institute; 2008.

TAKEAWAY

- The fact that female releasees have different health-related reentry experiences than male releasees suggests that organizations addressing female reentry may need to provide greater attention to health concerns than a similar service provider more accustomed to serving men.

- For those services providing care to female reentry populations, designing creative ways to provide mobile or accessible primary care and service navigation will be beneficial.

LOGISTIC BARRIERS TO STABILITY AND CARE

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- In the weeks and months post-release, remale releasees struggle with obtaining stability in
  - housing,
  - training,
  - employment and
  - transportation,
- This limits access to care and insurance, and heightening stress and vulnerabilities that could lead to negative health outcomes.
- In California, the safety net is more robust than in other states, so local resources made health insurance more available to female releasees than in some other states, but female releasees nonetheless experienced reduced access to care, particularly mental health providers.
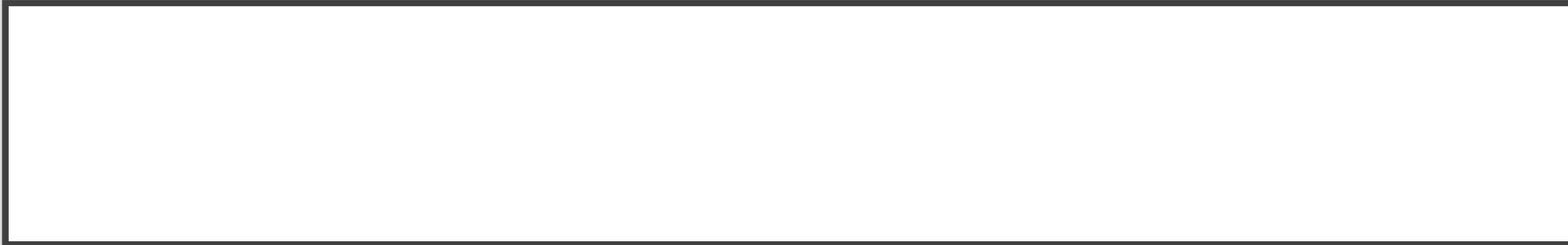
- The literature on access to care, particularly insurance, is mixed with respect to post-incarceration females.

- One study of the post-release population in los Angeles county did not find statistically significant differences in insurance levels when compared to those without a history of incarceration, but the sample is small and the study may not have had enough participants to fully test this question, and California has established a series of programs to address the otherwise uninsured population.*

- In a multi-state study comparing postincarceration insurance rates, women with a history of incarceration reported high rates of being uninsured in their first year post-release.*

- This latter study may also be affected by selection bias, as it reports findings from Texas, the state with the highest uninsured rate in the country. Additionally, the changes brought by the Affordable care Act may have changed these trends, though even here, recent policy alterations by the trump Administration may reduce the access female releasees have to health insurance.*

- Regardless, most studies of post-incarcerated women report that female releasees face barriers to medical and dental care regardless of their insurance status, when compared to women without a history of incarceration, and cost frequently is a barrier to timely care.*

- Mignon S, "Health issues of incarcerated women in the United States." Cien Saude Colet. 2016 Jun; 21(7):2051-60; Young D. Health status and service use among incarcerated women. Family and Comunity Health 1998; 21(3):16-31.
- Mallik-Kane K, Visher C. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Washington DC: Urban Institute; 2008.
- On the positive impact on ex-offender health under the Affordable Care Act, see: Juliette Forstenzer Espinosa, and Marsha Regenstein, "How the Affordable Care Act Affects Inmates," Public Health Rep. 2014 Jul-Aug; 129(4): 369–373. On the increasingly detrimental impact on releasees health of Trump Administration ACA rollbacks, see Adam Wisnieski, "Medicaid, ACA Uncertainty Threaten Success Of Ex-Offenders' Health Care Programs," Hartford Courant, April 21, 2017. Accessed at courant.com/news/connecticut/hc-medicaidcards-prisoners-20170421-story.html
- Colbert AM, Sekula LK, Zoucha R, Cohen SM, "Health Care Needs of Women Immediately Post-Incarceration: A Mixed Methods Study," Public Health Nursing, 2013, 30(5):409-419; Kulkami SP, Baldwin S, Lightsone AS, Gelberg L, Diamant AL. "Is Incarceration a Contributor to Health Disparities? Access to Care of Formerly Incarcerated Adults," J Community Health, 2010 Jun, 35(3):268-274.

TAKEAWAY

- Reentry programs must work to improve access to care for female releasees.

- Reentry programs that couple health access with housing and employment stabilization services may reduce recidivism and improve health outcomes.

TRANSITION IS A TIME FULL DEPRESSION, STRESS AND MENTAL ILLNESS
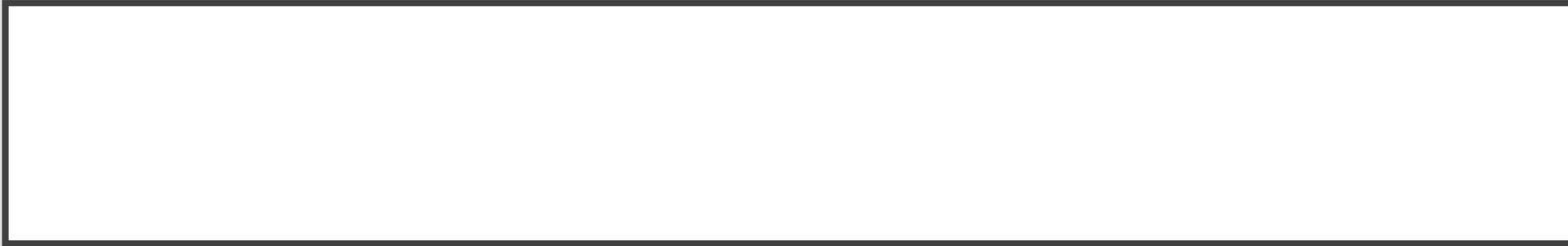
- Many female releasees struggle with stress and depression during their transition back to civil society.

- These experiences are not new, as prison itself is a very stressful place and depression and self-stigma are not uncommon.

- Our preliminary work suggests the experience of stress and depression are different for women then men, however, owing to the different and new stresses faced by women trying to navigate their lives after incarceration.

- For women with a longer history of incarceration and reincarceration, and those with past histories of abuse and addiction, these stressors and pressures feel even greater.
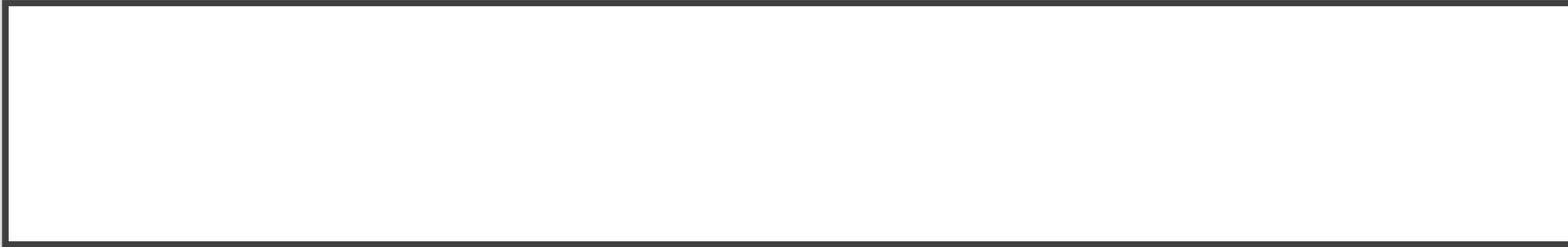
Our preliminary data resonates with other research on post-incarcerated women.

- Mental illness may affect (or become manifest) post-incarcerated women more
  - Studies indicate that female releasees are more likely to report mental illness after release than while incarcerated (45.1% vs. 34.9%),
- Formerly Incarcerated women report higher rates than man of
  - depression (56.4% vs. 29.7%),
  - post-traumatic stress (70.8% vs. 40.6%) and
  - undiagnosed mental illness (25.7% vs. 22.1%). 32

- Mallik-Kane K, Visher C. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Washington DC: Urban Institute; 2008.

TAKEAWAY

- Comprehensive mental health services must therefore be a key part of the reentry process for women to be successful in civilian life.

ADDICTION AND SUBSTANCE USE IS A DIFFICULT AND SUSTAINED PROBLEM
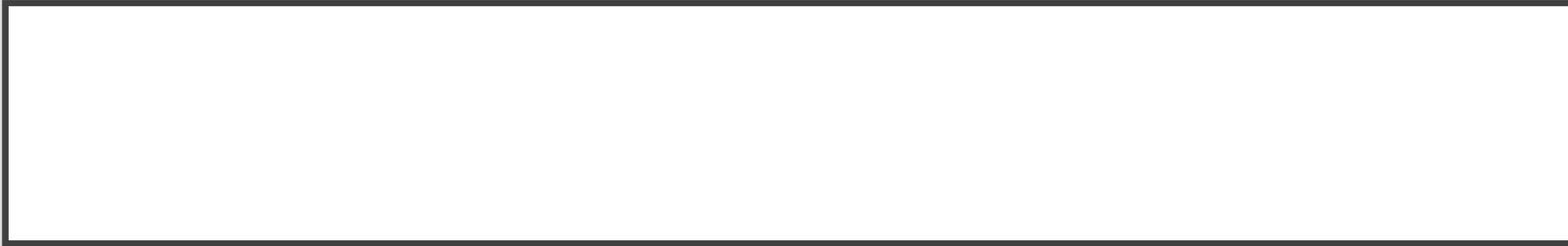
- Our research suggests that substance abuse is a difficult challenge for female releasees.

- The reentry process does provide some women with motivation to remain clean — either for purposes of parole, conditions of housing eligibility or in an effort to avoid returning to jail — but this is not true for all women.

- Access to addiction services can be limited.
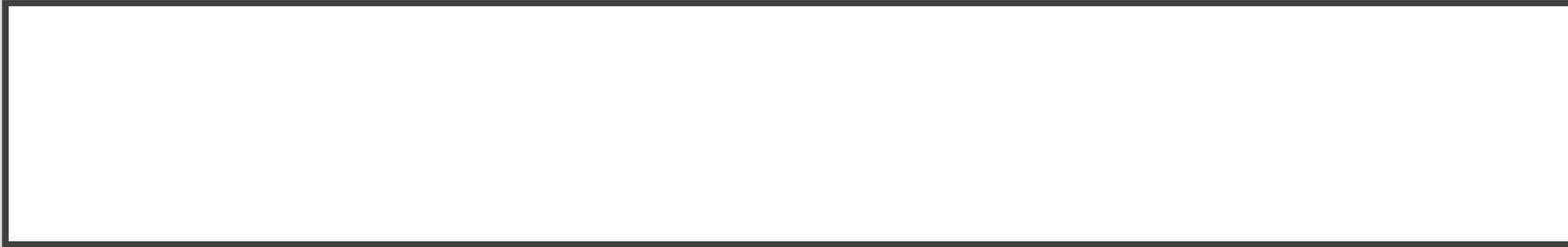
- Our preliminary findings broadly reflect what we see in the literature.

- Addiction is not only a problem in its own right, but it renders women vulnerable to recidivism.

  - Substance abuse makes women less likely than those not using substances to be employed at three months (30% vs. 32%) and 10 months (25% vs. 53%) post-release.*

- Mallik-Kane K, Visher C. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Washington DC: Urban Institute; 2008.

TAKEAWAY

- Since unemployment and substance use are both strongly associated with recidivism, reentry programs focusing on women must provide strong services in addiction therapy, personal motivation, and job/lifeskills training.

FEMALE RELEASEES HAVE A LONG HISTORY OF TRAUMA
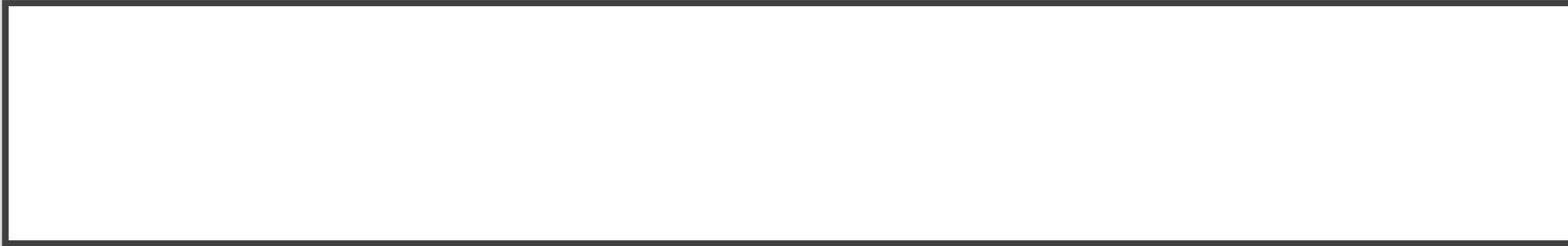
- Trauma — physical, psychological, and sexual — is common in the background stories of these women.

- Some chose to find protective halfway houses and temporary residences (the services associated with our study sample) owing to the fact they did not want to return to a context where that abuse might continue.

- Many participants considered these past experiences related to their present mental and physical health challenges.
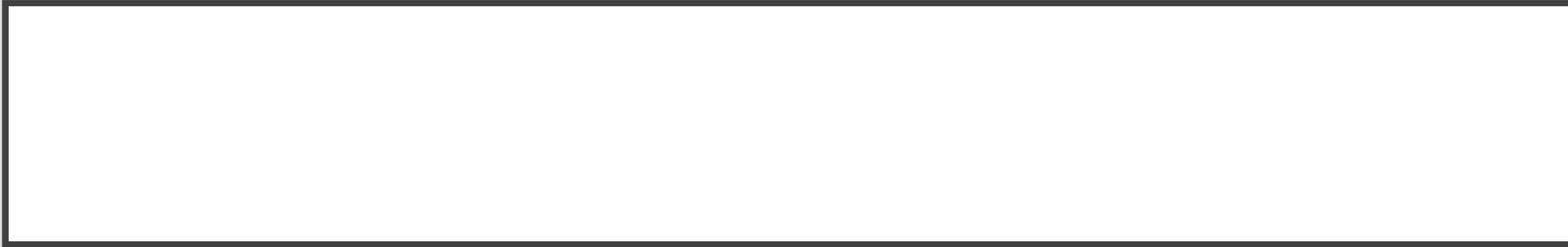
- Here again our work resonates with the broader literature about female releasees and trauma.

- Studies show that most incarcerated women were the victims of trauma and abuse at the hands of strangers, friends and family prior to their incarceration.*

- Research from women in California prisons suggests that, unfortunately, women of all races report previous trauma in almost equal rates.*

- Regardless of race, approximately 90% of incarcerated women with drug dependency report histories of childhood trauma (one or more experiences).*

- 34 Browne A, Miller B, Maguin E. "Prevalence and severity of lifetime physical and sexual victimization among incarcerated women." Int J Law Psychiatry, 1999; 22:301-322; James, D. J. Profile of jail inmates, 2002 (NCJ No. 201932). Washington, DC: Bureau of Justice Statistics, 2004.
- Messina, Nena and Christine Grella, "Childhood Trauma and Women's Health Outcomes in a California Prison Population," Am J Public Health. 2006;96:1842–1848
- Messina, Nena and Christine Grella, "Childhood Trauma and Women's Health Outcomes in a California Prison Population," Am J Public Health. 2006;96:1842–1848
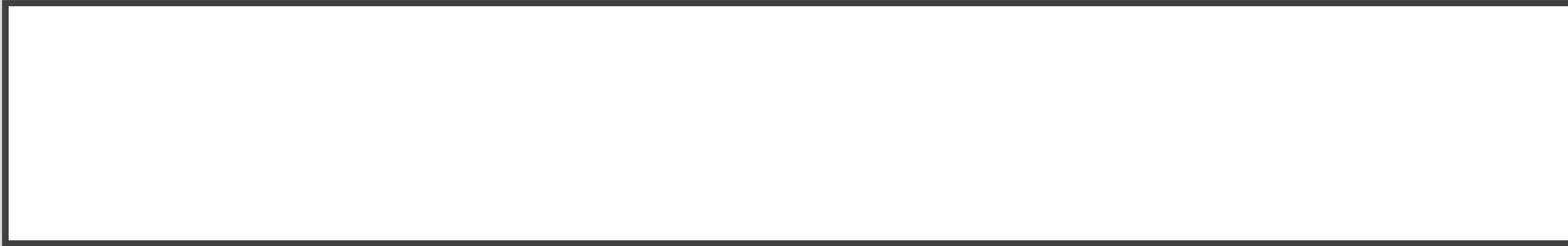
- Mental health services provided for reentry populations will need to take this longer life course into consideration when designing programs aimed at preventing recidivism. While responding to these childhood traumas will require cultural competence and ethnoculturally targeted interventions, the need for care appears to be relatively ubiquitous among this population and, perhaps, important to effective reentry

EXPERIENCES IN JAIL/PRISON OFTEN EXACERBATE THESE TRAUMAS
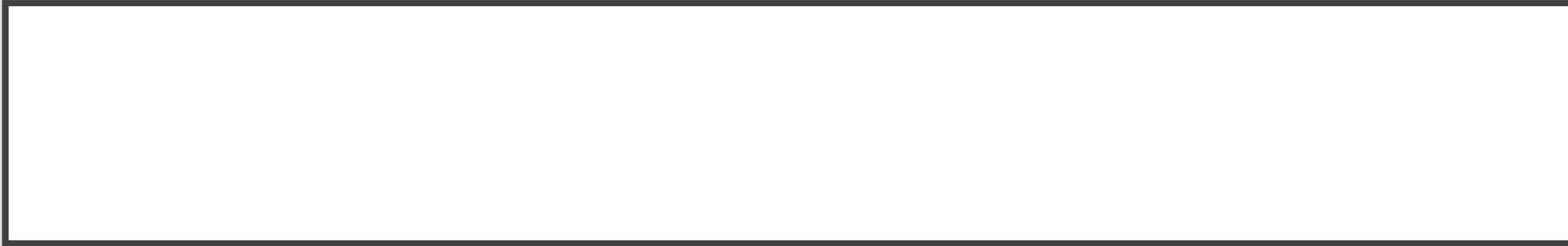
- For some women, the traumas they had experienced prior to incarceration were only exacerbated in prison.

- Some women experienced violence — physical and even sexual — while incarcerated, while others found that the time in jail did not provide them access to mental healthcare that might have helped them address their previous traumas.
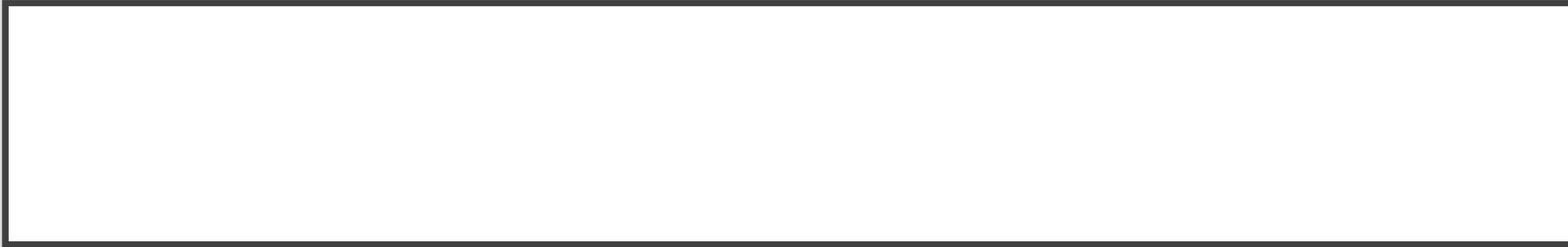
- Our findings align with some work in the literature that suggests incarceration can magnify previously-experienced trauma. The most obvious way is through re-victimization while incarcerated.

  - Two studies with small sample sizes suggest anywhere from 6 to 19% of incarcerated women report sexual victimization while in prison, but other studies suggest it may be as high as 25%.38

  - 45% of women reporting such victimization indicated it involved prison staff.39

  - Exacerbated trauma is not limited to actual experiences of victimization, however, as the literature also suggests that procedures common to incarceration – forced searches, strip searches, minimal privacy, isolating experiences, and power differentials with male authorities – often recapitulate abuse experiences for previously victimized women.40

- Struckman-Johnson C, Struckman-Johnson D, Rucker L, Bumby K, Donaldson S. Sexual coercion reported by men and women in prisons. The Journal of Sex Research 1996; 33(1): 67-76; Struckman-Johnson C, Struckman-Johnson D. Sexual coercion reported by women in three Midwestern prisons. The Journal of Sex Research 2002; 39(3):217-22 Mardorossian CM. "Victimhood in the carceral culture of women's prisons." International Review of Victimology 2012; 19(1):69-83
- Mardorossian CM. "Victimhood in the carceral culture of women's prisons." International Review of Victimology 2012; 19(1):69-83
- Young D. "Health status and service use among incarcerated women." Family and Community Health 1998; 21(3):16-31.

TAKEAWAY

- To the extent that trauma continued or went untreated, women reentering civil society felt mental health issues to be an important and unaddressed need.

- Our findings and the extant literature suggest that services addressing formerly incarcerated women will need to address the mental health needs of victimized women.

- These needs, it is clear, are unlikely to be adequately addressed or resolved within 12 months of release.

SENIOR WOMEN ARE AN OFTEN-OVERLOOKED POPULATION WHO FACE FURTHER COMPLICATIONS
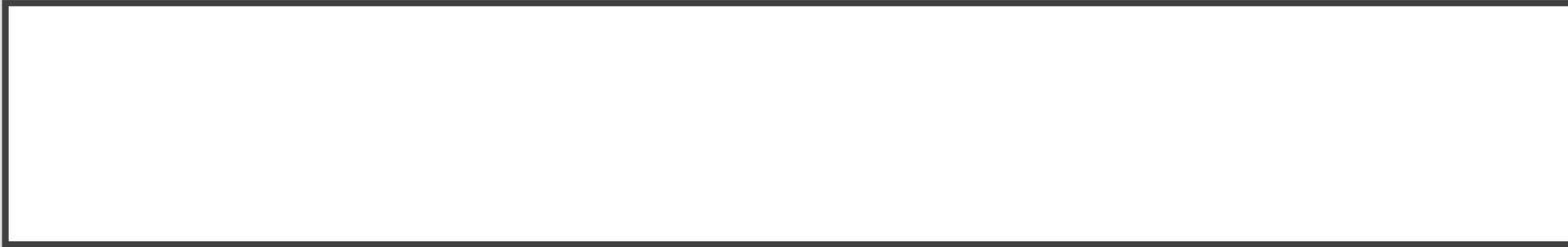
- An important finding in our initial research was the small but growing population of senior women leaving prison.

- Defining "senior" is difficult, because American society at large tends to put that number at age 65 and over, but prison populations tend to view senior women as those who are 50 or 55 and older, or those who have received a "life in prison" sentence, even if they receive parole or are released in their 50s.

- These women, our studies show, face considerably different challenges than their younger counterparts, and also find themselves facing different health insurance and employment challenges than younger releasees. They also report longer periods where mental health issues require attention
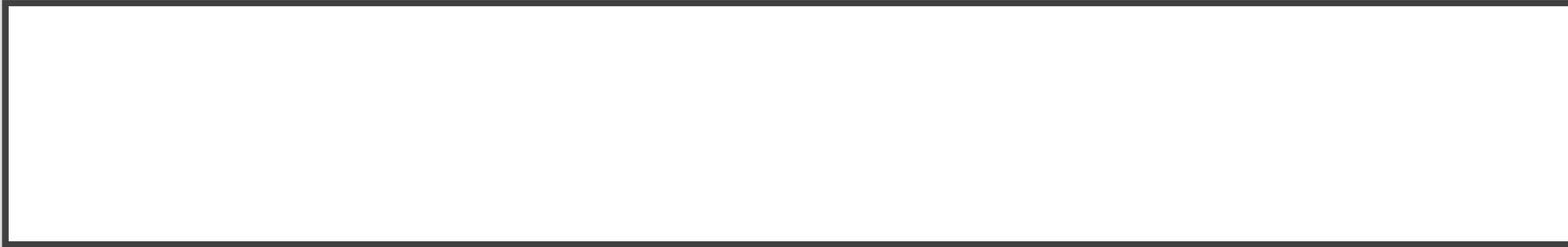
- While our sample is small here, our findings about the growing problems experienced by senior women leaving prison aligns with findings in the larger literature.*

- Studies indicate that prisons and reentry programs are ill-equipped to deal with the long-term poor health and mental health needs of "lifers" and other senior women, especially those trying to deal with terminal illnesses, later-stage cancer or other debilitating chronic diseases.

- Aday RH, Krabill JJ. Women aging in prison: A neglected population in the correctional system. Boulder: Lynne Rienner Publishers; 2011.

MOTHERS AND REENTRY
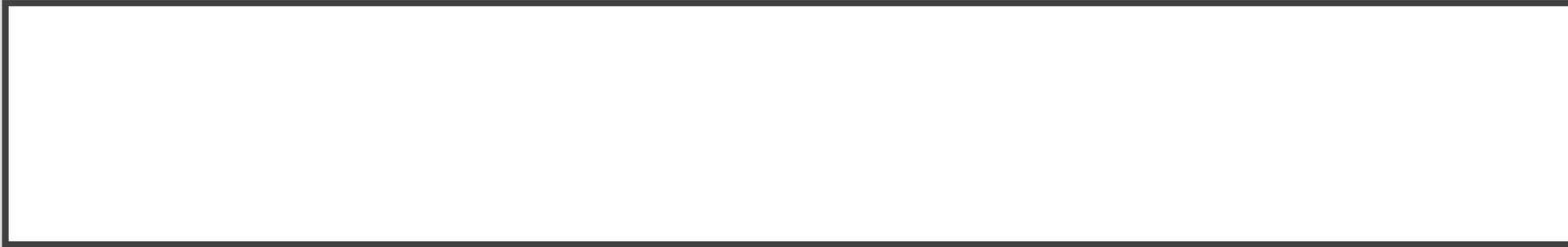
- Our preliminary work found less of a focus on the needs of families than appears in the literature.

  - Studies suggest that about 75% of incarcerated women are mothers, which means that, upon reentry, they will be responsible for not only their own health needs, but also the health needs of their children.

  - In many cases these children may be eligible for Medicaid or Children's Health Insurance Program (CHIP), but reentry programs that focus on women should include education on how to navigate the social services available to their kids.

- Bureau of Justice Statistics. Women in Prison: Special Report. Washington, D.C.: U.S. Department of Justice, 1994.

THE EVIDENCE-INFORMED CURRICULUM

BRIDGES TO FREEDOM RE-INTEGRATION PROGRAM

INTENSIVE LIFE SKILLS TRAINING

- A 12-week behavioral modification component that provides deep emotional and cognitive reasoning concepts. An alternative to jails/prisons shaped to provide emotional wellness, resources, and support. Shaped to modify old ideas. Restores relationships and brings family's back together. Leads to healthy attitudes about life and helps individuals find solutions that break barriers which prevent them from moving forward. Developed specifically for incarcerated, formerly incarcerated, and individuals with criminal backgrounds that are preventing them from making ground breaking moves in their lives.

EMOTIONAL INTELLIGENCE:

- **Helping clients understand the dynamics of self-evaluation, motivation, and healthy thought processes.**

SUSTAINING HEALTHY MOTIVATION:

- **Helping clients understand the concepts of healthy motivation, personal empowerment, and self-esteem building.**

EFFECTIVE MEDITATION

- Leading clients to reduce stress, build character, and walk through a better decision making processes.

UNDERSTANDING THE FAMILY SYSTEM

- **Helping clients look at their participation in the family structure and how family members can either help or hurt the processes of growth in their lives.**

MALE VS. MAN/FEMALE VS. WOMAN

- Helping clients understand their maturity level.

- To form a bond with self.

- It is designed to help folks look at their behaviors in society and with family

LEARNING INTIMACY

- **Helping clients learn how to have healthy relationships and practice self-care financially, mentally, and physically.**

DECREASING SOCIAL CONFLICT

- **Helping clients understand how to change the direction of their lives by understanding the concepts of living in a society with positive ideas and to recognize resources that enhance their lives.**

FACING RECIDIVISM

- **As it relates to policy, advocacy, life development, the re-entry round table, and leadership development.**

DECREASING ISOLATION

- **Helps clients push to gain access to living a productive and satisfying life with confidence.**

- **Connecting clients to mental health and addressing depression**

UNDERSTANDING FAMILY ROLES

- **Overcoming unhealthy expectations by utilizing healthy alternatives**

FACING MY FEARS

- **Overcoming the anxieties of migrating back into society**

- **Navigating mental health and social services**