Practice Inquiry Project Final Manuscript

Improving Self-Efficacy Strategies of Health Maintenance in Post-Incarcerated Women: Implementing Healthcare Access and Education

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ABSTRACT

According to the World Health Organization, social determinants of health are, "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels". Social determinants of health in medically underserved and underrepresented population such as incarcerated women are discussed. According to evidence-based research, incarcerated individuals have commonalities stating, women incarcerated have displayed higher rates of poverty, lack of housing stability, are from a disadvantaged background and typically fall in the category of being Native Hawaiian, African American or Pacific Islander. In addition, literature shows that many of these women have reported a presence of violence and/or trauma exposure, with the abuser typically being a family member, family-friend, acquaintance or significant other. Furthermore, the lack of connectivity and access to health care providers increases their risk of morbidity and mortality. The objectives of this project were to build an awareness of health disparities, apply culturally sensitive lessons learned through direct demonstrations of self-care knowledge and improve healthcare within the justice system for better health outcomes.

TABLE OF CONTENTS

Improving Self-Efficacy Strategies of Health Maintenance in Post-Incarcerated Women: Implementing Healthcare Access and Education

Chapter 1: Statement of the Problem

Introduction and Background

It is described that a vast majority of incarcerated women are of minority and medically disadvantaged backgrounds, with the greatest number represented by African Americans, Native Americans, Native Hawaiian, Pacific Islander and Alaskan natives (Peterson, 2015)[1]. According to the World Health Organization (2017)[2] there are five common health disparities present within the incarcerated population in the United States in both men and women detainees; substance abuse, mental illness, chronic disease, infectious diseases and sexually transmitted infections. To understand the magnitude of these disparities, Lewis "Treating Incarcerated Women: Gender Matters." *Psychiatric Clinics of North America*. (2006)[3], Stated mental illness is highly prevalent amongst incarcerated women who also display severe symptoms of post-traumatic stress disorder (PTSD), with nearly one-third having experienced physical or sexual abuse prior to incarceration, and the Bureau of Justice Statistics Selected Findings Report offered, 1 in 4 women in State prison reported sexual abuse before age 18 compared with 1 in 20 men (Harlow, 1999)[4]. Freudenberg "Adverse Effects of US Jail and Prison Policies on the Health and Well-Being of Women of Color." *American Journal of Public Health*.

[1] Peterson, B. (2015).
[2] World Health Organization. (2017).
[3] Lewis, Catherine. (2006).
[4] (Harlow, 1999)[4].

(2002)[5], Stated people with serious psychiatric needs are more likely to be victims of violent crimes, more likely to be housed in solitary confinement, and are at higher risk of suicide and self-harm while incarcerated. In addition, Freudenberg (2002) highlighted how social economic status and social environments influence social determinants to health and become drivers to health behaviors, both positive and negative. By clearly identifying and truly understanding the role social determinants of health plays in the impact of health disparities. Our role as nurse practitioners is to become evident and intentional in our care, identifying its significance and placing it at the forefront, to find solutions and combat social determinants linked to bad health outcomes in incarcerated women.

Significance of the Problem

Statistical support offered by the Sentencing Project, shown in figure 1, depicts a profound shift in the criminal justice system within the last decade. And according to Carson (2015)[6], author of "Prisoners in 2014", states federal and state initiatives have called for firmer drug regulations and an intolerance of mal-behavior amongst women offenders which have dramatically increased the number of incarcerated women tremendously, with the last statistical data offered from 2012, stating nearly 114,000 women were incarcerated in the United States in both federal and state prisons. Twenty-four percent of female prisoners have been convicted of a drug offense, compared to 15% of male prisoners; 28% of incarcerated women have been convicted of a property crime, compared to 19% among incarcerated men (Carson, 2015)[7]. Also highlighting a

[5] Freudenberg, N. (2002).
[6] Carson, E.A. (2015).
[7] Ibid

comparison of 1986 statistics at only 12% of women in state prisons were incarcerated for a drug offense; by 2014, 24% were incarcerated for a drug offense (Carson, E.A., 2015)[8]. Between 1980 and 2014, the number of incarcerated women increased by more than 700%, rising from a total of 26,378 in 1980 to 215,332 in 2014.

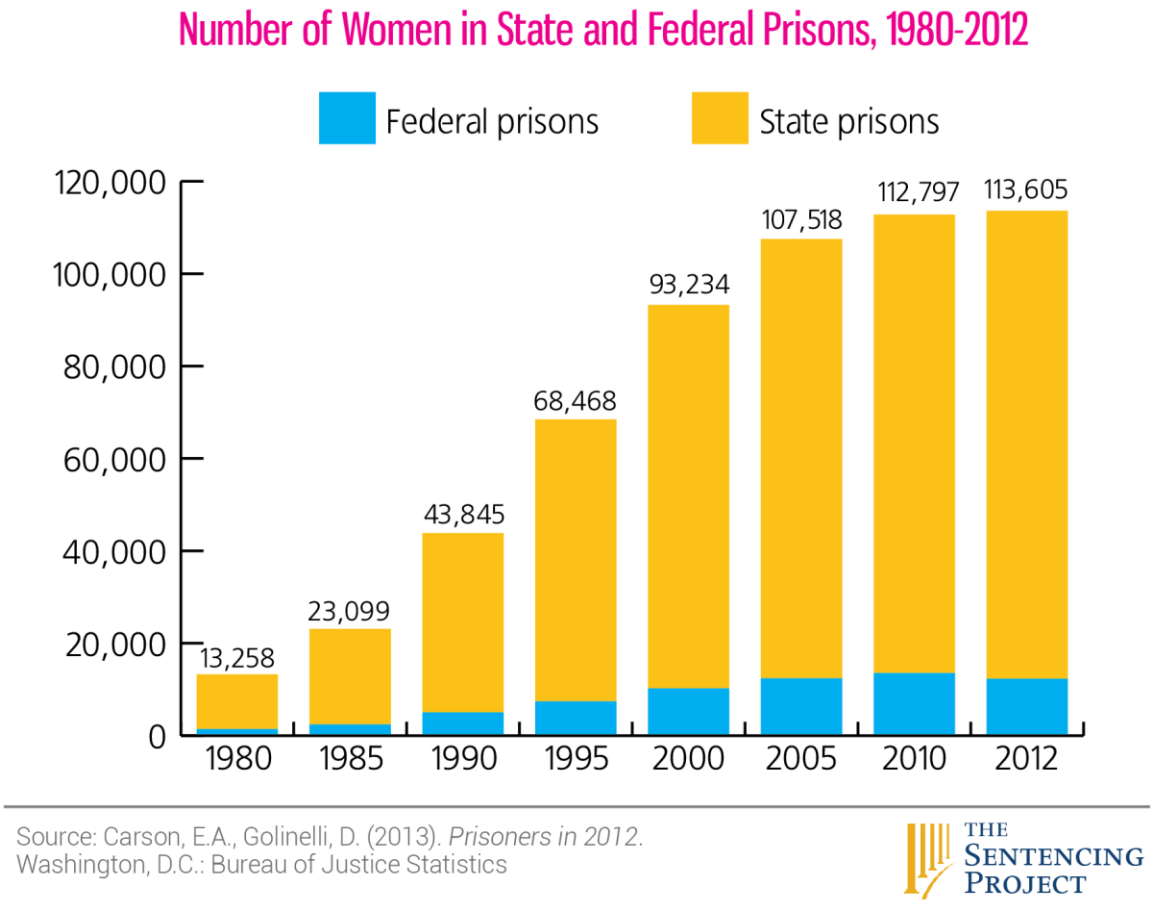

Figure-1 Image courtesy of Bing.Com

Brinkley-Rubinstein (2013)[9], identified incarceration as a catalyst to poor health placing these women at a disproportionally higher rate of developing chronic illnesses, mental health illnesses and infectious diseases. Three pressing contributors to social determinants of health as identified by Brinkley-Rubinstein are socio-economic status,

[8] Ibid, 6
[9] Brinkley-Rubinstein, L., (2013).

violence, abuse and trauma and finally, race and/or ethnicity. As previously highlighted, in many instances, incarcerated women have experienced traumatic events, develop drug dependencies and at some point, elude or inhibit the ability for proper self-care and sagacity of self-worth and ability. Through literature review, a trend resonates on causative factors surrounding these women. Many psychologists believe incarceration and outward display of risky behaviors are far from being unintentional, but that these behaviors typically go hand in hand. Many are severe substance users, seeking reality-altering medications (e.g. amphetamine, heroin, cocaine or benzodiazepines) to mask or submerge the pain of traumatic past events (Haywood, Kravitz, Goldman & Freeman, 2000)[10]. Nevertheless, it is factual that the women in U.S. prisons are medically underserved and it is equally (Kane & DiBartolo, 2002)[11], and imperatively, necessary for women to maintain health during childbearing age, for the sake of their overall health and the health of their offspring.

To understand the underlying issues inducing health disparities for incarcerated populations, it is essential to understand what a social determinant is and how it influences ones behavior. According to Peterson (1994)[12], social determinants include individual resources corresponding to education, occupation, income and wealth. The availability of neighborhood resources e.g. as housing stability, food accessibility, safety and security, transportation, access to parks and recreational areas are also considered. Lastly, the political impact may become a stimulus for social determinants to health and

[10] Haywood, T. W., Kravitz, H. M., Goldman, L. B., & Freeman, A. (2000).
[11] Kane, M., & DiBartolo, M. (2002).
[12] Ibid,. 5

will ultimately carve foundations for life. Peterson (1994)[13], revealed biases within the prison health care system, affecting the quality of care, access to health resources specific to preventive care, and restorative services for prisoners. In addition, many state of Hawaii and privately owned prisons, house approximately 54% of Hawaii prisoner population, with a great deal living in the Saguaro Correctional Facility (Arizona) and Watonga Correctional Facility (Oklahoma). Many of these prisons have inadequate policies that lack consideration in addressing these unique needs of detainees. In recent years, many facilities both state and federal have progressed to systems that provide primary and comprehensive care to prisoners; however, the increase in the number of inmates makes provision of adequate care difficult. Educational provisions and programs have been limited due to financial constraints and budget cuts in recent presidential terms restricting educational opportunities and advancements for women detainees. Currently, state of Hawaii prisons allow non-profit organizations to provide rehabilitative services, some culture-based, some faith-based, but inconsistencies in securing funding makes it difficult to provide continuity of services and programs.

Healthy People 2020 emphasizes the importance of addressing the social determinants of health by including the objective, "Create social and physical environments that promote good health for all" as one of the four overarching goals for the decade. This encumbrance is shared by the World Health Organization, whose Commission on Social Determinants of Health (CSDH) published the report, *Closing the gap in a generation: Health equity through action on the social determinants of health*

[13] Ibid., 5

(2008)[14]. Other nationwide health initiatives such as the National Partnership for Action to End Health Disparities and the National Prevention and Health Promotion Strategy have also highlighted such goals for a healthier community (Healthy People 2020)[15]. These programs have raised national awareness on health disparities and the overarching issues of social determinants of health. On a local level, the state of Hawaii, Department of Health in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA) was awarded a grant to create programming initiatives similar to Access To Recovery (ATR Ohana). ATR Ohana project goals are to strengthen and heal lives and families shattered by substance use through 1) support of clients choice in re-integrating into society post-incarceration, 2) expand access to a wide range of treatment and recovery support services for substance abuse, including faith- and culturally-based providers; and 3) to increase capacity of the treatment and recovery support services in Hawaii's recovery-oriented system of care. The ATR project foresees a system where individuals with substance use disorders are treated with dignity and respect, and to have choice among treatment and recovery support service providers, to be maximized and expedited wherever possible. ATR's vision is *"To build resilience and facilitate recovery" offering "a life in the community for everyone."* The ATR project will serve to emphasize and facilitate post-incarcerates choice among substance use disorder treatment and recovery support service providers through electronic voucher payment system where the funding follows the client to their choice of service and agency from the ATR Ohana network of approved providers to prevent a break in service coverage. The purpose of this program is to promote self-care at the most basic levels,

[14] National Commission on Correctional Health Care. (2002, March).
[15] Healthy People 2020, (2014).

including empowering individuals to select their service providers and to be actively involved in decisions affecting their life, care, and treatment. The criteria for ATR Ohana eligibility will be previously incarcerated individuals re-integrating into community settings, drug court offenders, Native Hawaiians and Asian Pacific Islanders, deployed veterans, military personnel, national guard or reservist, and their families, and those experiencing health disparities such as dental disease/ dyscrasias related to use of methamphetamines and HIV/AIDS patients. This program is in partnership with Hawaii's recovery-oriented systems of care, including community-based, faith-based, culture-based, and secular providers to maximize local access to ATR Ohana clients for services in categories relevant to their individual recovery needs (State of Hawaii.gov, 2017)[16].

Problem Statement

In the past decade, an influx of women detainees within the prison system have yielded astronomical numbers by nearly two-times that of men prisoners (Hatton, D. C. & Fisher, A.A. (2008)[17]. Many of these women are admitted into the prison system with pre-existing chronic illness, mental health disorders and health issues that need medical attention, treatment and monitoring. The lack of focused health services for incarcerated women exacerbates preventable communicable diseases, chronic illnesses and mental health problems (Van den Bergh, B. J., Gatherer, A., Fraser, A., & Moller, L. (2011)[18].

What are the catalysts for improving health in incarcerated women? The concept of offering comprehensive health services within the prison system, both state and

[16] State of Hawaii.gov. (2017).
[17] Hatton, D. C. & Fisher, A.A. (2008)
[18] Van den Bergh, B. J., Gatherer, A., Fraser, A., & Moller, L. (2011).

federal, would allow opportunities to introduce health education in the prison system directly affecting the environment and health attitudes of our target population. Its purpose supports the need to increase the knowledge of the women detainees to make well-informed decisions for their own health and be active participants in self-care teachings. An article published by the Pew Charitable Trust (2016)[19], supported the concept of offering comprehensive health services within the prison system for all prisoners, stating "Effective treatment of inmates' physical and mental ailments, including substance abuse, improves the well-being of prisoners and can reduce the likelihood that they will commit new crimes or violate probation once released", ultimately decreasing recidivism amongst our target population. The principle of effective health education and the ideology of improving self-efficacy for women inmates to make better health and life choices, will resonate in the lives of these women throughout there stay as a prisoner, but furthermore, upon release into the community.

As highlighted thus far, incarceration is a social determinant to health, and Peterson (2015)[20] supported the importance of appreciating the social and economic impact incarceration plays on communities at the local, state, and national levels. It is important to understand that these issues greatly impact our patients' health outcomes. Understanding the impact of incarceration and recidivism on patient outcomes provides opportunities for providers to effectively engage new and returning inmates.

An article published by the American Civil Liberty Union (ACLU)[21] on incarcerated women's right to access health care, identified in a report stating, "Upon examining the

[19] The Pew Charitable Trust,(2016).
[20] Ibid, 5, 8.
[21] American Civil Liberties Union, ACLU. (2012)

health care policies of county correctional systems nationally, many facilities had policies established by correctional administrators, however, it provided broad guidelines for health care protocols and offered minimal standards of care. Many left policies for individual interpretations, distorting capabilities of maintain continuity to care for all prisoners. This policy as the ACLU has highlighted, allows jail administrators, medical staff, and correctional officers to respond to women's medical requests at their discretion, meaning that care can vary depending on who responds to a request for assistance (ACLU, 2012)[22], regardless of medical expertise and experience, or lack thereof. As stated by the ACLU, the allowance of such actions to take place within any state, local or federal prison, is a violation of our human rights acts set in place to protect vulnerable populations, such as women prisoners, and undeniably places these women in harm's way. The ACLU highlighted several concerns stating issues with denial of access to elective procedures such as abortions, risk of pregnancies undetected and long waits for receiving routine screenings and delaying treatment to time sensitive health issues. In addition, financing of correctional facilities, including health care, depends on legislative appropriations that compete with other priorities. In general, Medicaid funding cannot be used for care of adults and adolescents in secure confinement (Haywood, T. W., Kravitz, H. M., Goldman, L. B., & Freeman, A. (2000)[23]. Currently, provisions for addressing the needs of women offenders have been unsuccessful in meeting basic necessities and are far short of what is required by human rights policies and social justice recommendations. Through a consortia of local health care and social service providers, rural communities can develop innovative approaches to challenges related to their specific health needs.

[22] Ibid, 12
[23] Haywood, T. W., Kravitz, H. M., Goldman, L. B., & Freeman, A. (2000).

Outreach projects focus on the improvement of access to services, strategies for adapting to changes in the health care environment, and overall enrichment of the respective community's health. Project such as The Outreach Program (HRSA.gov. 2018)[24], is a community-based grant program aimed towards promoting rural health care services by enhancing health care delivery in rural communities. Furthermore, the program creates an opportunity to address the key clinical priorities of the U.S. Department of Health and Human Services (HHS): serious mental illness, substance abuse, and childhood obesity. (HRSA.gov, 2018)[25].

The financial impact associated with incarceration is discussed by the Vera Institute of Justice, titled "The Price of Prisons: Examining State Spending Trends, 2010-2015" (Mai & Subramanian, 2017)[26], it is estimated that Hawaii housed 6,063 prisoners in 2015, costing taxpayers a total of $178,406,163 in financial expenditures, with an average cost of $29,425 per prisoner. The national average cost per inmate being at $33,274. With that in mind, prison officials are quick to note, that a reduction in inmate numbers will not reduce the cost or expense on the prison expenditures. This is because the average cost includes many fixed costs such as organizational services and facility maintenance, which typically do not change when the population decreases. The high cost per inmate also correlated with the aging population, age 55 and older, nearly doubling between 2003 and 2013, far surpassing the change in the overall prison population over that period. With the rapid aging of the prison population, a growing cohort of state prisoners are in need of specialized care that addresses the common

[24] Rural Health Care Service. HRSA, (2018).
[25] Ibid, 13
[26] Mai, C. & Subramanian, R. (2017).

chronic medical and mental illnesses that afflict the elderly, including dementia, impaired mobility, and loss of hearing and vision. In addition, due to medical histories, involving substance use and inadequate medical care, people who are incarcerated are on average substantially older physiologically than people who are not incarcerated — meaning that the symptoms and conditions they experience are those common to someone who is older than their actual age (Mai & Subramanian, 2017)[27].

Chapter 2: Comprehensive Review of the Literature

Review of Literature

Health Education Needs of Incarcerated Women

Dinkel published the first article reviewed in 2014, entitled, "Health Education Needs of Incarcerated Women", released in the *Journal of Nursing Scholarship* offered findings through a naturalistic qualitative study using a participatory research method. Dinkel, S. and Schmidt, K. (2014)[28], conducted focus group sessions within the correctional facility where inmates provided unique insight into their lives within the prison confinements. The two focus groups, both maximum (A) and medium security (B) included adult women incarcerated in a state corrections facility. Group A consisted of eight women housed in the maximum-security area and ranged in ages 25 to 51 years of age. Group B consisted of eight women housed in medium security holdings, ages ranged from 22 to 48 years of age. Data was analyzed using a constant comparison approach to identify emerging patterns. Information analyzed consisted of three topic questions, they

[27] Ibid, 14
[28] Dinkel, S. and Schmidt, K. (2014)

included: 1) “What are the top ten health education needs of inmates in this facility?”, 2) “What is the best method for educating inmates on these topics?” and last, “What would a health fair look like for you?” The research team included two members, doctoral prepared, with one having expertise in qualitative analysis. The third research member had many years of expertise in correctional health care; all three were involved in analyzing the data.

The outcomes of this research offered six specific themes which included the importance of nutrition, exercise to prevent and treat obesity, women’s health concerns, communicable disease transmission and prevention, dental hygiene, pathophysiology and complications of chronic disease, and mental health conditions. The women also added a necessity for building rapport with the providers and gaining trust amongst the inmates for education to really be effective. In practice, this study is replicable and offers thorough insight on study methods, design and description of participants. Dinkel, S. and Schmidt, K. (2014)[29], clarified dependability in qualitative research stating inherent biases and limitations occurred throughout the study, therefore questioning the validity of the results.

Prisoners' Perspectives of Health Problems and Healthcare in a U.S. Women's Jail

The second article by Hatton, D. C. & Fisher, A.A. (2008)[30] entitled “Prisoners' Perspectives of Health Problems and Healthcare in a U.S. Women's Jail”, presented a participatory research project exploring health problems and healthcare from the perspectives of women incarcerated in a county detention facility located in the western United States.

[29] Ibid, 15
[30] Ibid, 11

The women in this study identified barriers to care including concerns about privacy and dignity as well as waiting time for treatment, co- payments, and concealing problems in order to obtain work opportunities. Hatton, D. C. & Fisher, A.A. (2008)[31] highlighted consistencies in many of the women lives, noting many suffered from physical, mental, and iatrogenic health problems while incarcerated and many don't quite understand the etiology of such disease, prevention and proper care while incarcerated.

Improving Access to Health Care for California's Women Prisoners

The third article by Stoller (2001)[32], "Improving Access to Health Care for California's Women Prisoners", offered results supporting the concrete idea of injustices occurring in United States prison systems and offered outcomes that supported education and preventive care in the prisons, stating it is necessary to maintain health of the overall population.

The study findings suggested recruitment/retention, training and further education of health care professionals and staff should be improved to better serve inmate needs. Stoller, N. (2001)[33] emphasized the importance of clinical services being provided to inmates should be conducted by an independent non-profit agency given the political biases that exist with the prison system. In conclusion, this article supports regular scheduled health checkups and reminders for incarcerated women underlining the need for screening and treatment according to national standards such as the American College of Obstetricians and Gynecologist (ACOG) for breast and cervical cancer, dental

[31] Ibid 11, 16
[32] Stoller, N. (2001).
[33] Ibid

prophylaxis, and routine tuberculosis testing which currently is the only prevention noted by Stroller during inmates stay.

Incarceration as a Catalyst for Worsening Health

Brinkley-Rubinstein, L., (2013)[34], "Incarceration as a Catalyst for Worsening Health", explores the link between health and incarceration classified into three distinct categories. The first category examines the incarcerated experience and health of the individual exploring relationships between mental and physical health; and incarceration and the delivery of healthcare in correctional facilities. The second category includes research, explores the link between incarceration and actions that may also influence health, such as risky sexual behavior and substance use. The third and final category includes support that explores the post-release transition and well being focused on these barriers to community rehabilitation and the sustained effects impacting health.

This study's aims presented a theory that supports the relationship between health and incarceration via an empirical framework that hypothesizes how incarceration affects community, family and individual health, and consequently, exacerbates health disparities, and last illuminates the policy, programs, interventions and future research implications that are necessary to address the effects of incarceration on health, and therefore, address health disparities among those who are most likely to experience incarceration. This article confirmed that African Americans more often experience incarceration, and typically have disproportionate numbers of chronic illness and infectious diseases due to the many other social determinants of health that differentially affect at-risk populations.

[34] Brinkley-Rubinstein, L., (2013)

Project Description

This DNP project was a 2-day health symposium among previously incarcerated women with a year or greater post incarceration in state or federal facilities. The symposium took place at Waianae Health Academy, Butler Building, 86-088 Farrington Hwy, Suite 202, in Waianae, Hawaii. The overarching goal of this project was to influence positive health-seeking behaviors by enhancing prisoner's awareness of potential health threats modeled by issues and the importance associated with actions aimed at reducing the risk.

Specific Aim 1

Identify and connect incarcerates to key figure, which provide influential support and mentorship. **Objective 1**: Through individual and group-centered sessions incarcerates set goals and standards for self-care.

Specific Aim 2

The second aim of the project was to demonstrate self-advocacy for safe sex practices, including abstinence and emergency contraceptives and chronic illness management.

Objective 1. Through support groups and a cohort approach, interventions (education) focused on encouraging the women to be informed about health care access and health issues. Factual information about conditions under which preventable health issues occur was provided. **Objective 2**. Education to facilitate women negotiation skills for pregnancy prevention. Increase women's knowledge, skills, and motivation for effective use of healthcare facilities which could be an important strategy to prevent communicable diseases, unintentional pregnancies and chronic illness.

Specific Aim 3. Address health stigmas related to cultural biases and engage in multicultural health practices offering an understanding of cultural competencies.

Objective 1. Identify personal and family values through quarterly family involved sessions and a final Ho'ike (Presentations).

Chapter 3: Project Design and Evaluation Plan

Project Design

The project design was a pre and post educational symposium. The implementation of the project was a symposium conducted by experts in areas of the objectives. Prior to the start of the symposium a pre survey was administered to participants. The survey was conducted to obtain descriptive statistical data such as participant characteristics and demographics. The pre and post survey was a Likert ordinal scale design. The results were coded to calculate a mean score for the scale items. To evaluate the effectiveness of this project, a pre and post survey was designed and utilized.

Theoretical Framework

The Health Belief Model (Figure 2) can be used as an cognitive model to assess individual thinking patterns to perceived health. The HBM was established in the 1950's and was developed by a group of social psychologist wanting to explain motives of research participants that refrained from accessing government sponsored health programs promoting health and disease prevention. The objective and role of HBM will be to influence positive health-seeking behaviors by enhancing prisoner's awareness of potential health threats modeled by issues and the importance associated with actions

aimed at reducing the risk. The Health Belief Model's theoretical framework states, "An individual's readiness to take action is based on four ideas: Perceived susceptibility to illness, discernment of the potentially severe consequences of contracting a disease in terms of lethality and disability, the belief in the effectiveness of preventive actions and lastly, the barriers to taking that action" (Current Nursing, 2012)[35]. These health beliefs have been shown to be significant factors in motivating people to learn risk-reducing behaviors. Offering health education to these women to introduce healthier ways of living, health maintenance, and self-efficacy can have a significant effect and influence them to maintain their own health (Stoller, N. (2003)[36]. The Health Behavior Model addresses the relationship between a prisoner's health beliefs and health behaviors. It provides a way to understand and predict how prisoners respond in relation to their health and how they will employ health care resources and treatments available within the prison system.

[35] Current Nursing, (2012).
[36] Stoller, N. (2003).

Figure 2- Health Belief Model Courtesy of Theories At-a-Glance (2017)

Conceptual Model

The conceptual model titled, "Spectrum of Prevention" introduced by Larry Cohen (1999)[37] identifies multiple levels of organizing prevention strategies. The Spectrum of prevention model identifies six levels of intervention, and encourages providers and collaboratively moving beyond the perception that preventing a health problem is solely about teaching individuals to adopt healthier behaviors. Instead, this approach is designed to yield a more comprehensive understanding of prevention via six strategy development

[37] Cohen, L. & Smith, S. (1999).

levels, extending from the individual to government policies and stakeholders (Figure 3). The first level of prevention is strengthening the individual's knowledge and skill, which ultimately prevents injury caused by knowledge deficits and lack of knowledge to health promoting principles. Second level is promoting community education and involvement. Third, is the need to educate health care providers who will be responsible for disseminating health information and promotional tools. Fourth prevention will be to foster coalitions and networks to broaden health promotional goals for a greater impact in the community. The fifth level is to change the organizational practices and culture, which will involve adapting regulations and shaping organizational and individual norms to improve health and safety of women detainees. Final level of prevention is influencing policy and legislation to develop and change laws and policies that influence positive outcomes, which may also include financial allocations to increase programmatic improvements and implementations.

LEVEL OF SPECTRUM	DEFINITION OF LEVEL
6. Influencing Policy and Legislation	Developing strategies to change laws and policies to influence outcomes
5. Changing Organizational Practices	Adopting regulations and shaping norms to improve health and safety
4. Fostering Coalitions and Networks	Convening groups and individuals for broader goals and greater impact
3. Educating Providers	Informing providers who will transmit skills and knowledge to others
2. Promoting Community Education	Reaching groups of people with information and resources to promote health and safety
1. Strengthening Individual Knowledge and Skills	Enhancing an individual's capability of preventing injury or illness and promoting safety

Figure 3- Spectrum of Prevention (Larry Cohen, 1999) Courtesy of Google Images.

Methods

Data Analysis Methods

A pre and post symposium survey was conducted to obtain descriptive statistical data such as participant characteristics and demographics. The pre and post symposium survey was developed utilizing a Likert ordinal scale. The results were coded to calculate a mean score for the scale items. Questions 1-6 were calculated using the 5-point Likert scale that classifies an ordinal variable. Question 7 included health concerns, which were calculated. To evaluate the effectiveness of this pilot project, the quasi-experimental pre/post test as the research tool will be utilized, pre and post implementation of the

proposed intervention as measured. The pre/post tool has been used by Stoller (2001)[38], "Improving Access to Health Care for California's Women Prisoners", which offered results supporting the concrete idea of injustices occurring in United States prison systems and offered outcomes that supported education and preventive care in the prisons, stating it is necessary to maintain health of the overall population and tested for validity and reliability (Stoller, 2001)[39]. Throughout this symposium, Mindfulness Based Stress Reduction (MBSR) training will offer a structured group program that engages mindfulness meditation to alleviate suffering associated with physical, psychosomatic and psychiatric disorders through out the symposium. The program has no religious basis and non-esoteric, presents a systematic procedure to develop enhanced awareness of moment-to-moment experience of perceptible mental processes (Grossmana, P., Niemannb, L., Schmidtc, S., & Walachcd, H. (2004)[40]. The approach assumes that greater awareness will provide more realistic perception, reduce negative affect and improve vitality and coping. The Health Belief Model and Mindfulness Based Stress Reduction will in combination facilitate growth, healing and self-efficacy. Although the study will be derived from a moderately small number of subjects, the study results should suggest that MBSR may help a comprehensive range of individuals to cope with their medical and/or non-clinical efforts (Grossmana, P., Niemannb, L., Schmidtc, S., & Walachcd, H. (2004)[41].

Human Subject Protection

[38] Ibid, 17
[39] Ibid, 17, 25
[40] Grossmana, P., Niemannb, L., Schmidtc, S., & Walachcd, H. (2004).
[41] Ibid

The University of Hawai'i at Hilo School Nursing Department approved this project to proceed. Application for this practice inquiry project was submitted to the Institutional Review Board (IRB) and approved to conduct this study. The population consisted of post-incarcerated women over the age of 18 who have been post incarceration for at least one year. Each participant was informed of voluntary participation and the option to opt out at anytime. Each participant, who voluntarily wanted to participate, was provided with an informed consent prior to the start of the project (Appendix I). All information remained confidential and names were never collected.

Chapter 4: Results

Demographic: Gender

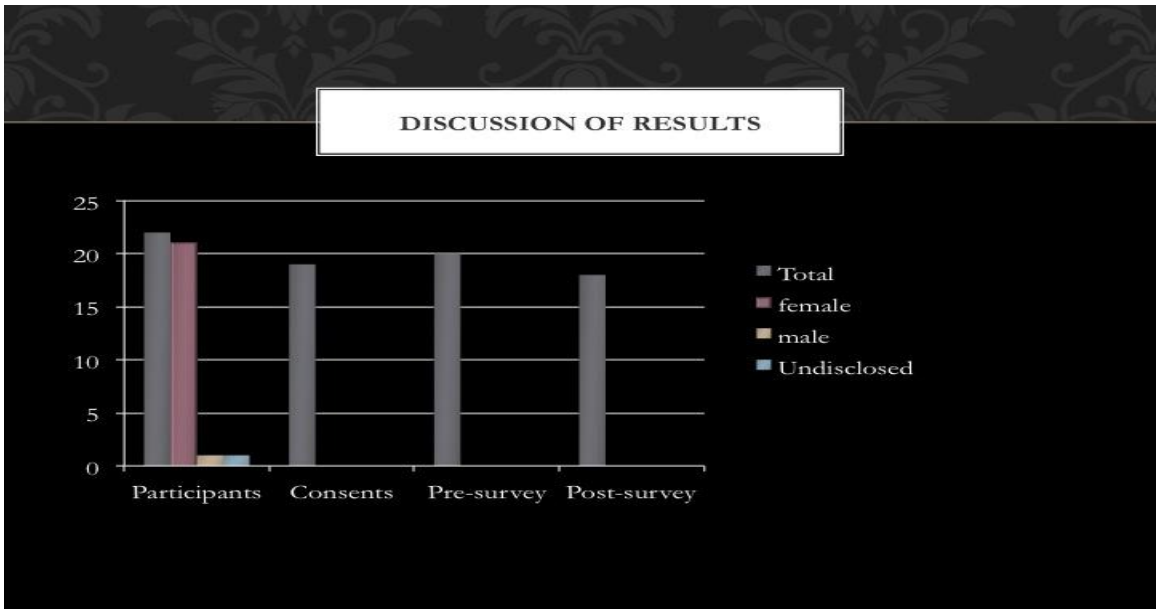

Figure 4-Results of Study: SELF-EFFICACY STRATEGIES

Total participants: 22, Female, 21. Male,1. Undisclosed, 1. Pre-Surveys collected 20, Post-surveys collected were 18.

Related to family planning and women's health, the question was asked, "Have you been seen by a Health Care Professional for contraceptives? The response to the survey question was 58% stated yes and 42% stated "no".

Demographic: Age

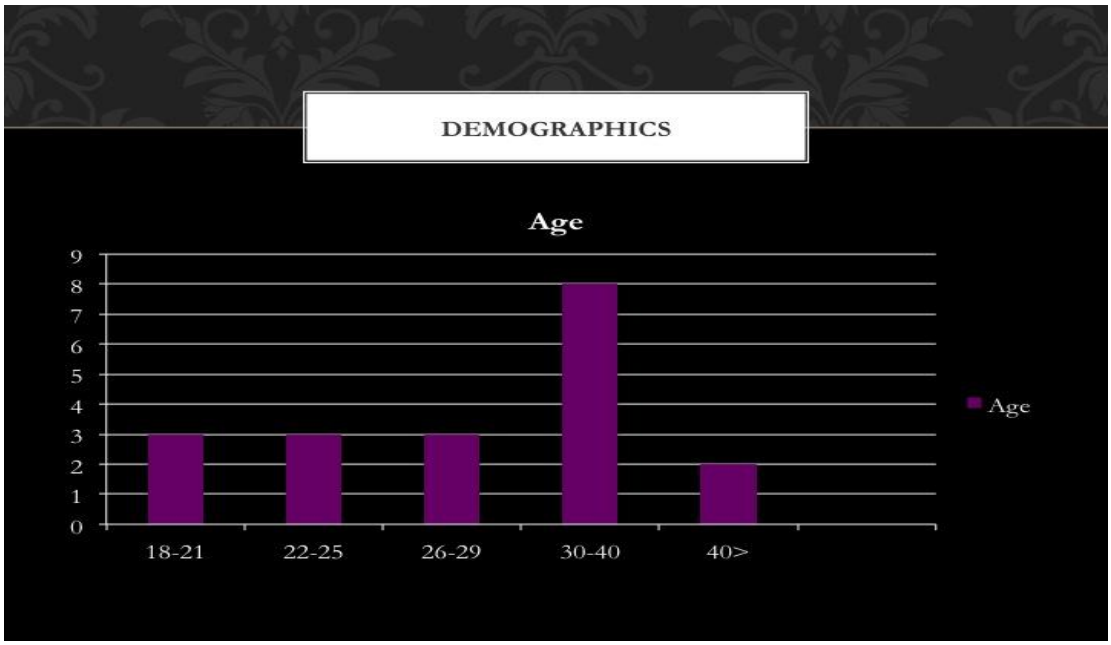

Figure 5-Demographic Age: SELF-EFFICACY STRATEGIES

Of the participants, 42.25% of participants were 30-40 years of age., 47.25% of population were between the ages of 18-29 and 10.5 % were 40 or older (See Figure-5).

Survey included questions addressing sexual health and practices post-incarceration. Responses addressed, "Have you seen a healthcare provider for family planning counseling?" Of the results, 30% of participants who stated, "yes" and there were 70% who stated "No".

Marital Status

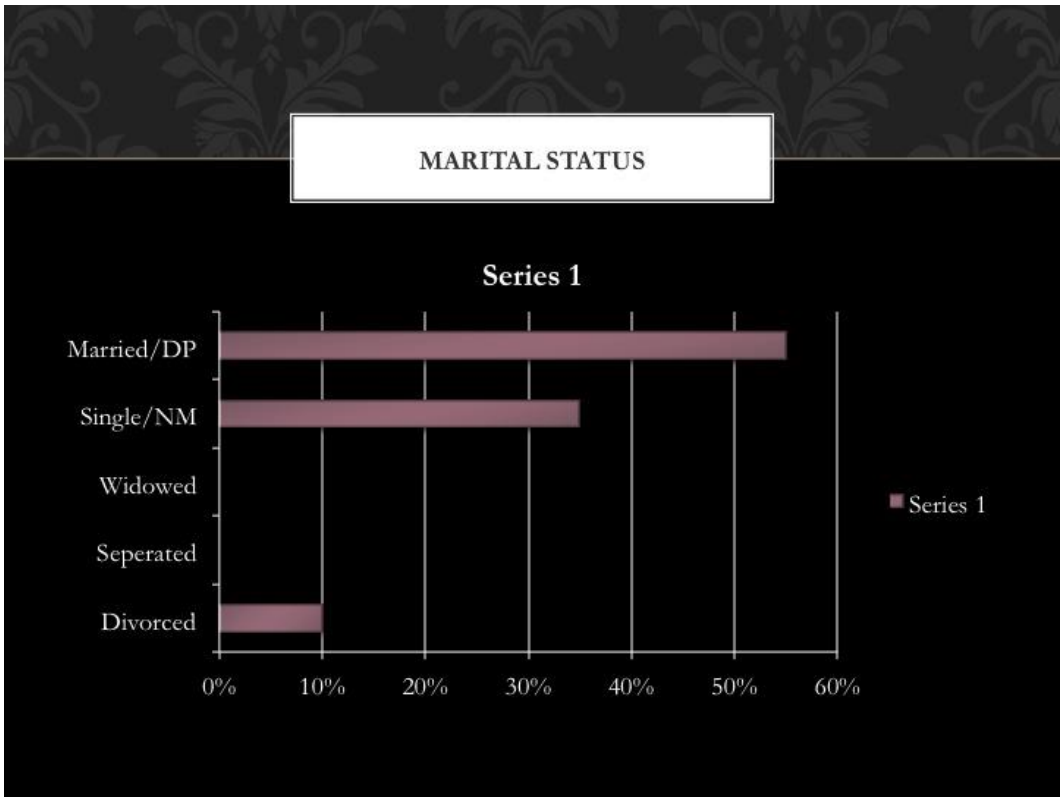

Figure 6- Marital Status: SELF-EFFICACY STRATEGIES

Participants of the study stated 55% were married, 35% single, and 10% Divorced (See Figure-6).

Furthermore, family planning questions included " Are you currently sexually active?" There were 72% of respondents who stated "Yes" and 28% stated, "No". Next question was " Are you in a safe relationship?" There were 89% of respondents who stated "Yes" and there were 0 % who stated "No". There were 11% of respondents who stated "N/A".

Access to Healthcare

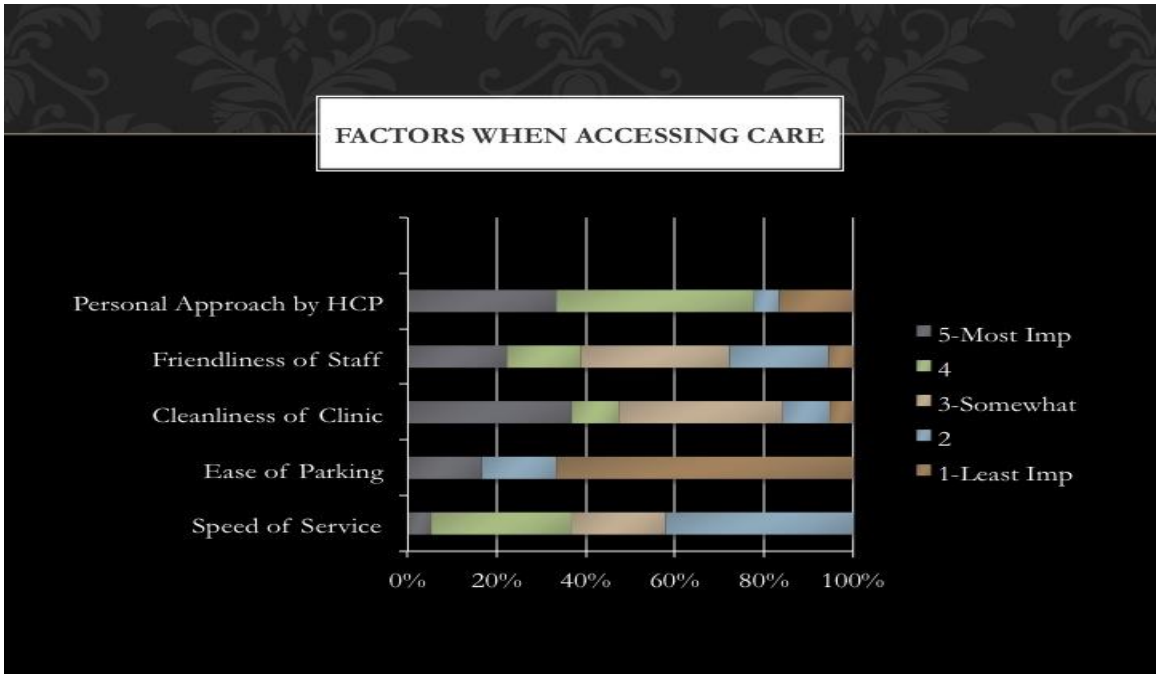

Figure 7- Access to Healthcare: SELF-EFFICACY STRATEGIES

The participant's response requested to list of most importance when accessing healthcare services. Respondents were given selections listed: 5- most Important when accessing care, 4-often important, 3-somewhat Important, 2-occasionally important, 1-Least important. Shown in the graph (See Figure-7) above suggest the most important aspect of accessing healthcare is the cleanliness of the clinic, and least important is the ease of parking.

Health Rating

Figure 8- Health Rating: SELF-EFFICACY STRATEGIES

Health rating in the perspectives of the participant's revealed 16 out of 20 participants reported as being in good health, 1 participant in excellent condition and 3 in fair condition. Of all participants, 61% of surveys stated they have been to the hospital within 1 year or greater (See Figure-8). When asked when was your last health physical, 55% stated > than 1 year, within 1 month (20%), within 3 months (5%), within 6 months(15%).

Chapter 5: Discussion and Conclusion

Discussion and Conclusion

In closing, it is imperative for healthcare providers to identify and address social determinants of health in the medically underserved and underrepresented population such as incarcerated women. Within the same context, treatment of prisoners and opportunities to empower and educate is highly encouraged to ensure healthier outcomes and promote healthier communities. Braithwaite, R. L., Treadwell, H. M., & Arriola, K. R. J. (2005)[42], left us with an impactful statement, stating "Incarcerated women are "invisible," there has been little in the way of research and policy development that would advance their health status. Consequently, it is no surprise that for the most part, the health of incarcerated women is worse than that of incarcerated men and that of women in the general population". Key concepts in educating detainees about health behaviors and health promotion are necessary for inmate to be self-efficient when making health decisions. The significance of creating policies and practices focusing on health aspects and self-care techniques will address the educational needs of women detainee's, enhance knowledge and self-efficacy which subsequently leads to reduced recidivism (Braithwaite, R. L., Treadwell, H. M., & Arriola, K. R. J. (2005). [43] of bad health habits, incarceration and increase healthier families.

Project Strengths and Limitations

The women studied in this project were aware of the need for access and accessibility of health care needs. The women in this study were also found to be

[42] Braithwaite, R. L., Treadwell, H. M., & Arriola, K. R. J. (2005).
[43] Ibid

connected to their community “behind bars”. The first hand encounters of their experiences proved to be very powerful, as evidenced at the symposium. Also noted was a public concern that became evident as a strength of the project.

Limitations of the Study

Some of the limitations of this project reflect the small sample size. Perhaps a larger participant group with increased advertising and networking would yield a larger participant size. In addition, additional funding for possible program implementation and increased symposium presentations would increase the effectiveness of the project. Also including all incarcerated women versus post-incarcerated women would increase the educational opportunity for this sub culture in need.

Conclusion

In conclusion, it is imperative that Primary Care Providers identify and address social determinants of health in an underserved and underrepresented population. This is critical work towards prevention of further harm and illness. It is very important to advocate for the underrepresented and underserved in our rural communities.

A proposal to seek joint grant writing for funding opportunities will help support programs that assist in this process. The key concept of educating incarcerates about health behaviors and health promotion is needed for self-efficacy when deploying self-care mechanisms. The significance of creating policies and practices that focus on healthcare educational needs, specifically women detainees, ultimately enhance knowledge and skills leading to reduced recidivism amongst women prisoners

(Braithwaite, 2005)[44]. These women will return to our communities and they are our responsibility. We are aware of the policies and procedures that may be in place, but self-efficacy can greatly increase the accessibility for improved health outcomes of our post incarcerated women population.

Are we doing enough? Are we doing all we can as healthcare providers for our communities? It is imperative to work together and improve our healthcare system for the health of our community.

[44] Ibid, 31

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Appendix A: Pre/post survey questions:

Pre/post survey questions:

Please circle your option from 1-5. At the end of the survey, please add the total points accumulated.
Thank you for your cooperation.

1.	What is your age: (Circle one) ☐ **18-21** ☐ **22-25** ☐ **26-29** ☐ **30-40** ☐ **40>**
2.	Are you male or female? (Check the box that apply) ☐ Male or ☐ Female
3.	Household Composition, your parents are/were: (Circle one) 5: Divorced 4: Separated 3: Widowed 2: Single/Never Married 1: Married/ Domestic Partner
4.	How would you rate your health: (Circle one) 5: Excellent 4: Good 3: Fair 2: Poor 1: Unknown
5.	How often do you see your health care provider/physician: (Circle one) 5: Often (5-6 per/yr.) 4: Somewhat often (4-5 per/yr.) 3: Occasional (2-3 per/yr.) 2: Rarely (0-1 per/yr.) 1: Never (0 visits)
6.	Please rank the following in order of importance from 1 to 5 where 1 is the least important and 5 being the most important to you when accessing care: ☐Speed of Service ☐Ease of Parking ☐Cleanliness of the Clinic

	☐Friendliness of Staff ☐Personal Approach by the healthcare provider/Doctor
7.	Have you seen a healthcare provider for contraceptives? 5: Yes or 1: No Are you currently sexually active? 5: Yes or 1: No Are you in a safe relationship? 5: Yes or 1: No Have you seen a healthcare provider for family planning counseling? (Circle One) 5: Yes or 1: No

Have you been told you had any of the following illnesses?

☐Diabetes or High Blood Sugar
☐Hypertension or High Blood Pressure
☐Hyperlipidemia or High Cholesterol
☐Gout
☐Cancer
☐GI (Gastrointestinal) or GU (Gastrourinary)
☐Emotional, social or psychological
☐Women Health (breast, reproductive, etc)
Other: _____

How do you deal with stress? Pick your main way: (Select ALL that apply)

☐Talk to a friend (1)
☐Smoke (5)
☐ Sports / exercise (1)
☐Talk / think positively (1)
☐Drink alcohol (5)
☐Take action to deal with the cause (4)
☐Relaxation / Meditation (1)

☐Get counseling / professional help (1)
☐Take illegal drugs (5)
☐Talk to a parent (1)
☐Other (please tell us below)
_____
_____

Please circle your ethnicity: (Select ALL that apply)

5: Pacific Islander
4: African American/Native American
3: Hispanic/Latino
2: Asian
1: Caucasian/White

Upon release, were your health concerns and needs met during your incarceration?

5: No or 1: Yes

Were you on medications prior to confinement?

5: No or 1: Yes

Household Composition:

1: Myself

2: Myself+1

3: Myself +2

4: Myself +3

5: Myself >4	
Total Points	_____

Appendix B: Post survey questions

Post Symposium Survey

Please circle your option from 1-5. At the end of the survey, please add the total points accumulated.
Thank you for your cooperation.

1.	What is your age: (Circle one) ☐ **18-21** ☐ **22-25** ☐ **26-29** ☐ **30-40** ☐ **40>**
2.	Are you male or female? (Check the box that apply) ☐ Male or ☐ Female
3.	Current Marital status: (Circle one) 5: Divorced 4: Separated 3: Widowed 2: Single/Never Married 1: Married/ Domestic Partner
4.	How would you rate your health: (Circle one) 5: Excellent 4: Good 3: Fair 2: Poor 1: Unknown
5.	How often would you prefer to see your health care provider/physician: (Circle one) 5: Often (5-6 per/yr.) 4: Somewhat often (4-5 per/yr.) 3: Occasional (2-3 per/yr.) 2: Rarely (0-1 per/yr.) 1: Never (0 visits)
6.	Please rank the following in order of importance from 1 to 5 where 1 is the least important and 5 being the most important to you when accessing care:

	☐Speed of Service ☐Ease of Parking ☐Cleanliness of the Clinic ☐Friendliness of Staff ☐Personal Approach by the healthcare provider/Doctor
7.	

For future health conferences, are there topics you would be interested in? (Please select all that apply)

☐Diabetes or High Blood Sugar
☐Hypertension or High Blood Pressure
☐Hyperlipidemia or High Cholesterol
☐Gout
☐Cancer
☐GI (Gastrointestinal) or GU (Gastrourinary)
☐Emotional, social or psychological
☐Women Health (breast, reproductive, etc)
Other: _____

Have you seen a provider for any of the illnesses above? (Circle One)

5: Yes or 1: No

If YES, which one:_____

Would you attend this symposium again?_____
_____
Would you recommend it to others? Why?_____
_____

Please circle your ethnicity: (Select ALL that apply)

5: Pacific Islander
4: African American/Native American
3: Hispanic/Latino
2: Asian
1: Caucasian/White

How may we better prepare or provide a better experience for future symposiums?	
Total Points	_____

Appendix C: Symposium Itinerary

XII. SYMPOSIUM ITINERARY

THURSDAY, 2019

8:00 am Check-in Registration E Komo Mai (Welcome) --- Refreshments and Coffee

8:30 Pule, Oli Aloha, Sense of Place

9:00 Hi‘uwai (Ocean *cleanse – in the evening)* – Hawaiian 11:00 Lunch & Keynote

PANEL: “Voices from the Field Supporting Women & Girls – Hawaii’s Girl Court, DOH Public Health Nurse; WCCC”

12:00 Lomi Lomi *(Hawaiian massage)* – Hawaiian cultural practice

“Bridging & Integration – Connecting the Cultural Practice with Science” The Ancient Art of Healing - Lomi Lomi

FRIDAY, 2019

8:00 am Check-in Refreshments and Coffee

8:30 Pule, Oli Aloha, Sense of Place

9:00 Breakfast and PANEL: "Adopting a System of Healing in Hawaii – The Trauma Informed Care Initiatives at Women's Community Correctional Center (WCCC) Family Court, Office of Youth Services"

11:00 Lunch & Keynote

"Innovation & Integration: Justice Reform in Hawaii – Creating Places of HOPE & Healing"

1:00 pm Building a Beloved Community

2:00 pm Oli Mahalo, Dr. Manulani Meyer

Speakers:

Dr. Manulani Meyer, *Director of Indigenous Education, University of Hawaii, West*

Oahu.

Dr. Kyle "Kaliko" Chang, Psychologist, Waianae Coast Comprehensive Health Center &

Lomi Practitioner

Honorable Karen Radius, Hawaii Girls Court Founding Judge

Toni Bissen, Executive Director, Pū'ā Foundation

Dayna Miyasaki, Program Coordinator, Hawaii Girls Court