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HEALTH SERVICE UTILIZATION AND VICTIMIZATION AMONG INCARCERATED FEMALE SUBSTANCE USERS

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ABSTRACT

Women represent the fastest growing population of prison inmates, which has increased dramatically in the past decade. Generally, women use more health services than men but with limited access to health care, incarcerated women tend to experience multiple problems, including problems with drugs, alcohol, and victimization. The purpose of this exploratory qualitative study was to identify specific factors related to health, mental health, drug use, and violence among incarcerated female substance users. Perspectives from 34 females who participated in focus groups in prison are discussed. Key findings indicate that drug use, victimization, and living in a rural area were barriers to accessing health services. In addition, implications for interventions targeting women are presented. [Translations are provided in the International Abstracts Section of this issue.]

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INTRODUCTION

Drug use has been consistently related to crime and criminal justice involvement (1,2,3). In fact, it has been estimated that nearly 80% of prison inmates have experimented with illicit drugs, and half used an illicit drug during the 30 days prior to incarceration (4,5). In addition, women represent the fastest growing population of state and federal prisoners, which increased 506% from 1980 to 1996 compared to a 265% increase in the number of males (5,6). It has been reported that 25% of women were under the influence of at least one illicit drug at the time of their offense compared to 16% of men, and a higher percentage of women report committing crimes to get money for drugs than men (24% vs 17%) (5). Many women offenders initiated their use of drugs and/or alcohol at early ages, and many used drugs, especially cocaine, daily prior to their incarceration (7).

In general, women in prison may have multiple health problems that are compounded by limited health care they received before incarceration (8,9). In addition to "alcohol and drug abuse", the most frequently cited health concerns among incarcerated women include HIV, sexually transmitted diseases, pregnancy-related problems, gynecological problems, obesity, dental problems, and chronic health problems such as hypertension and asthma (9,10,11). Incarcerated women also experience a variety of mental health problems which include depression, anxiety, and post-traumatic stress disorder (PTSD) (12,13,14).

Further, a consistent finding in the literature is that a high number of incarcerated women report being victims of physical or sexual abuse (13,15,16). In fact, it has been estimated that more than 4 in 10 female inmates reported they had been abused at least once before their current incarceration (4) with about one-third reporting physical and sexual abuse. Lake (17) reported that over 85% of female inmates in her study had at least one type of victimization experience in her life.

Thus, while it is logical that victimization and drug use would have important implications for health, there has been limited focus in the literature on the relationship between drug abuse, victimization, and health service utilization among incarcerated female drug users. The purpose of this exploratory qualitative study was to identify specific factors related to use of health, mental health, and drug user treatment as well as the impact of

victimization on seeking services. Specifically, this study used focus groups to:

- examine availability, accessibility, and use of health services among female drug users;
- examine prevalence of victimization and associated service utilization among this population; and
- describe barriers to seeking treatment services.

METHOD

Participants

The 51 participants were incarcerated females from the Kentucky Correctional Institute for Women (KCIW) in Pewee Valley, Kentucky (see descriptive sample information in Table 1). KCIW, the only women's prison in the state of Kentucky, houses minimum, medium, and maximum-security classifications. There are approximately 650 women in the institution. Subjects were selected from the facility parole list between January, 1998 and March, 1999. The parole list ranged from 25–32 clients each month over the 14-month period. A total of 251 women attended the screener sessions. Study eligibility was based criteria for acceptance into the substance user treatment program. For example, to be eligible for the study, these women must have (1) self-reported problems with

Table 1. Selected Sample Descriptors

Age	35
Race	53% African-American 47% Caucasian
Education	Average of 11.4 years
Homebase	61% urban (50,000 people or more) 39% non-urban (< 50,000 people)
Marital status	47% separated or divorced 41% single 12% married
Employment	50% employed full-time 18% unemployed
Average number of lifetime arrests	5.6
Average number of months of incarceration	34

drugs—defined in the screening process as use at least 3–5 times per week during the year prior to incarceration; (2) no self-reported current or past violent charges; (3) been scheduled to see the parole board within the upcoming months; and (4) consented to participate in the study.

Procedure

Inmates received letters informing them of the larger study focusing on health and use of health care systems, and of a general screening. The letter indicated that the University of Kentucky was conducting a research project in which they could earn up to $50 for participating. Confidentiality for participation was ensured. Any interested inmates were invited to attend a group screening for more information. The group screening for eligibility was administered within the institution. Subjects were recruited into two groups: (1) Chronic drug users receiving treatment while incarcerated ($N = 16$) and (2) Chronic drug users in the general prison population ($N = 18$). For the overall project, inmates were interviewed individually regarding factors that are associated with their health and use of health services as part of a NIDA-funded grant. The overall study methodology has been described by Logan *et al.* (18). Baseline interviews took approximately 2 hours, and participants were paid $25. About three weeks following the initial interview, groups of six participants were asked to participate in a focus group. Three of the groups had seven participants. Each focus group lasted about 1.5 hours, and participants were paid $15.

Generally, focus groups are used to collect qualitative information using group interaction to produce insights and data (19). These focus groups allowed for more in-depth, and sometimes sensitive, conversations about victimization and associated barriers to health service utilization. Focus group questions were based on the literature, and a pilot group of six women in a court ordered treatment program. A series of questions were suggested as most important to service utilization. The questions were used to guide the discussion in the groups, and expansion around the topic depended on the interaction between clients. The questions included:

1) What kinds of health, mental health, and other resources are available for your children?
2) What kinds of health, mental health, and drug user treatment services are available in your community?

3) Do you use health care services on a regular basis or do you primarily seek care only when you are sick?
4) If a person is victimized, where would that person go in your community to get services?
5) Are there any special services available in your community for victims of physical, sexual, and psychological abuse?
6) If a person were an abuse victim, where would that person go for help?

For this study, focus groups were scheduled in the reserved visitation room at the institution. A white female served as moderator and guided each group discussion. Field notes were taken during the focus group discussion by a co-moderator.

The following introduction was used with each focus group:

Thank you for taking time to meet with us today. My name is (moderator). For this group, I will be asking questions to help our discussion. Everything we say today is strictly confidential. The project has a federal certificate of confidentiality and has been approved by the University of Kentucky human subjects committee to protect your confidentiality. (co-moderator) will be recording things said, but your name will not be used in any way. Each of you participated in the first part of this project which involved an interview that included your health and your use of health services. We're very interested in the health of women and how prison may affect health service utilization following release. This is the second part of the project. We are interested in hearing what you have to say about some of the same things. Since we believe there were things we weren't able to ask in the interview, we wanted to discuss those issues. We are here to learn from you. There are no right or wrong answers, and we ask that everyone's opinion be respected.

It is important that we hear from everyone. We're very interested in your opinions and views. We ask that only one person talk at a time. You will be paid for your participation, please be sure to fill out the payment form before you leave. Does anybody have any questions about the study or this focus group?

FOCUS GROUP THEMES

Qualitative content methods were used to generate themes by analyzing narrative data obtained through the focus group interviews. The respondents' comments followed five major themes, which paralleled the protocol

questions. However, as expected, a number of other themes emerged. These five themes are discussed below.

Theme #1: Health, Mental Health, and Substance Abuse Service Utilization

Common reasons for seeking health and/or mental health treatment included mental health concerns, substance use, and being separated from children. The most commonly used treatment facilities included health departments, emergency rooms, and community clinics. Almost half of the women indicated they used health care services regularly for preventative care and emergency situations. The remaining half of the women in each group indicated they would not go to the doctor regardless of the situation—"*I just go to bed when I'm really sick and suffer, I will not go to the doctor*."

Approximately two-thirds of the women reported using preventative gynecological services. Of those who used preventative care, participants indicated "*... that they heard what could happen to a woman's body*," and they were scared. In addition, respondents indicated that it's mandatory to use preventative medical care when a person has a medical card. Most women who reported being pregnant received prenatal care from regular doctors, Ob/Gyn physicians, health departments, and methadone clinics. Many of the women rated their relationships with health care providers to be average or better than average. Participants indicated they were tested for HIV on the street, and many had multiple HIV tests. These women also indicated they were tested regularly for sexually transmitted diseases and TB with yearly exams.

Health care, including dental care, in prison was not viewed favorably. Participants discussed difficulty getting appointments, problems with medications, having to pay for services, and a general lack of empathy by treatment staff. Participants stressed that it was difficult to get a proper diagnosis as well as access to needed specialized medical treatment while in prison. However, participants reported that they received yearly gynecological exams in prison. Participants discussed their general distrust and dislike for prison doctors. For example, "*I gave up on doctors here, I don't like them, and I don't trust them*." Despite negative impressions of prison health care, many of the women used more health services in prison than in the community.

In contrast, substance user treatment in prison was viewed very favorably. "*[It] is the best thing that has ever happened to me. I'm tired, I've been in and out of here [prison] since I was 22. Now I'm 45. I'm ready to live. I'm up for parole, I'm going to a halfway house, and I'm ready to get my life together and raise my grandchildren*."

Theme #2: Victimization and Health Services Utilization

An overwhelming majority of women had experienced physical, emotional, and/or sexual abuse at some point in their lives. However, victimization services were primarily used only if they were court ordered, or if a woman had "*reached rock bottom*." "*You have to do something before he kills you, or you kill him*." Participants indicated there were special services available for domestic violence victims, but mainly in urban areas. Some of the specific resources participants mentioned included private, public, and semi-public mental health facilities. Participants indicated that they found out about victimization services through the Yellow Pages, by word of mouth, from case workers, TV, newspapers, referrals from other services, from social workers, and from lawyers. In general, participants were very knowledgeable about services for victims.

Participants reported several reasons for not seeking domestic violence services which included being ashamed and embarrassed, fear that their families might be harmed, dealing with "*small town gossip*," not being ready to leave their abusive partner, guilt, and fear of going jail. In addition, these women suggested that a main reason for continuing to stay in abusive situations is fear of their abusers. This finding is consistent with community samples in other research literature (20,21). Also, being under the influence of drugs and/or alcohol was mentioned as a barrier to seeking treatment. Other barriers to seeking treatment for victimization experiences included the lack of privacy and/or insured confidentiality. For example, "*In a small town, privacy is an issue. Everyone is talking, and it affects your family, too. There is no confidentiality in a small town, but there is very little you can do about it*." One woman suggested that mental health services should be more sensitive to the needs of women who are victims, that services should be gender specific, and that services should be available in a case of domestic violence, "*I just want to put it behind me and not deal with it*."

The criminal justice system was not seen as a source of help. Participants also reported being treated unfairly by the police—"*especially if they know you use drugs*." One respondent reported that "*Being in prison would make me less likely to seek services after being victimized, due to my history with the criminal justice system*." "*The police are not helpful, and generally both people go to jail*." "*I would never ever call the police*." "*If you're on parole/probation and you're involved in domestic violence, you're going to prison, and he knows that. He'll use it against you*."

Stalking was a common experience among one or two women in each of the focus groups. Some reported being followed by their batterers, being phoned repeatedly, and having stalkers drive by their houses. "*I lived in*

constant fear. The police told me to buy a gun and kill him.'' ''*The police watch how many times the victims go back, and they won't help anymore.*''

Participants indicated that they believed domestic violence has a large impact on health. ''*I still see spots to this day, and you can't always go for treatment because you are afraid.*'' It also affects mental health, ''*. . .especially low self esteem.*'' Women also reported being depressed, anxious, and hopeless. For example, one woman reported that ''*I believe I was put on this earth to be abused. It's been a pattern throughout life.*'' Domestic violence greatly enhanced drug use among these women, ''*I started using after the abuse started. My drug abuse just continued to get worse.*''

When these women were asked about specific sources of support for victims of domestic violence, their responses were inconsistent. Some women believed they could seek help from their families, but ''*They get torn because you often go back to the abuser.*'' Several indicated that friends could also be contacted to help if they were being abused, but it could be difficult for the same reasons. Several women indicated they felt comfortable going to the police if they were victimized. When asked if they could seek the services of a social worker, most women said ''*No.*'' They stated that social workers would take advantage of the opportunity to take away their children. Other participants indicated they were comfortable turning to a religious counselor if one was available and could be trusted. A couple of women indicated they could talk to their employers, mental health professionals, and others used hotline numbers.

Theme #3: Barriers to Health Service Utilization

A major theme emerged related to barriers in seeking health care. Consistently across the focus groups, drug use was the predominant barrier to service utilization. ''*I used to go regularly until I started drugging—then I'd only go when things got really bad, and I'd go to the ER [emergency room].*'' All of the women indicated that it was very important for women to pay attention to themselves. However, when they were using, they didn't care about anything but drugs. Of the women who sought services, they reported most commonly visiting the ER for things like broken wrists, broken ribs, broken back, stitches, and labor pains. ''*Once, I took my daughter to the doctor, and they admitted me. I was seriously ill with pneumonia and so out of it on drugs that I didn't even know.*'' In addition, these women indicated that when they had problems they usually turned to drugs.

Other drug-related barriers to accessing health services included fear of being identified as a drug addict and the need to self-medicate—using

drugs to take away the pain they felt. Most of the women indicated that they used services only during an illness, but they all agreed that they never visited a doctor when they were using drugs. "*My back would hurt real bad, but I would just keep using drugs and didn't go*." "*When I was drugging, my blood pressure didn't seem like a problem to me. I felt great*." "*When I was using, I didn't have any worries*." Another woman said, "*I would have to switch doctors because I kept lying to cover my use. No wonder I kept being misdiagnosed, I never told them the truth about drinking every day and using drugs*." "*I would rather use money for drugs than to go to the doctor*." One participant indicated that she failed to get pre-natal care while using drugs because she was afraid of being identified as a drug user. In fact, in addition to not seeking medical care when ill, drug use was mentioned as the primary reason for not getting regular check ups and physicals.

Payment for services was the second most common treatment barrier. Several participants indicated they were embarrassed because they didn't have much money, and staff at several health care facilities "*treat you nasty*". There was considerable discussion related to the lack of emergency room (ER) service coverage by Medicaid. "*I took my daughter to the ER, and they sent us home with an emergency and told us to wait until the next day*." "*I went to another ER and didn't tell them about Medicaid—so they billed me, and Medicaid was not happy*." "*Because of payment, I couldn't get into a doctor so I have to go to different hospitals. I could never get help because I don't have children*." "*The ER is the only place you can go to, and they want to refer you to a specialist, but you can't go because of the money*." "*My brother was turned away because of no insurance and went to another ER and was told he was diabetic*."

The long wait to get an appointment at publicly funded community treatment, sometimes taking up to two months, also emerged as a major barrier to using treatment. However, if treatment was court ordered, participants indicated that treatment access was easier.

Theme #4: Urban/Rural Differences in Treatment Access

Participants in the focus group represented different regions of the state. Over half were from larger cities, but others were from smaller towns and rural areas. A general theme related to service utilization and service availability emerged. Women from metropolitan areas reported more and increasing access to services, less difficulty in making appointments, decreased waiting times, and had more favorable attitudes towards health, mental health, and substance use facilities when compared to women in rural areas. In fact, participants agreed that people have more treatment

options and an increased sense of confidentiality in larger cities. In addition, children's health and other services were limited in small towns. For example, several rural participants indicated that their towns had only one health department and the nearest hospital was miles away.

Comments from women in metropolitan areas included: "*The housing project where I live offers a lot of services—health care, drug stuff, and recreation for the kids. Some people use these services, not the number that should, but they're there if you want them.*" "*The [university] hospital has dentists from the dental school and doctors in the clinic in my neighborhood. We use those services a lot.*" "*There are lots of services. Shelters for domestic violence in major cities... [my city] offers things like victims rights which is offered through the courts, and some mandate classes on anger management.*"

Comments from women in rural areas included: "*It's different where I'm from and where she's from. There aren't enough staff in smaller towns, not enough docs, they may come to town once a month.*" "*In the place where I live, there's only one place for everything—mental health, substance abuse, everything. I'm sure it's different in a big town.*" For domestic violence issues, "*If you call the police in rural areas, you'll both go to jail...we both went to jail, no services, we get separated, granted domestic violence orders, he usually violates, and we both go back to jail. I've had stitches, he's tried to kill me, tried to kill my baby—nothing ever happens.*" "*They are not at all helpful.*" "*They want to tell your business.*" "*I don't like the women that work there—they're typical small town.*" "*They tell your test results ... (to others).*"

Theme #5: Health, Mental Health, and Substance Abuse Service Utilization for Children

An apparent theme in the focus group discussion centered on health care services for children. The majority of women (88%) said they had children (an average of three children each), and a large reason for contact with services involved seeking care for their children. Several of the children had participated in counseling, mental health treatment, and/or substance abuse treatment. A variety of resources were available for children's health and mental health care. Specific examples of health care services included a range of private, public, and semi-public services across the state including local health departments, emergency rooms, and mental health treatment centers.

When these women took their children to a doctor for health care services, most of them indicated they used a local health department. However, some women used clinics, private doctors, or a family physician. Most women reported they had a medical card and used the services

designated by their medical card. Most participants indicated that they took their children to the doctor when it was necessary, sometimes as often as every three months. Other women only took their children to the doctor when they needed something like a physical. Common complaints with the health department included long waits (3–5 hours) and rude staff. However, most participants indicated that "*Medical care was pretty good, once you get to see a doctor*." Overall, it appears that services were available. The consensus among participants was that they always took their children to the doctor for check-ups and for health problems. But only a few participants reported that their children had received treatment for substance abuse problems.

Less than half of respondents indicated that the Women, Infants and Children's (WIC) program was a good resource for their children. For the most part, the WIC program tries to keep participants with a consistent doctor, which was perceived as positive. The women also indicated that it was easy to get appointments for their children with WIC. However, sometimes services were not favorable. For example, one respondent indicated, "*We had to change because they would always give some medicine that didn't work anymore, and they wouldn't listen to me that he needed different medicine*."

Less than 10% of the participants indicated that they would mention their own personal problems when taking their children to the doctor. Overall, they were very satisfied with the community health and mental health services their children received. Most of the participants indicated that they had a good relationship with their children's health care providers. In addition, most of the women indicated that they took their children to the doctor for both routine physicals and for health problems.

CONCLUDING REMARKS

These focus group findings indicate that there are a variety of health related services in rural and urban communities for women and their children. Overall, participants indicated that they used community health services for their own routine check-ups and when they experienced physical health problems. Participants specifically indicated that they went to the doctor when they needed services, but there was a general distrust and dislike of physicians. The number of women in this study who reported seeking health care for physical illnesses, preventative health care, and care for their children was somewhat surprising given the general lack of accessibility to these services mentioned in the literature (11).

While service availability did not seem to be an issue, accessibility appeared to be limited by a variety of factors. The literature indicates that a large percentage of incarcerated women are poor minority women with inadequate housing and dependent children—thus limiting their access to community-based health systems (11). However, the most significant identified barrier to health care in this study was drug and alcohol use. Some feared getting caught while others said they did not care enough about themselves to seek treatment when they were using drugs. Other participants indicated that they used drugs to self-medicate and treat their own health problems. Other issues affecting access to health care included lack of money (sometimes due in part to supporting a drug habit), living in a rural area, and victimization.

Like other studies focusing on incarcerated women (13,14), a large percentage of these women reported past victimization experiences. While most women were familiar with community resources for domestic violence, they indicated that these services were rarely used. Major barriers to seeking services included "substance abuse" and their ability to self medicate through use of drugs and/or alcohol. This finding is consistent with other studies which report that victimization is associated with substance abuse (22,23,24,25). Additional barriers to seeking services reported by these women included guilt, shame, and fear, which are also consistent with barriers identified in the literature (20,21,26). The literature also indicates that other reasons for victims not seeking services include cost, lack of time, unsympathetic doctors, fear of being identified as a victim, and denial of injury (27,28,29,30,31). In summary, according to these focus group findings and the recent research literature, not only did domestic violence have a tremendous impact on the health and mental health of the victim, it also serves as a major barrier for seeking services.

There are limitations to this study. This paper provides information about a small, selected sample of incarcerated female substance abusers in Kentucky. For this reason, results may not be generalizable to other incarcerated women. In addition, there is a potential bias of responses given the focus group setting, even though confidentiality was assured and maintained. Despite these limitations, implications from this study provide important insights for further research. The finding that health services, substance user services, and mental health services are available and used was not expected—particularly for these women and their children given some of the previous research literature (11). This raises the question of who seeks health services and what are the necessary conditions for service utilization—which if answered, could create an opportunity for community-based systems to better target outreach and other services, particularly in rural areas. While the issues affecting service use need to be further explored,

our focus groups indicate that prior to entering prison, female drug users have increased barriers to seeking needed health, mental health, and substance user treatment. Research should examine these issues in more detail in order to reduce barriers by designing the most appropriate and cost effective interventions for drug using women and their children.

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