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# The scope of the problem: The health of incarcerated women in BC

Women in prison face a number of challenges not faced by their male counterparts, including lack of gender-specific health services and traumatic separation from their children.

**ABSTRACT: About 10% of the prison population in British Columbia is women; the annual number of provincial admissions for women may be as high as 3700. Consistent with the rest of Canada, Aboriginal people are overrepresented in the criminal justice system. There is a greater prevalence of bloodborne infections in incarcerated women. Women in prison tend to be of childbearing age, and the problem of separation from their children is inadequately dealt with in our current system. Continuity of health care delivery as women revolve from the community to prison and back to the community is essential for improved health outcomes. Incarcerated women share their ideas regarding their health goals and recidivism.**

In 2009 37 057[1] individuals were admitted to the correctional system in BC, of whom approximately 10% were female. Women in BC are incarcerated in either the federal or the provincial correctional system.

Women in the federal system (Correctional Service Canada) have received a sentence of 2 years or longer. Women may serve their sentences in custody, on parole in the community, or a combination of both. The Fraser Valley Institution (FVI) in Abbotsford houses all federally sentenced women in BC. On any one day, 57 women will be housed at FVI and 39% of them will have a sentence of no longer than 40 months.[2]

Women in the provincial system include those remanded to custody (awaiting trial) and those sentenced to less than 2 years. Women may serve a custodial sentence, a community sentence, or a combination of both. Those who serve a custodial sentence will be housed in one of two facilities in BC: the Alouette Correctional Centre for Women in Maple Ridge or the Prince George Regional Correctional Centre. Because of increasing incarceration rates, projections indicate the provincial correctional system will eventually need 189 additional staff members to oversee approximately 300 new cells.[3]

On any one day, the provincial correctional system houses 2800 individuals, of whom 10% are women.[4] However, because of short prison stays and high recidivism rates, the annual number of provincial admissions for women may be as high as 3700. Recidivism rates for women with short prison stays in BC are difficult to define, determine, and interpret. The so-called revolving door scenario contributes to the problem of unmet health care needs for women, both outside and inside of prison.

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## Demographic characteristics and health status of incarcerated women

Throughout the world incarcerated women tend to be younger than the general population; they tend to be of childbearing age and to be poorly educated. In addition, women who are imprisoned have usually experienced physical and sexual abuse.[5]

Aboriginal peoples are overrepresented at all levels of the Canadian criminal justice system and account for approximately 20% of offenders serving a sentence in custody across Canada,[6] even though only 3% of Canadians are Aboriginal.[7] In BC approximately 40% of women in the provincial system and 25% in the federal system are Aboriginal.[7] Incarcerated adult Aboriginal people are generally younger, have less formal education, and are more likely to be unemployed than are incarcerated non-Aboriginal people.[8]

The guiding principles of the 2003 World Health Organization (WHO) Moscow declaration states that "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[9] The WHO Kyiv statement identifies women in prison and their children as a population with particular health needs that require gender-sensitive approaches.[10] Incarcerated women are a minority and are therefore often housed in prisons that were designed for men and are located at a great distance from their families and communities.

Consistent with world literature findings on the health of incarcerated women,[11] many health conditions are more prevalent among incarcerated women in BC than in the general population. Because the majority of women with provincial sentences are incarcerated for crimes associated with substance abuse,[4] there is a greater prevalence of bloodborne infections such as HIV and hepatitis C among incarcerated women.[11] Prevalence estimates for psychiatric illness are as high as 80% for female offenders.[12]

A disproportionate number of marginalized women with HIV are incarcerated[13] and these women face many challenges when accessing care. These challenges include physical isolation, issues of confidentiality/stigma, organizational constraints, and limited access to harm-reduction and other therapies. In addition, many women face interruptions in their therapy when they are released because of the time needed to make new connections in the community for HIV care.[14]

Women in prison globally experience greater mental and physical illness than men in prison, and than the general population.[15-18] The higher prevalence of mental health problems is frequently a result of abuse and victimization. Psychiatric diagnoses can include posttraumatic stress disorder, depression, anxiety, and phobias.[19-24] Women in prison also report massive weight gain during their imprisonment, which has been attributed to the metabolic changes of drug withdrawal, high-carbohydrate prison diets, methadone maintenance, prison canteen options limited to high-calorie snacks, boredom, and inactivity.[25-34]

## Separation of women from children

In Canada 85 000 prison admissions involve women every year, with admissions for remand and other reasons being double that number. Based on these figures, an estimated 20 000 Canadian children are separated from their mothers because of incarceration every year, and that number rises as penal populations increase year after year.[35] It is now recognized internationally that children need to maintain parental relationships with their incarcerated mothers.[36] Indeed, a 1990 Task Force for Federally Sentenced Women recommended an expansion of infant and mother health initiatives in Canadian correctional facilities. Previous research has demonstrated that the relationship between a mother and her child is a positive predictor of a woman's successful transition into the community following incarceration.[37,38] Women who experience traumatic separations from their children are significantly more likely to be reincarcerated.[39]

Some women are separated from their children before their incarceration because their children are apprehended by child welfare authorities. In most cases this is because of concerns about maternal substance abuse. For these mothers and children, incarceration then prolongs or intensifies the separation. In other cases, the incarceration itself precipitates the separation of mother and child. Moreover, because there is only one major provincial women's prison in BC (and in most other Canadian provinces), women may be incarcerated far from home. Poverty and limited social resources exacerbate the effects of geographic dislocation, as the high cost of travel and long-distance telephone calls further separates female inmates from their children.

Housing is a basic determinant of health.[40-43] Homelessness and unstable housing (living in shelters and temporary accommodation) negatively influence health and well-being[44,45] by increasing the risk of contracting tuberculosis and HIV,[46,47] contributing to higher rates of mental illness and substance abuse, and increasing mortality.[47-49] Historically, homeless populations were predominantly white, male, and single.[50] However, recent studies report more housing instability among women, and indicate this is

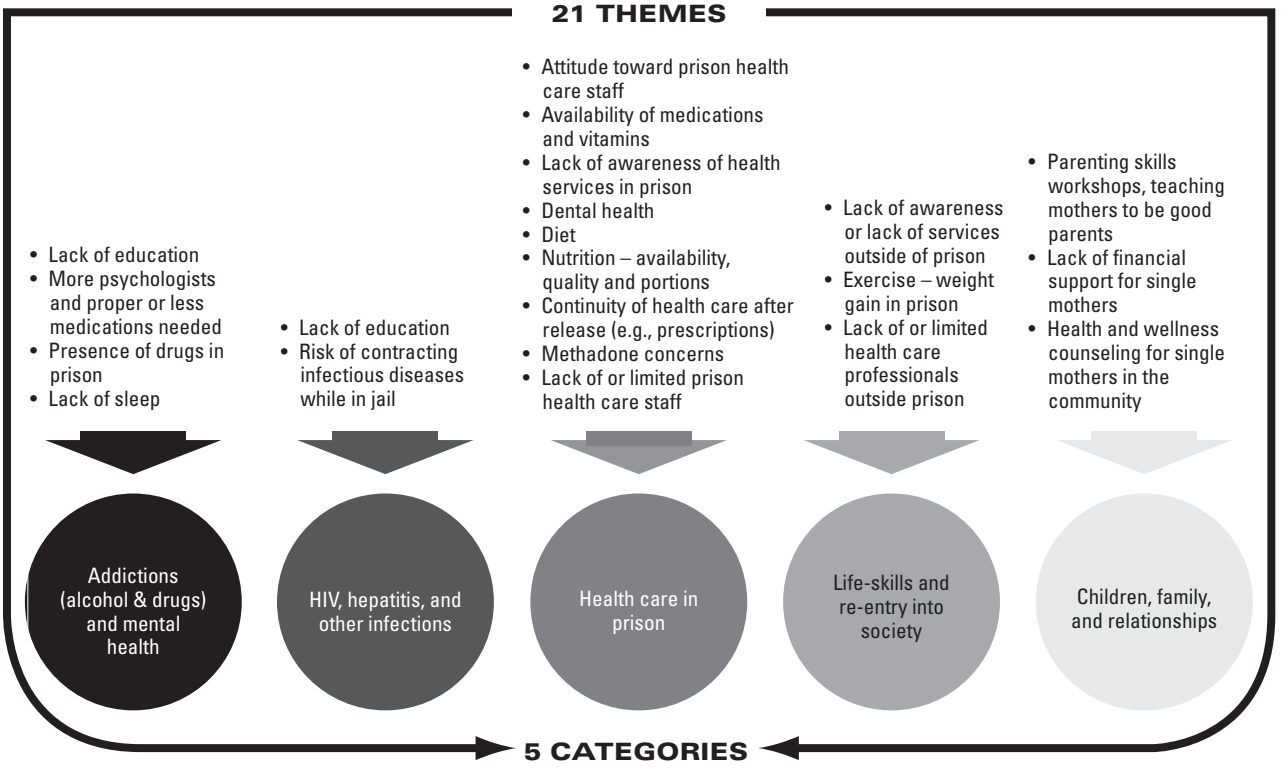


**Figure 1. Twenty-one themes and five categories identified by incarcerated women and prison staff.[10]**

Source: Martin RE, Murphy K, Chan R, et al.[61]

associated with substance abuse and depression,[51,52] mortality among young women,[53] and positive HIV status.[54] In BC, an estimated 30% of people with substance abuse, mental illness, or both (SAMI) live in unstable housing.[55] Homelessness and incarceration appear to increase the risk of each other, and both seem to be mediated by mental illness and substance abuse, and disadvantaged sociodemographic status.[56] A recent report on BC provincial corrections states that 76% of female and 53% of male inmates were found to have SAMI; additionally, 37% of women and 21% of men were found to have a non-drug-related concurrent mental illness.[12]

## Need for throughcare

Internationally, it is recognized that "throughcare"—the continuity of health care services as an offender moves from the community to the correctional facility and then back out into the community—is essential for improved health outcomes. The WHO and leading medical journals recommend that countries align their prison health care services with the public health and primary care services provided for their general population.[11,57-59] Accordingly, several jurisdictions (Norway, United Kingdom, France, and New South Wales in Australia) have transferred the provision of health care for their incarcerated populations from the Ministry of Justice to the Ministry of Health.[58]

In Canada, health care for people who are sentenced to 2 years or more (federal sentences), are delivered by Correctional Service Canada Health Services,[60] a stand-alone entity operating under the auspices of Correctional Service Canada. In BC, health care for people in provincial correctional centres has been contracted out to private health care providers since 2004. In Nova Scotia, health care for provincial correctional institutions was transferred to the jurisdiction of the Capital District Health Authority in 2001.

## Research into health and recidivism

During the summer of 2005, in preparation for a research project about enhancing the health and social well-being of women in custody, the following open-ended question was asked during in-depth one-on-one interviews with 16 incarcerated women, and in group interviews with 16 correctional officers: "Tell us what you think are the major health concerns for women in prison that the prison participatory health research

project should address?" Twenty-one themes emerged from an analysis of these interviews.

In October 2005, a full-day face-to-face meeting with 120 incarcerated women, 10 correctional services staff (correctional officers and contracted health and allied staff), and 5 academic researchers was held to discuss the summer findings. During this meeting, the 21 themes were grouped under five headings:

- Addictions and mental health.
- HIV, hepatitis, and other infections.
- Health care in prison.
- Life-skills and re-entry into society.
- Children, family, and relationships. (**Figure 1**)[61]

During the October meeting, participants also agreed on five shared values, namely, to ensure transparency of all information, to break the code of silence, to respect diversity ("listen and be heard"), to build on strengths, and to involve all who wish to participate in the research process. These values became guiding principles for developing all research processes. When a participatory health research project began inside a BC provincial correctional centre for women in October 2005, these values ensured an equitable partnership approach for the creation of the research team, with community members (incarcerated women and prison staff), organizational representatives (prison managerial staff), and academic researchers sharing their experiences and expertise, and all contributing to all aspects of the research.[62-64]

Subsequently, nine health goals emerged from the five health categories (**Figure 2**).[65] These were identified by incarcerated women as essential for their successful reintegration into society following their release from prison, and reflect the women's desire

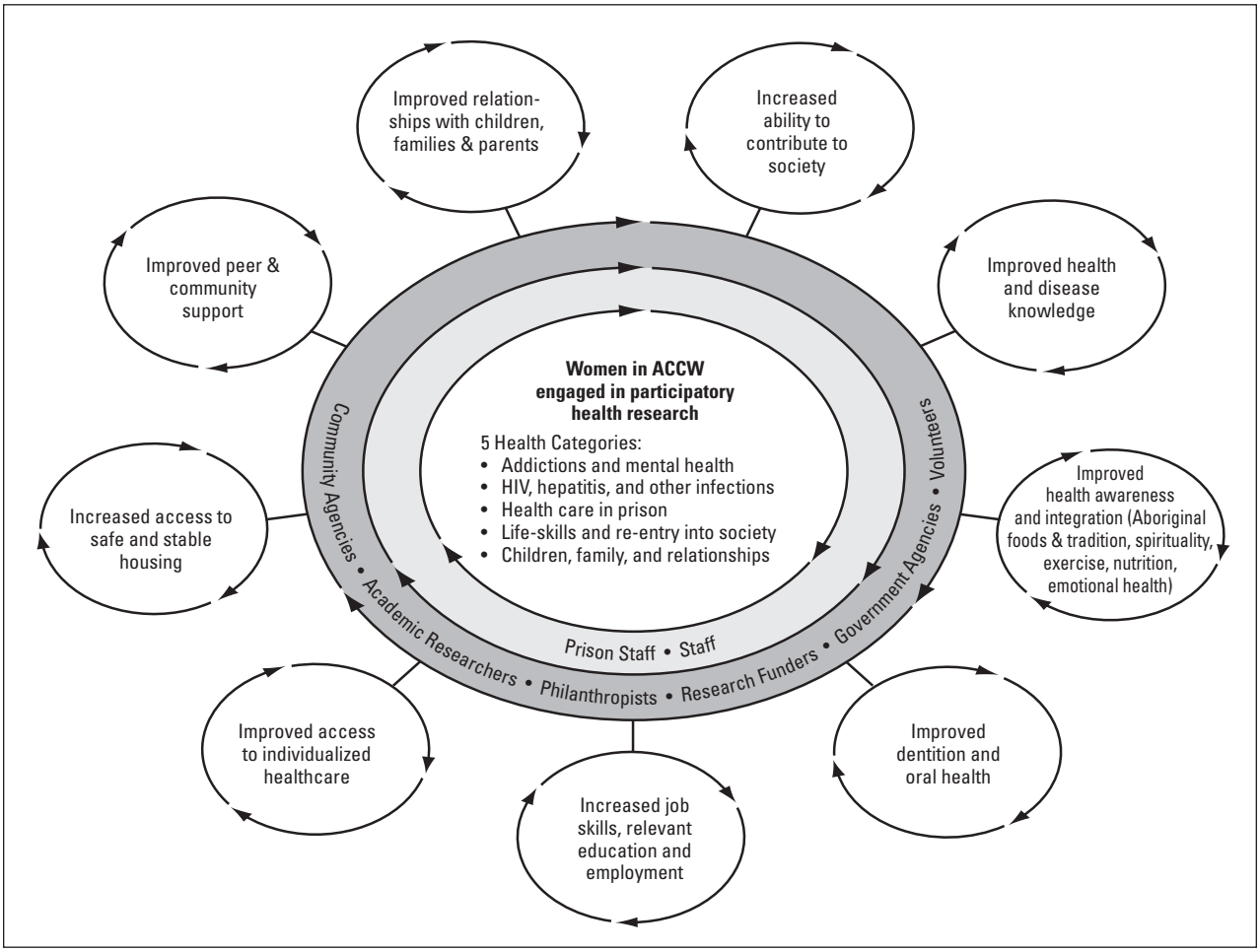


**Figure 2. Nine health goals emerging from five health categories.[11]**

Source: Martin RE, Murphy K, Hanson D, et al.[65]

for health not only while in prison but also in the community after release from prison.

During the participatory health research project, incarcerated women designed and implemented a cross-sectional survey with both closed and open-ended questions. Data from the survey illuminate the role played by homelessness and unmet housing needs.[66] Eighty-three women completed the survey (72% response rate). Of 71 respondents who were previously incarcerated, 56% stated that homelessness contributed to their return to crime, 63% reported difficulty finding housing upon previous release, and 34% desired relocation to another city upon release. Those with five or more previous incarcerations were more likely to report difficulties finding housing (OR 6.51, 95% CI: 1.53-27.71), and less likely to report a desire for relocation (OR 0.18, 95% CI: 0.04-0.86). Although 83% of respondents said they preferred housing exclusively for ex-prisoners, there was no "one sort fits all" type of accommodation requested.

Most women saw financial restrictions as the main barrier to finding housing upon release, as illustrated by the following responses:

*"Rents too high, lack of references. Released with five bucks and nowhere but the street. How are you supposed to live with that?"*

*"It's hard to get a place when you're released with nothing. Not having housing prior to coming to jail or any family to go to upon release. You get out and [have] no one to share [costs] with."*

*"Social assistance gave me a hard time when applying for rent."*

Women also reported that the lack of basic needs associated with homelessness led them to crime in order to survive.

*"Gotta do what you gotta do to survive. Need $ for place to sleep and food. Turn to crime to survive."*

*"If I only had a place to sleep I would not have to commit so much crime… I had nothing and no money and no house and no food or drugs. I do crime to eat, support my [drug] habit, [have] place to rest."*

*"Every time I have been released I have always started out on the street. Being left on the street it's easy to fall back into the street life. No place [to live] means back on drugs and do crime to support it—it's a vicious cycle."*

In addition, women described homelessness as a barrier to employment, which in turn contributed to their return to crime:

*"I was on the street again. I had to make money by selling dope because if you don't have a [home] address no one will hire you."*

*"Without a place to live it's hard to sleep and without sleep it's hard to get work."*

*"I had nowhere to live so I was not able to gain employment, therefore I stole someone's money to survive."*

From 2008 until 2011, another community-based participatory health research project[67] followed over 400 incarcerated women for up to 18 months after their release from provincial correctional centres in BC. The project aimed to determine which of the barriers that women face as they seek to achieve their nine health goals also contribute to their high recidivism rates. Preliminary analysis of this data supports the hypothesis that incarcerated women's recidivism rates are directly related to their unmet health and social needs.

## Summary

Women in both the provincial and federal correction systems in BC tend to be younger than the general population and poorly educated. Many are also mothers. Bloodborne infections such as HIV and hepatitis C are more prevalent among incarcerated women than incarcerated men, as is mental illness; in addition, women commonly have a psychiatric diagnosis, post-traumatic stress disorder, and a history of abuse and victimization. Incarcerated women in BC identified nine health goals as essential for their successful reintegration into society following their release from prison, including the provision of safe housing and improved relationships with their families.

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**Competing interests**

None declared

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