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The Experiences of Criminalized Women When Accessing Health Care Services During Incarceration Within Provincial Jails: A Critical Narrative Study

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A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science

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THE EXPERIENCES OF CRIMINALIZED WOMEN WHEN
ACCESSING HEALTH CARE SERVICES DURING INCARCERATION
WITHIN PROVINCIAL JAILS: A CRITICAL NARRATIVE STUDY

(Thesis format: Monograph)

by

Shamiram Zendo

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science

The School of Graduate and Postdoctoral Studies
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Abstract

There has been a noticeable increase in the imprisonment of women in Canada, within the last 20 years. The purpose of this critical inquiry was to capture and promote the voices and stories of criminalized women, in order to serve their interest. Five individual in-depth interviews were conducted with women, who were incarcerated in provincial jail. A critical paradigm was used to explore how socioeconomic and gender inequalities, embedded in the social, political, and historical contexts, influenced criminalized women's experiences when accessing health care. The findings of this study described how criminalized women experience fragmentation in health care access, which encouraged the women to engage in sharing of illicit drugs. Furthermore, the study findings illustrated that neo-liberal policies have negatively influenced the criminalized women's ability to self-care.

Keywords

Criminalized women, health care access, provincial jail, narrative inquiry, critical theory, qualitative

Dedication

To my father and mother,

Mansour Zindo and Juliet Khayel

Thank you for your love and words of wisdom

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Chapter One: Introduction and Background

In this chapter I will provide an introduction and background information about the study topic, and include a discussion regarding the concept of criminalization, the state of criminalized women in Canada, definitions of health and wellness, and frame health care as a human right. I will also provide a discussion regarding the life contexts of criminalized women (i.e., gender, ethnicity, social, and economic status) as influential in shaping women's health and access to health care. I will conclude this chapter by stating the purpose of this study, and my personal story as a researcher.

Criminalized Women in Canada

Women have been underrepresented in the correctional system in the past, and as a result women's diverse needs have often been neglected (Braithwaite, Treadwell, & Arriola, 2005; Holtfreter, & Morash, 2006). There has been a noticeable increase in the imprisonment of women in the last 20 years. The number of women incarcerated in federal correctional institutions within Canada has increased by 69.9% from 204 individuals in 2003 to 350 individuals in 2012 (Public Safety Canada, 2014). The total number of individuals sentenced to provincial/territorial jail in the year 2011 was 74,356 (Public Safety Canada, 2014). According to Statistics Canada 12% of admissions into provincial/territorial jail are women (Statistics Canada, 2010).

The increase in the imprisonment of women, in provincial/territorial correctional jails, results largely from minor property crimes (i.e., shoplifting or fraud), drug-related crimes, public-order offences, drinking offences, traffic offences or drug offences. According to the Ministry of Community Safety and Correctional Services, only 9% of

women incarcerated in provincial/territorial jail have committed violent offences relative to 98% of men (Braithwaite, Treadwell, & Arriola, 2005; Correctional Services Canada [CSC], 2015); furthermore, many women have been incarcerated in provincial institutions for non-threatening minor infractions such as breach of their court or probation orders (Braithwaite et al.). According to the CSC about a 25% of the women serving sentences in provincial correctional institutions are repeat offenders of minor offenses (CSC, 2015). The approximate population of women serving time within Canadian federal institutions, between 2011 and 2012, was about 350 women; a small number of these women have been convicted of serious offences such as manslaughter or murder (CSC, 2015). Criminalized women incarcerated in federal correctional institutions are sentenced to a period of time longer than 2 years for infractions and persistent offenses usually linked to robbery, drugs, theft, and fraud (CSC, 2015).

The characteristic of many women who have been charged with a criminal offense and who have spent time in correctional institutions include experiences of unemployment, low levels of education, physical abuse, substance abuse, and mental health issues (Amaro, Raj, & Reed, 2002; Johnson & Raphael, 2009). An estimated 70% of criminalized women in Canadian correctional institutions are mothers, and 70% of these are single mothers; furthermore, an estimated 53% of these women have been sexually abused. Their children are often left with family, friends, or children's services when the mothers are serving their sentence (Amaro et al.).

The Definition of Crime and Criminalization

Crime, in democratic societies, is defined as “that which a democratically selected legislative body has determined to be unlawful activity (commission) or (omission), for which there is a prescribed legal sanction” (Hunter, & Dantzker, 2011, p.21). In order to be labeled a “criminal” one must commit an illegal act or not act in a way required by the law (Hunter, & Dantzker). Criminal behaviour is viewed as “any action or failure to act as defined by criminal law” (Hunter, & Dantzker, p.21). Criminality occurs when specific behaviours are transformed by society into crime, and the individuals that engage in those behaviours are identified as criminals (Hunter, & Dantzker).

According to Mosher & Brockman (2010), “criminalization simply captures a categorization or a classification choice- the choice to legislatively define (usually through the exercise of federal criminal law power) particular unwanted or undesirable conduct as a ‘crime’” (Mosher & Brockman, 2010, p. 3). Federal criminal law power refers to section 91(27) of the *Constitution Act, 1867* consisting of the legislative powers allocated to the federal government, and it has been the foundation of federal legislation in matters relating to health (The Parliament of Canada, 2013). The Supreme Court of Canada has taken a comprehensive view of the criminal law power, which seeks to protect the physical health and safety of the public through methods that control possibly risky products and situations (i.e., controlled substances, drugs/food, medical devices, industrial/consumer products, tobacco, cosmetics, & radiation) (The Parliament of Canada, 2013). Therefore, “crime” is socially constructed and the characterization of a specific behaviour or conduct as a “crime” is one of the many ways to build and order social reality. Furthermore, “crime” is not the object of the criminal justice strategy, but

produced by it (Mosher & Brockman). As an example, gambling is condoned by the government and is a legal and legitimate activity; however, gambling outside the parameters set by the government is still seen as criminal behaviour. Since gambling exists as an illegal and legal activity, it indicates that the “criminal” status is a result of choice rather than being an intrinsic quality of the activity itself (Mosher & Brockman). Criminalization is based on the view that the state commands a certain set of behaviours and individuals obey, or receive punishment for disobedience; thus, criminalization assumes the unidirectional exercise of power between the state and subjects (Mosher & Brockman).

Within the literature that explores the experiences of women, who serve time in federal prisons and provincial jails, women are referred to as “criminalized” and not as “criminals”. I will also be using the term “criminalized women” throughout the study (Laberge, 1991). The notion of “crime” encompasses different types of behaviours and/or situations. Recent critical analysis of “crime” noted that crime is socially constructed through the process of “incrimination”, where different entities that make up the criminal justice system actively contribute to the construction of criminality (Laberge, p. 50). There are three issues associated with the classifying women as “criminals” (Laberge, p. 49). Firstly, this notion supports the impression that crime is the manifestation of the individual, and fails to take into consideration the broader social factors influencing the construction and definition of “crime”. Secondly, “crime” is a social product resulting from the interaction of women with various government agencies (e.g., provincial jail), and this is important since criminality and incrimination are strategies contracted by agents within the correctional system (Laberge). Thirdly, the notion of “criminal” is very

powerful at constructing negative images that are not appropriate to use when representing women in conflict with the correctional system (Laberge). Critical criminologists aim to illustrate how specific groups of individuals are criminalized (Pollack, 2004). This is done by using a critical approach that seeks to explain how socioeconomic, ethnic, gender marginalization and the resistance to these conditions may lead to criminalization (Pollack). A critical approach is taken in order to challenge the dominant constructed narrative which assumes that ‘good’ choices are equally available to everyone, and all people have the inherent freedom to pursue their goals. The critical approach aims to unpack the impact of social context on people’s ability to have choices (Pollack).

Canadian Correctional System and Health of Criminalized Women

The Canadian Correctional System

Canadian correctional system is divided into federal prisons and provincial jails. In Canada there are 42 federal institutions, six of which are for women (Correctional Service Canada, 2014). Men’s federal prisons are divided into minimum security facilities, medium security facilities, and maximum security facilities (Correctional Services Canada [CSC], 2014; Statistics Canada, 2014). The women’s federal prisons are multi-level security prisons, and this means that women serving minimum, medium, or maximum prison sentences are placed together in one institution. Correctional Service Canada (CSC) is responsible for supervising incarcerated individuals (CSC, 2014).

Individuals who are sentenced to custody for a maximum of two years less a day are placed in provincial and territorial jails (Statistics Canada, 2013). Adults who are ordered to be held in custody before or during trial (i.e., immigration holds) are also

placed in provincial/territorial jails (Statistics Canada, 2014). The Ontario Parole and Earned Release Board has the authority to grant supervised conditional release to adults that are incarcerated in provincial institutions (Correction Services Canada [CSC], 2014). In Ontario there are nine jails, nine correctional centers, ten detention centers, and four treatment centers, which are all under the supervision of the Ministry of Community Safety and Correctional Services. Incarcerated individuals are sent to halfway house on day parole upon their release from prison/jail (Ministry of Community Safety & Correctional Services [MCSCS], 2014).

Health Care Services in Correctional Settings

The Canadian federal government has signed multiple international charters that protect the right of individuals incarcerated for civil and political reasons (UN, 2015). The charters signed by the Canadian government protect the rights of individuals incarcerated in domestic settings. The International Covenant on Civil and Political Rights (ICCPR) is an example of one international charter that Canada has signed (Human Rights Watch, 2013; Parliament of Canada, 2013). Although the ICCPR does not explicitly state provisions that protect the right to health, there are multiple rights within the Covenant which are linked to the individual's enjoyment of their right to health. For example, article 7 for the ICCPR states that individuals have the right to not be subjected to torture, cruel, inhumane, or degrading treatment or punishment; furthermore, individuals have the right to not be subjected without free consent to medical or scientific experimentation (UN, 2014). The United Nations Human Rights Committee takes the stance that adequate, appropriate, and timely medical care must be available to all incarcerated individuals (International Penal and Penitentiary Foundation

[IPPF], 2008). The United Nations Human Rights Committee refers to the following articles, found in the ICCPR, to set the guideline for the treatment of incarcerated individuals: article 6 section 1 states that “every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life” (UN, 2015). Finally, article 10 section 1 ICCPR states that “persons deprived of their liberty shall be treated with humanity and respect for the inherent dignity of the human person” (UN, 2015).

American Declaration on of the Rights and Duties of Man (ADHR), and the American Convention on Human Rights (ACHR) are other examples of the international charters that Canada has signed to protect the rights of individuals incarcerated in domestic settings (Human Rights Watch, 2013; Parliament of Canada, 2013). Article VI of the ADHR states “[e]very person has the right to establish a family, the basic element of society, and to receive protection” (IPPF, 2008, p. 40). The state has the duty to guarantee security, and keep order in prison settings; article 4 section 1 of the American Convention on Human Rights (ACHR) requires for the protection of life and personal protection of all inmates (i.e., physical, mental, & moral) (IPPF, 2008).

The Canadian Charter of Rights and Freedoms states that the wellbeing and health of incarcerated individuals is the obligation of the government (CSC, 2014); furthermore, incarcerated individuals have the right to the same health care provided to community members. Individuals incarcerated in federal institutions are governed under the Correction and Conditional Release Act (CCRA). CCRA states that each incarcerated individual has the right to essential health care, and also access to health care such as

mental health care. The CCRA seeks to provide rehabilitation for incarcerated individuals and assist in their reintegration into society (Government of Canada, 2015). According to the WHO *Alma Ata declaration (1978)*, essential health care is primary health care and it includes primary care services (i.e., family doctor, emergency room), health promotion, disease prevention, and population- level public health functions (WHO, 2015).

In Canada, the provincial and territorial correctional institutions are guided by the Ministry of Community Safety and Correctional Services (MCSCS, 2007); thus, are not obligated to abide by the international human rights standards issued by the UN and the WHO, to the extent of federal prisons (Canadian HIV/AIDS legal network, 2009; MCSCS, 2007; Schizophrenia Society of Ontario, 2012). In criticism, select health care organizations/patient advocacy groups have identified a discrepancy between what is stated in policy and what is actually enacted in provincial jail health care settings (Bernier & MacLellan, 2011). For example, medications must be first approved by the medical staff at the correctional facility and administered by the health services staff; this often means that inmates experience delays in receiving the medication which leads to severe health complications (Kilty, 2012). This is critical since many incarcerated individuals who require methadone treatment do not have access to Methadone Maintenance Therapy (MMT), a type of Opiate Replacement Therapy (ORT), when serving time in prison (Nunn, Zaller, Dickman, Trimbur, Nijhawan, & Rich, 2010). Moreover, incarcerated individuals do not have the ability to receive health care delivered from their own family medical doctor. Incarcerated individuals receive care from a medical doctor or a nurse employed by the correctional institution (CSC, 2015). Many provincial/territorial correctional institutions will employ a medical doctor on a contract base, to make regular

visits to the facilities. The health services department within provincial/territorial correctional facilities that do not employ medical doctors provide nurses instead (CSC, 2015).

Defining Health and Wellness

Health and wellness are distinct yet related concepts. The theoretical underpinnings of this discussion are framed by a human rights perspective (Segall & Fries, 2011). The concept of wellness describes the process that integrates all elements that compose a human's wellbeing (i.e., physical, mental, social, and environmental wellbeing) (Segall & Fries). According to Segall & Fries (2011), wellness is defined as "the optimum capacity of an individual to fulfill personal goals and to perform socially defined roles in a way that meets cultural expectations" (p. 66). Health and wellness are often used interchangeably in scientific literature; however, the concept of wellness is broader and subsumes health (Segall & Fries). Wellness, therefore, includes good health, quality of life, and satisfaction with life conditions.

The definition of health is socially constructed, and can change depending on cultural and social structures. Traditionally, health is defined as an experience of the absence of illness or disease; however, health is a multi-dimensional concept (Segall & Fries, 2011). The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Official Records of the World Health Organization, no. 2, 1948, p. 100). Therefore, health is much more than measurement of illness, death, and disability. Health also includes mental health, social soundness, quality of life, life satisfaction, and

happiness (Segall & Fries). Health is composed of the feelings of sufficient performance on psychological, physical, and social levels of functioning.

Human Rights and Equity in Health

Human rights are abstract concepts that are not dependent on culture, gender, ethnicity, social/economic status, and age (Seear, 2007). There are many ways to categorize human rights. Karel Vasak suggests a common categorization of human rights based on liberty, equality, and fraternity. Liberty is composed of civil and political rights, such as the right to life, free speech, privacy, political and religious practices (Salili, & Hoosain, 2010). Equality consists of social, economic, and cultural rights (i.e., rights to education, equality among citizens, and employment). Finally, fraternity includes collective rights (i.e., the right to clean environment, respect for cultural traditions, and right to peace) (Salili, & Hoosain).

In the constitution of the World Health Organization's (WHO) health is positioned as a human right, and individuals are entitled to the highest attainable standard of health (Braveman, & Gruskin, 2003; WHO, 2006). All human rights are related; thus, the right to health cannot be segregated from other human rights. For example, the right to health is dependent in part on individuals' right to decent standards of living, the right to education, and freedom from discrimination. Ensuring that human rights are protected is accomplished through equalizing opportunities to be healthy (Braveman & Gruskin). Equalizing opportunities is established by addressing important social and economic determinants of health and policies/programmes that impact the health of the population. Braveman & Gruskin (2003) define equity as the absence of systematic health disparities

among individuals from various levels of social/economic backgrounds (Braveman, & Gruskin). Equity occurs when social justice/fairness thrives and “resources are distributed and processes are designed in ways most likely to move toward equalising the health outcome of disadvantaged social groups with the outcomes of their more advantaged counterparts” (Braveman, & Gruskin, p. 257). Health inequity is defined as “differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust” (Reutter & Kushner, 2010, p. 271).

Equitable Access to Health is a Human Right

According to the United Nations’ (UN) Article 12, regarding the International Covenant on Economic, Social and Cultural rights, “everyone has the right to enjoy the highest attainable standard of physical and mental health” (World Health Organization [WHO], 2007, pg. 7). The UN’s Basic Principles for the Treatment of Prisoners states that incarcerated individuals are entitled to receive the highest attainable standard of health care access to the same health services provided to the general population without discrimination (WHO). Prison/jail administrations and staff have the responsibility to promote the well-being of incarcerated individuals; moreover, incarcerated individuals should not leave prison/jail in a worse health condition than when they entered (WHO).

The concept of access to health care services is complex and it is concerned with understanding how people use appropriate health care resources in order to preserve and/or improve their health (Gulliford et al., 2002). Access to healthcare services can be measured through the potential or the actual entry of an individual or a population group into the health care system. Gaining access to healthcare requires adequate supply of healthcare services, and the availability of healthcare services has been traditionally

measured via the number of doctors or hospital beds (Gulliford et al.).

Researchers have critiqued the use of health care availability (i.e., number of doctors or hospital beds) to determine healthcare access. The proof of access to health care is better reflected by the actual use of services (Gulliford et al, 2002). Beyond the direct factors (i.e., health human resources, “bed” availability), indirect factors influencing access to health care services can include personal barriers, financial barriers, and organizational barriers. In fact, access challenges exist within the current healthcare delivery system (e.g., long wait times), and individuals have difficulties finding the appropriate care to treat their illnesses and can face difficulties choosing among the various types of healthcare available (e.g., individual’s expectations from health care service users may not always be consistent with those of health care professionals) (Gulliford et al.). Individuals may also face difficulties overcoming the racial/ethnic male dominated healthcare institution (Spector, 2004).

The Impact of Social Determinants on Health Access of Criminalized Women

According to the Public Health Agency of Canada (PHAC) (2013) social determinants of health include income and social status, social support and networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, health child development, biology and genetic endowment, health services, gender, and culture (PHAC, 2013). Social determinants of health can influence the extent to which a person uses physical, social, and personal resources to identify and achieve aspirations, satisfy needs, and cope with a changing environment (Ashton & Seymour, 1998; Baum, 2002; & Raphael, 2004).

Raphael investigated the social determinants by exploring the characteristics of individual (e.g., income, gender, & ethnicity), and examined how those characteristics impacted their health (Mikkonen, & Raphael, 2010). Raphael found four themes (1) empirical evidence regarding the social determinants of health, (2) pathways by which social determinants of health influence health, (3) life course perspective, and (4) the influence of policy in determining the quality of social determinants of health (Raphael, 2004).

Gender as a Social Determinants of Health

Gender is a critical social determinant of health (Cockerham, 2005). Research indicates that women are more likely to seek preventative care than men, and engage in physical exercise (Abel, Walter, Niemann, & Weitkunat, 1999; Blaxter, 1990; Cockerham, Snead, & Derek 2002; Grzywacz & Marks, 2001). Furthermore, studies indicate that adolescent females are more likely to adopt their mothers' health behaviours, and male adolescents are more likely to follow their fathers' health behaviours (Wickrama, Conger, Wallace, & Elder, 1999). By adopting their parents' health lifestyles, both adolescent males and females establish gender-specific health lifestyles that will impact the rest of their lives (Wickrama et al.). Recent studies indicate that gender becomes an even more powerful indicator of health when combined with social class. Studies conducted in the USA and the UK indicated that women from lower socioeconomic class were less likely to participate in physical activities, experience violence, and income inequality (Pollard, Kirk, & Cade, 2002; Raphael, & Bryant, 2006; Reid, 1998). This is a critical finding for the present study since many women who are incarcerated in provincial jail come from a lower socioeconomic class.

Class as a Social Determinants of Health

There are multiple social/economic factors that contribute to the disproportionate rate of illnesses among specific social groups, including individuals under the supervision of the criminal justice system, individuals who live in poverty, female-headed single-parent household, individuals who rely on social benefit payment as methods of income generation, individuals who use drugs, and individuals with mental health issues (Fischer, & Baum, 2010; Galea & Vlahov, 2002). The lives of most criminalized women have been marked by some of the social/economic circumstances stated above, specifically since criminalized women often experience partner violence. Family dynamics and history of violence may lead to depression, substance abuse, anxiety, and post-traumatic stress disorder; these conditions may often lead to their imprisonment, and become worse after their release into the community (Franklin, 2008). Research indicates that traumatic experiences often begin from a young age, and this includes physical and sexual abuse which continues into adulthood (Franklin). These social events impact criminalized women's physical and mental health, and influence their personal coping skills and biological makeup (e.g., increased likelihood of low self-esteem, self-hatred, and post-traumatic stress disorder) (Franklin).

Research indicates that the accumulation of social, physical, and material stressors, resulting from lower social hierarchy, has a critical influence on health (Gastaldo, Carrasco, & Magalhães, 2012). Allostasis is defined as “the adaptive processes that maintains homeostasis through the production of mediators such as adrenalin” (McEwen, 2005, p. 315), and can produce wear and tear on the regulatory systems in the human body and brain. Allostatic load has been used to illustrate how

chronic stress of brain response can have a negative impact on overall physiology (e.g. metabolism, cardiovascular, immunity). Individuals who live in low social/economic conditions are exposed to acute and chronic stress; therefore, they are more likely to accumulate allostatic load over their lifetime. Allostatic load can explain determinants of conditions such as cancer, hypertension, hyperglycaemia, which lie behind the morbidity and mortality that is parallel to the socio-economic gradient (Gastaldo et al.).

Marginalization as a Social Determinant of Health

Many women involved in sex work experience marginalization due to a constant shift in social identity from a young age (Orchard, Farr, Macphail, Wender, & Young, 2013). Many of these women develop and manage separate identities in their home and at their work; however, research indicates that women involved in sex work are often identified through the use of defamatory labels associated with their work; whether or not these labels reflect their real identities is a question rarely asked (Orchard et al.).

Marginalization predisposes many criminalized women to experience elevated levels of social exclusion before and after incarceration, when compared to the rest of the population (Condon, Hek, & Harris, 2008). The concept of marginalization has been classified as a critical social determinant of health, particularly influencing the individual's ability to equitable access to health care (Lynam & Cowley, 2007).

Marginalized individuals are at a disadvantage and lack the ability to use resources available in their communities; thereby, further enhancing their social/economic/health inequalities (Lynam & Cowley). Contrary to common misconceptions it is not the inherent predispositions to illness that leads to great health inequalities/disparities; rather, it is the material circumstances coupled with the social conditions experienced by the

individual that allows for the occurrence of ill health (Lynam & Cowley). Research indicates an association between social/material disadvantages and poor mental/physical health; therefore, leading to further health inequities among various groups of people (Lynam & Cowley).

Ethnicity as a Social Determinant of Health

Aboriginal women are overrepresented in the Canadian justice system. Although Aboriginal people in Canada make up approximately 4.4% of the Canadian population, it was estimated that 27% of inmates in federal institutions and 20% of inmates in provincial institutions were Aboriginal from 2010 to 2011 (Statistics Canada, 2012). There are multiple underlying factors that contribute to the high rate of incarceration among Aboriginal people in Canada; for example, colonization has had a negative impact on the health outcome of the Aboriginal population in Canada. High rate of unemployment is also understood as a major consequence of colonization that has negatively impacted the health of Aboriginal people in Canada (Peters, 2011). Discrimination, resulting from colonization, against Aboriginal people in Canada is thought to be linked to their overrepresentation in prison. In public inquiries, it has been suggested that discrimination and stereotyping towards Aboriginal people in Canada still exist (Whitehead & Hayes, 1998). Substantial amount of crime committed by Aboriginal people in Canada is alcohol-related. A study conducted in Winnipeg determined that 77% of offences committed by Aboriginal men and 84% by Aboriginal woman were crimes that violate provincial *Liquor Control Act* (Whitehead & Hayes). Homicides committed by Aboriginal individuals in Canada highly likely involve intoxicated offenders

(Whitehead & Hayes). There is a large gap in Canadian research which examines the role of colonization on the health of Aboriginal people in Canada.

Purpose

The purpose of this thesis project was to explore the factors that influence access to healthcare service among women incarcerated in provincial jails. Moreover, this study aimed to add to the current social dialogue regarding the health of criminalized women and their access to health care services within provincial jail settings in Ontario, Canada. For the purpose of this study I sought to explore the lives of criminalized women and the factors that shaped their experiences when accessing health care services in jail. Narrative inquiry was the school of inquiry used for this study. This was done to provide study participants with opportunity to voice their experiences and stories. My objective in capturing the stories of criminalized women is to help inform change, which may lead to improvement in the current health care system based on the women's health needs.

My Story

The desire to conduct this research study evolved over a long process of examining issues related to marginalized people groups in Canada. During my undergraduate career I had the opportunity to study and learn about the complexity of health from a microbiological level to its delivery on a structural level. Although most of my undergraduate education highlighted the study of disease/illness, human anatomy, and human physiology, I was curious to learn more about the larger contextual issues that impact the health/wellbeing of people. During the third year of my undergraduate education I enrolled in a course that focused on global health and infectious diseases.

This specific course provided me with a background on the social determinants of health, and how the individual's context has a critical influence on their health. The course involved a two week in class discussion on tropical diseases in Central America, and a two week trip to the country of Honduras. While in Honduras there was the opportunity to visit multiple private and public health care facilities; furthermore, we travelled throughout urban centres to the rural villages. This experience allowed me to visualize how context impacted people's health and wellbeing due to lack of access to health care services, compromised literacy, gender, and economic class.

The experience and knowledge that I gained while in Honduras inspired me to focus my graduate studies in a related field. As I decided to continue on with my education at a graduate level I was determined to enhance my knowledge base and focus my research on the impact of social determinants of health on particular population groups here in Canada. Through some deliberation with my thesis supervisors, and an overview of the current hot topics in Canada I developed awareness about the health challenges of criminalized people. I became increasingly interested in the topic of criminalization and health and was curious to learn about criminalized individual's context and stories when seeking health access, particularly within correctional institutions. Therefore, I framed this study in a way that will permit the reader to learn about the health and health care experiences of criminalized women who have served time in a Canadian provincial jail. The stories collected come directly from women who spent time in jail, which was done to get a better understanding of the obstacles that they have faced, and the experiences that they have endured.

Overview of Thesis Layout

This study presents the different stages of the research process that I have been engaged in, through five chapters. The first chapter of this study includes the background information, the purpose for the study, and my personal story. In the second chapter I present a literature review to explore the major themes that reflect the experiences of criminalized women in existing literature. The literature review provides information about health and wellbeing of criminalized women before entering a correctional institution, while serving their sentence, and upon their re-entry into the community. I also provide a description of the gaps in the literature and the implications of the review.

In the third chapter of this study I provide a description regarding the paradigm position, methodology, and methods used. I discuss the use of critical theory as a paradigm position, narrative inquiry as a methodology, and the methods for participant recruitment, data collection, and data analysis.

In the fourth chapter I present the individual narratives as well as the individual themes that emerged from the first stage of data analysis. In chapter five I present a discussion that includes the themes across the narratives as well as how these findings relate to concepts of health and wellbeing. The final chapter of this study will also highlight its limitations and will provide recommendations for future studies that look at the experiences of criminalized women in Canada.

Chapter Two: Literature Review

A scoping review of literature (Armstrong, Hall, Doyle, & Waters, 2011) was conducted to a) explore the current literature regarding criminalized women and their health concerns; b) summarize current literature findings regarding the experiences of criminalized women in correctional facilities; c) identify gaps in existing literature; and d) explore areas for future research within the subject. I examined published and unpublished (grey literature) written on the health of women that have been incarcerated, and identified themes and gaps in knowledge/research and recommend future research areas that could inform policy. The findings of this scoping review are reported in this chapter.

Search Strategy

A scoping review of literature is an approach that allows the researcher to examine a wider range of articles on a specific topic. Scoping review is used to map and critique the existing literature in order to identify research gaps and summarize findings (Armstrong, Hall, Doyle, & Waters, 2011). The following databases were used to conduct the search: Scopus, Cinahl, Medline, and Google Scholar. I also reviewed grey literature publications such as government documents, community organization documents. The following search words were included: criminalization, women, Canada, and health.

I used specific inclusion and exclusion criteria to identify relevant studies. For example, the literature published from 2000-2014 was included in the review to present a recent account of the research on criminalized women, their health issues and access to health care services while in custody within Canada. Articles that fell outside the scope of

this project and the timeline were not included (Arksey & O'Malley, 2005). The literature reviewed was composed of published articles and related documents written in English. Since the search resulted in few publications that examined criminalized women in Canada, the search strategy was broadened to include published research and grey literature from the USA and the UK.

Fifteen articles were used to construct this literature review, with three studies that examined the lives of criminalized women in a Canadian context. The articles reviewed for this chapter focused on health care access of criminalized women before their entry into a correctional facility, health issues while incarcerated, and the struggle of reintegration post the experience of incarceration. Since most of the studies were conducted in a non-Canadian context none of them distinguished between the experiences of women who served in federal or provincial institutions. Therefore, this indicated that there is a need for studies that focus on the experiences of criminalized women in the Canadian correctional system.

Health Status and Life Context of Criminalized Women Prior to Incarceration

The life contexts of women engaged in sex work are complicated, where multiple structural and interpersonal factors influence their life outcomes (Orchard, Farr, Macphial, Wender & Young, 2012). Many women involved in sex work, have experienced physical and sexual abuse, juvenile delinquency, poor performance in school, addiction, and poverty (Orchard et al.). This is consistent with the findings of Condon, Hek, & Harris (2008), which has indicated that prior to incarceration many individuals experience homelessness, unemployment, low levels of education, and

substance abuse; furthermore, 70% of criminalized women suffer from mental health disorder, compared to 2% of women in the general population (Condon et al.). Structural violence is a form of violence where some social institutions (e.g., economic, political, legal, religious, and cultural) may cause harm to people by preventing them from meeting their basic needs; for example, unequal access to resources, political power, education, and health care (Farmer, Nizeye, Stulac, & Keshavjee, 2006). Structural violence and economic/social disparities are amongst the most influential factors that negatively impact the health of individuals (Rosenthal & Levy, 2010), and prior to incarceration many criminalized women endure domestic violence; one in three criminalized women has experienced sexual abuse at some point in her life (Condon et al.). Moreover, it has been estimated that 70% of criminalized women in Canadian correctional institutions are mothers, and 70% of these are single mothers. Their children are often left with family, friends, or children's services when the mothers are serving their sentence (Amaro, Raj, & Reed, 2001; Eliason, Taylor, & Williams, 2004; Johnson & Raphael, 2009).

Economic and social inequalities, experienced by criminalized women prior to incarceration, are linked to poverty, involvement in survival sex work, violence, and participation in illegal activities (Bungay, Johnson, Varcoe, & Boyd, 2010). Furthermore, before entering prison/jail, many women are more likely to be engaged in illicit drug use, tobacco use, and alcohol use, compare with the rest of the population (Condon, Hek, & Harris, 2008). Factors such as an increased number of sex partners, and injectable drug use (IDU) places criminalized women at a higher risk of poor health. Relative to non-criminalized women, criminalized women are at a higher risk of contracting infectious

diseases such as HIV/AIDS, hepatitis C (HCV), and tuberculosis, and other Sexually Transmitted Infections (STIs) (Bungay et al).

As mentioned before, many women who are engaged in sex work, are exposed to abuse from a young age and are 13 times more likely to have been placed into child care services (Condon, Hek, & Harris, 2008; Orchard, Farr, Macphail, Wender, & Young, 2014). The study by Orchard et al. (2014) explored the experiences of women involved in sex work, and examined their childhood and early family experiences, and found that most of the women left home during their early adolescent years. Many criminalized women experience addiction to illicit substances, live in poverty, and experience limitations in accessing health care services (e.g., safe housing, drug treatments, & mental health support workers) when accessing social and health services (Orchard, Farr, Macphail, Wender, & Young, 2012).

Criminalized Women's Health Status While Incarcerated

Upon entering a correctional facility, 70% of women are dependent on prescription medication, tobacco, and have significant health conditions) (Amaro, Raja, & Reed, 2001; Eliason, Taylor, & Williams, 2004). Previous literature also indicates that criminalized women and men experience high levels of physical and mental health issues (e.g., chronic conditions, mental health issues, and infectious disease) compared to the rest of the population, and this is largely linked to various behavioural and socioeconomic factors (Bernier & Kristin MacLellan, 2011). A mix methods study, conducted to understand the health status and health services use by incarcerated individuals in provincial jail, noted that women are more likely to have physical health

problems in jail when compared with men (Bernier & Kristin MacLellan). The most common physical health issues reported by women impacted the brain/nervous system (e.g., dizziness/fainting, seizures, blackouts, & forgetfulness/memory loss), the skin, muscles and bones, and the gastric system. The study reported that infectious diseases (e.g., HIV/AIDS, Tuberculosis, Hepatitis C, and other Sexually Transmitted Infections) were also common among incarcerated women. Women also reported more complications with sexual and reproductive health compared to men (Bernier, & Kristin MacLellan).

An initial screening of 154 women entering a prison facility in the USA revealed that 87% of women had dental problems, 53% had issues with their menstrual cycle, 34% had sleep difficulties, and 33% had depression/suicidal thoughts (Eliason, Tylor, & Williams, 2004). Other studies noted that women serving time in prison often experienced anxiety, impaired concentration, forgetfulness, panic/phobias, and chronic headaches (Condon, Hek, & Harris, 2008; Robert, Frigon, & Belzile, 2007). As well, women's health is worsened by the experience of incarceration (Condon et al.). Many incarcerated individuals experience elevated levels of anxiety, anger, and frustration resulting from drug withdrawals and long periods of time spent locked in cells (Condon et al.).

The health and wellbeing of criminalized women is worse than women's reported health status within the general population, and many criminalized women experience difficulties while accessing health care services in prison (Sered & Norton-Hawk, 2008). A case study by Elison et al. (2004) examined the health of women serving time in US prisons, and focused on the role of social structures (i.e., ethnicity, class, gender, and

issues of addiction) on the health of women inside prison (Eliason, Taylor, & William, 2004). The research provided exemplar accounts of women's experiences in prison, and illustrated how health care staff often neglected to provide care to the women in prison. For example, participants with a long history of heart disease experienced a heart attack while incarcerated. The woman experienced delays in health care access which resulted in her death. The findings also indicated women experienced delayed or denied access to health care because the correctional officers did not believe that the inmates needed health care, and linked the inmates' pains to their dependency on illicit drugs (Eliason et al.).

Mental health issues are amongst the most common health concerns experienced by women in prison (Braithwaite, Treadwell, & Arriola, 2005; Condon, Hek, & Harris, 2008; Kilty, 2012). The number of federally incarcerated women, in Canada, diagnosed with a mental health disorder increased by 65% from the year 1967 to 2004. The factors influencing the health of criminalized women include a lack of community services available, homelessness, drug/alcohol use, engagement in sex work, and short term experiences of incarceration (Kilty). A study conducted to examine criminalized women's psychiatric health, in Canadian federal prisons and provincial jails, noted that women often experience medicalization in the form of psychiatric intervention (Kilty). Medicalization is a process where some components of human life become considered as medical problems; however, previously these components were not considered pathological (Maturo, 2012). The study by Kilty (2012) reported that women, living in prison and in the community, are prescribed psychotropic medications more often than men. The study noted that prescribing psychotropic medication in a prison setting is

problematic because the correctional system prioritizes security over therapeutic care. As a result, the medication orders become part of the inmate's correctional plan, making the consumption of the medication mandatory (Kilty).

Generally, incarcerated individuals have a significantly limited ability to engage effectively in self-health care or self-health promotion given the restriction inherent in the jail/prison environment where order, control, and discipline are prioritized. For example, inmates may be denied access to health care in the interest of jail/prison security (Condon, Hek, & Harris, 2008). The lack of autonomy related to self-care that many incarcerated individuals experience creates limitations to their overall health and wellbeing (Condon et al.).

Incarcerated individuals have limited access to information about prison procedures, and experience overcrowding, and lack of basic commodities such as fresh air when exercise is cancelled or allowed sporadically (Condon, Hek, & Harris, 2008). Many criminalized women have low level of health literacy skills, and their inability access, understand, evaluate, communicate, and use information to maintain and improve their health is severely limited (Donelle, & Hall, 2014). Many inmates engage in Intravenous Drug Use (IDU) while in prison and which lead to poor health (Condon, Hek, & Harris); for example, a national survey of 3000 prisoners in the UK reported that 25% of heroin users began using the drug while in prison. Inmates that use illicit drugs in the community are likely to use and share needles with other inmates while in jail; thus, elevating the risk of contracting multiple communicable diseases (i.e., hepatitis, and HIV/AIDS) (Condon et al.).

Women serving time in Canadian provincial jails can request to see multiple health care providers (e.g. psychologist, psychiatrist); but due to the lack of provincial funding and an increased incarcerated population many woman experience lack of consistency in health care delivery (Kilty, 2012; Sered & Norton-Hawk, 2008).

According to Sered & Norton-Hawk (2008), criminalized women need coordinated and continuous access to healthcare services to deal with the conditions that many of them face prior to incarceration. However, the event of incarceration causes fragmentation in health care delivery for many criminalized women, and as a result, many women do not always receive their existing medical treatments when incarcerated (Sered & Norton-Hawk). Lack of consistency in the delivery of healthcare during incarceration can cause anxiety, confusion, and distress for these women (Sered & Norton-Hawk).

Integration into Society Post Incarceration Experience

The experience of incarceration worsens the social exclusion experienced by many criminalized women. It has been estimated that 45% of inmates lose contact with their families while incarcerated (Condon, Hek, & Harris, 2008). Correctional programs, such as probation/parole, have been helpful in reducing the social isolation experienced by criminalized women and enabling women to maintain their family ties and work life to financially support themselves and their children (Carmichael, Gover, Koons-Witt, & Inabnit, 2005). In the United States there are few programs designed to help criminalized women to adjust to a law abiding life. Most of the “transition to community” programs focus on surveillance of criminalized activities, treatment for substance abuse, and finding employment for criminalized people. There remains an absence in adequate rehabilitative programs for criminalized women; thusly, contributing to the low success

rate of women completing their community supervision probation/parole period. (Carmichael et al.).

Previously incarcerated individuals often face discrimination upon their return to the community due, in part, to illicit drug dependency, poor mental health status, ethnicity, and criminal justice history (Freudenberg . Daniels, Crum, Perkins, & Richie, 2005). Many individuals released from incarceration and returning to their community struggle with health issues that the current health system has difficulties meeting (i.e., infectious and chronic diseases, addiction, mental health issues, low literacy rate, and other issues that make it difficult for them to navigate the system) (Freudenberg et al.). Targeted gender-responsive strategies are needed to improve the health and wellbeing of women returning to their communities, and this includes improved links between correctional institutions and community health services, case management, and partnerships between correctional facilities, health agencies, and service providers (Freudenberg et al.; Covington & Bloom, 2003).

Gaps in the Literature and Implications for Research

There is an evident gap in literature that looks at the health and wellbeing of criminalized women in Canadian provincial jails, particularly in terms of access to health care services. Existing literature provides limited personalized accounts of women's experiences in Canadian provincial jails; furthermore, existing literature does not provide the voice of criminalized women's health concerns, while in jail, and their recommendations to improve the system. This current study explored the experiences of criminalized women and their perspectives on their health and access to healthcare

services in incarcerated settings within a Canadian context. Most of the studies reviewed were not conducted in a Canadian provincial jail setting; thus, the contexts of the women included in previous studies may be different than that of women serving in Canadian provincial jails. Finally, reliance on literature from the USA and the UK is an indication that more studies are needed to examine the Canadian provincial jail environment (Carmichael, Gover, Koons-Witt & Inabnit, 2005; Eliason, Taylor & Williams, 2004; Kilty, 2012; Robert, Frigon & Belizile, 2007; Sered & Norton-Hawk).

Chapter Three: Research Methodology and Methods

In this chapter, the philosophical and theoretical frameworks used for the study are described. I utilized a critical narrative inquiry approach to explore the experiences of criminalized women, when accessing health care services within provincial jail institutions.

Research design and theoretical framework

Paradigm Position

Critical theory is a useful framework to guide this research since it aims to uncover power relations resulting from economic factors, cultural factors, and socially accepted gender norms (Carpenter & Suto, 2008). Gender, a socially constructed concept, is another critical factor, which influences and shapes the way reality is constructed by men and women (Guba & Lincoln, 1994; Pollock, 2004). Framing this research using critical theory focuses attention on the contextual forces that influence the experiences of criminalized women in their attempts to access health care within the provincial jail system. I sought to investigate how power relations, imbalances, and injustices influenced the way criminalized women come to understand and give meaning to their life experiences (Kincheloe & McLaren, 2005; Willis & Elmer, 2007). I was interested in exposing certain ways by which the social, historical, economic, and political forces influence the experiences of criminalized women.

The epistemological stance claimed by critical theorists proposes that knowledge is transactional and subjective; therefore, researchers and informants are linked together through an active process of inquiry (Guba & Lincoln, 1994). Qualitative studies that

claim to be rooted in a critical theory paradigm are value mediated, which means that the investigator and the participants are linked, with the values of the investigator influencing the inquiry (Guba & Lincoln); therefore, what can be known is intertwined with the interaction between the investigator and the participant. Therefore, knowledge is generated when researchers interact with informants (Guba & Lincoln). Methodologies used during research projects embedded in critical theory are dialogical and dialectical. Studies grounded in critical theory use methodologies that allow the researchers and informants to challenge accepted social norms and bring about feasible changes (Guba & Lincoln).

Various methods can be employed in order to fulfill the requirements of a critical theory paradigm position; however, in this qualitative study I employed narrative inquiry as the methodology by which I constructed the data with study participants (Guba & Lincoln, 1994). Utilizing narrative inquiry as a methodology allowed me to focus on the life stories of women involved in this study.

School of Inquiry

The purpose of this research study is to promote the voices and stories of criminalized women, which is done in order to serve their interest. It is critical to ask the following questions before selecting a school of inquiry to investigate the research questions: 1) whose voices and stories are promoted throughout the study? and 2) whose interests are fulfilled through the findings of the project? (Seda Dei & Johal, 2005). The research process is influenced by the researcher's positionality and geographical proximity to the research environment, the nature of the research project, the researcher's institutional background, expectations of researcher, and social/moral obligations (Seda

Dei & Johal). In the case of criminalized women, it is important to view their individual experiences as directly connected with their individual identity; thus, their stories and experiences must be analyzed in light of their intersection of gender, sexual orientation, class, and abilities/disabilities (Seda Dei & Johal).

Narrative inquiry is a suitable methodology to employ in this study since it allows the researcher to explore the life stories of participants (Riessman, 2005), as it relates to their experiences accessing health care in provincial jail. By using a narrative inquiry lens, criminalized women were able to communicate their stories, uncover their individual experiences of incarceration, and illustrate the connection of their experience of incarceration to larger social/cultural factors. Furthermore, using a narrative inquiry is suitable because many of these women lead busy and chaotic lives; thus, it is more efficient to capture their stories and experiences in a single interview. Narrative inquiry allowed me to overcome specific logistical challenges associated with the data collection process (e.g., participants' limited literacy level, and ability to meet multiple times to construct and review the data). Many of the challenges were linked to the unpredictable lives that all of the participants involved in the study lead.

The use of narrative inquiry complements the critical theory paradigm lens. Methodologies used in studies informed by critical theory aim to investigate the lives of oppressed people to form an understanding that may lead to change in social practices and policies (Guba & Lincoln, 1994). Moreover, the nature of knowledge generated in a study based on a critical theory paradigm is an outcome of "human interest and historical insights" (Guba & Lincoln, p. 112); hence, narrative inquiry is a fitting methodology to use in this study.

Narrative inquiry is a methodology that can be used to increase individuals' control over their lives by enabling individuals to reconstruct their life story and their realities (Larsson & Sjöblom, 2009). The use of narrative inquiry may also create space for participants to have personal growth through the process of storytelling (Larsen & Sjöblom). Narrative inquiry gives people a medium to speak about their biological, social, cultural, and historical conditions. Using narrative inquiry as a methodology for this study focused attention on the relationship between individuals' life stories and their daily experiences and social contexts. In this case, narrative inquiry was used to explore the stories told by women, how they communicated their experiences about access to health services within provincial/territorial jail, and the important details of their experience as determined by the women. Narrative inquiry was also used to explore how the women envisioned their future.

The research questions that I investigated throughout this research project were:

1. What are criminalized women's experiences when accessing health care services during incarceration within provincial jails?
2. What future expectations do criminalized women have when accessing health care services?

Methods

Sample Selection and Recruitment

Purposeful sampling was used to select participants for this study. Purposeful or purposive sampling is defined as: "judgmental sampling that involves the conscious selection by the researcher of certain subjects or elements to include in the study"

(Higginbottom, 2004, p.11). In this study, recruitment of participants was assisted by counsellors working at a community organization that supports the needs of marginalized women within the local community. The counsellors working at the community organization are familiar with the lives of the women that frequent the community organization, including their experiences of incarceration. During the initial phases of participant recruitment, counsellors working at the community organization forwarded the study information and researchers' contact information to potential participants by providing them with an information sheet (**Appendix C**). In order to protect confidentiality, potential participants were asked not to provide names of other individuals that may be eligible to participate in this study; furthermore, participants were cautioned not to mention names of other individuals during the interview.

During the recruitment phase potential participants contacted me via the phone number provided on the study information sheet (**Appendix C**). I had been volunteering at a local community organization for several months. My volunteer duties included operating the welcome desk, answering the phone, and looking up information for the clients. The counsellor at the community organization informed potential participants to approach me at while I was at community organization site, and expressed their interest in participating in the study. Upon initial contact, potential participants were screened to ensure that they fit the inclusion criteria for the study. I asked the participants open ended/biographical questions during the initial contact in order to determine whether the individual met the inclusion criteria or not (Patton, 2002). At an agreeable date and time, participants that fit the inclusion criteria for this study were asked to sign a consent form after reading the letter or information, which was done at the beginning of the interview

(Appendix A). Participants were eligible for study participation based on the following criteria: over the age of 18, self-reported to have served time in provincial/territorial jail, fluent in English, have served their sentences and/or are on parole/probation. Selecting women who have been incarcerated in Canadian provincial/territorial correctional facilities was critical because these institutions are not obligated to abide by international human rights standards issued by the UN and the WHO to provide care to its inmates (Canadian HIV/AIDS legal network, 2009; Parliament of Canada, 2001). I provided potential participants with detailed description of the research study and answered any questions and/or concerns they had. Upon agreeing to partake in the study, participants were given a \$30 stipend at the beginning of the interview to cover their transportation cost and serve as compensation for the time spent engaged in the interviews.

A total of eight individuals were interviewed, but only five of the interviews were completed and included in this study. There were many issues during the recruitment phase, particularly linked to the stipend offered. During the beginning stages of recruitment, counsellors passed the study information to potential participants who were in need financial assistant. These individuals were not necessarily interested in sharing their stories and experiences while in jail, but in receiving the \$30 stipends that was given at the beginning of the interview. Thus, two individuals interviewed did not complete the interview, and one of the individuals excluded from the study did not serve time in provincial jail, but rather spent a night in a police holding cell.

Setting

The study was conducted in a city located in South-Western Ontario, Canada. The interviews took place in public settings chosen collaboratively by participants and the researcher. The locations for the interviews were void of distractions, and this included private rooms at the public library, private office at the community site, and a qualitative research laboratory at an educational facility.

Data Collection

In this study, in-depth interviews were used to collect the narrative accounts of the participants' life stories (Riessman, 2005). I conducted one interview with each participant, and encouraged participants to reflect and recollect their significant life events related to the incarceration in provincial/territorial jail (Webster & Mertova, 2007). The interviews took approximately an hour long. I asked the participants open-ended questions about their health status, specific health concerns they may have, and their experiences when accessing health care services in provincial jail. The questions that used to guide the interviews are included in Appendix D; for example, participants were asked to describe the amount of time spent serving time in jail, when was the first time the participant entered jail, what were their experiences accessing health care inside of jail, and what were their personal views on health care access in provincial/territorial jail (**Appendix D**). The interview questions were influenced by critical theory. The questions aimed to generate a dialogue between myself, the researcher, and the participants. The questions were developed to help uncover and excavate "historical and subjugated knowledge" that point to collective struggle, conflict, and suffering (Guba & Lincoln, 1994, p. 110). Recognizing that the topics discussed in the interview process had

the potential to cause participants emotional discomfort I engaged them in frequent debriefing throughout the interview in order to reduce the discomfort. Appendix B includes the debriefing form (**Appendix B**) (Wengraf, 2001). The interviews with participants were audio recorded in order to accurately capture the women's narratives. With the participant's consent I also took notes to document the nonverbal communication used by participants. Some of the nonverbal communication signs that I was looking for included the variations in the tone of voice, changes in body posture, pauses, emotional distress, and pace of speech.

Data Analysis

A critical narrative analysis was used to understand how the stories constructed by participants are linked to broader contexts (Souto-Manning, 2012). Critical narrative analysis helped conceptualize how participants' personal stories are connected to the greater social environment (Wells, 2011). The methods developed by Chase (2005), and Lieblich et al. (1998) guided the analysis. The data was analyzed in two steps; the first stage included analyzing each interview for which I composed a narrative, a storyline, and a global impression unique to that individual's experience. The second stage of the data analysis included analyzing all the interviews together to find common storylines among the narratives collected from all participants. The two stages of data analysis were guided by the holistic content approach (Lieblich, Tuval-Mashiach, & Zilber, 1998). The holistic content approach is a narrative approach for understanding the meaning of the stories provided by individuals (Ollerenshaw & Creswell, 2000). It employs the life story of the individuals, and emphasize the content presented in the narrative. The life story of

the participant is considered as a whole, and sections of the text are construed within the context of the other parts of the narrative (Lieblich et al.).

First Stage

As they were completed, the interviews were transcribed verbatim, including nonverbal forms of communication using a notation system that uses symbols for the characteristics of speech and body movements (Holloway, 2008). Each interview took approximately 6-10 hours to transcribe, and in order to ensure the accurate transcription process the field notes and audio recordings were compared. The explicit and implicit content of the stories offered by participants was explored to distinguish the underlying meanings found in participants' stories. The holistic content analysis approach includes the following five steps: (1) Reading and re-reading the data until patterns emerged; (2) Documentation of my introductory thoughts regarding the findings emphasizing the general patterns initially found; (3) Identifying specific storylines emerging from each participant's interview; (4) Constructing storylines that cut across all participant's stories, and; (5) Documenting my concluding thoughts regarding each storyline (Lieblich, Tuval-Mashiach, & Zilber, 1998).

I immersed myself in each interview at the beginning of the transcription phase. I read and listened to each interview from every participant until patterns began to emerge (Lieblich, Tuval-Mashiach, & Zilber 1998). I proceeded to write down ideas that participants repeated throughout the interview. Participants' stories were not communicated in sequential order; thus, through a storyline frame, each participant's life events were temporally aligned (Wengraf, 2001). Each interview was then repositioned to

unveil life experiences that occurred prior to the incarceration experience, events during incarceration, and life after the incarceration experience. I documented my initial global impression of each interview in writing while noting the expectations and unusual features of the story (Lieblich et al.); thus, while listening/reading each interview I took note of repeated concepts and situations that caused disturbances in the lives of participants (i.e., addiction to illicit drugs, incarceration for the first time, relationships with the correctional officers, & access to medications, signs and symptoms of distress/diseases during incarceration, etc.).

In accordance with the holistic content analysis procedure I focused on the unique storylines that were emerging from each participant's narrative, and noted how the unique themes evolved from beginning to the end (Lieblich, Tuval-Mashiach, & Zilber, 1998). I highlighted situations where participants repeatedly spoke about specific topics that were critical in their narrative (i.e., prescription narcotics, influence of the correctional officers on health care access, and lack of hygiene in jail). In order to form the unique storylines for each participant I used coloured markers to highlight the various themes in the story (Lieblich et al.). Finally, I tracked my results by following each theme throughout the story and noting how the individual concluded that theme. I also noted when each theme appeared for the first and last time, the transitions between themes, the context of each one, and their relative salience in the text (Lieblich et al.).

Second Stage

Finding common storylines across participants' narratives composed the second stage of data analysis. Themes that occurred in the narratives of more than one

participant were highlighted. This is done in order to investigate the similarities in the life experiences of criminalized women accessing health care before, during, and after incarceration.

Reflexivity

I began the process of reflexivity prior to entering the data collection phase. I began by reflecting on the topics studied and the relationship that I have to them, which was done by exploring the literature and the lived world of criminalized women (Finlay, 2002). I also engaged in volunteer work at multiple organizations (e.g., designed to provide services for individuals with mental health and addiction issues) that provide services to women who have similar backgrounds to the women that I recruited for this study (i.e., similar demographics, similar social and economic backgrounds). I also continued to review current published reports and literature regarding the topic of incarcerated women and their access to health services. I was engaged in a process of self-reflexivity as the study participants were constructing the narratives; particularly by examining the type of relationships formed between the study participants and myself (Finlay). I was reflexive regarding my role as a researcher, and the power imbalance between the study participant and myself. Furthermore, I explored my values and worldviews to impact the construction of data (Morrow, 2005). The process of self-reflexivity was very difficult, and I was presented with multiple challenges throughout the process of data collection. I used the process of reflexivity to negotiate the different voices and meanings produced throughout the research process to acknowledge specific social, political, historical power structures that influenced the study. At the beginning of every interview I emphasized to the each participant that the purpose of the interview was

to collect their own story. The participants had the power to answer or refuse to answer any questions I asked. I also informed the participants at the beginning of every interview, they had the power over how their story developed, and my positionality as a researcher was to collect the story.

Quality Criteria

The criteria used to evaluate qualitative studies are dependent on the methodological framework employed by researcher and the specific philosophical positioning taken (Riessman, 2005). I was reflexive and transparent throughout the research process. I established coherence by ensuring that the research project's theoretical framework aligned with the design and aim of the study (Riessman).

Approach to Reflexivity

Reflexivity is a critical element of quality which helps establish the trustworthiness of the study (Holloway & Freshwater, 2008). According to Lieblich et al., (1998):

Working with narrative material requires dialogical listening (Bakhtin, 1981) to three voices: The voice of narrator, as represented by the tape or the text; the theoretical monitoring of the act of reading and interoperation, that is, self-awareness of the decision process of drawing conclusions from the material (p. 10).

Throughout the research process I kept field notes that documented my reflections and feelings during the pre-research stage, and the data collection and analysis stages. The

reflections were discussed with my thesis supervisors who questioned my assumptions, interpretations, and analytic direction throughout the course of the research study. I had multiple pre-existing assumptions about criminalized women prior to conducting this study. For example, I assumed that people have equal access to resources, and every individual in society is a product of the choices they make. I had limited and narrow views regarding the lives of criminalized women, especially regarding the social and economic inequities that many of them experienced from a young age.

During the pre-research stage I started to reflect on the research topic and my own relationship to it. I began to explore previous literature and also volunteered at two different community organizations that assist criminalized women with health related issues and find housing accommodations. During this time I began to question my assumptions regarding the lives of criminalized women, and I reflected on my interest the research project. During the pre-research stage I became increasingly interested in exploring criminalized women's health related experiences in relation to infectious diseases. However, my interests changed to encompasses criminalized women's health and wellbeing; this evolution occurred after exploring more literature on the lives of criminalized women, and interacting with them in the community. At this stage of the pre-research process, I noted that my aim from this research project was to bring positive change and help facilitate the stories, voices, and needs of a group of people that is often unheard in society.

Since data was collected using a critical lens, I reflected on my role as a researcher and a free woman who has never been incarcerated, and the amount of power, control, and choice that I have in relation to the participants. In order to reduce the power

differences between the participants and myself I chose to dress modestly, and wear clothes that did not have any brandings or logos. I also reassured the participants that they can withdraw their participation from the study at any point. Throughout the research process, I aimed to keep an open mind and an attitude of interest in order to prevent my own assumptions and attitude from dominating the research process. During the data collection stage I sought to keep the voice of the research participant at the heart of the interview process, while noting my own involvement in the data collection stage. I noted that my role was not to fix the problems in the lives of the women, but to hear and communicate their stories and experiences during this stage. At the end of every interview I wrote reflexive notes that included reflections of my own thoughts and feelings regarding the participant's story, their context, and past experiences. One of the most challenging experiences that I had faced during the data collection phase was the feeling of guilt. I often found myself feeling guilty during and after finishing an interview with a participant, and this was linked to feelings of privilege due to my social status. This was especially true when conducting the interview with Liz, who is a similar age to me.

During the data analysis phase I aimed to respect the subjectivity of the study participants by keeping their voices at the centre throughout the data collection stage; however, according to Lieblich et al., (1998) "every reader is inevitably bringing her cultural, language, experience and expectations into her interactions with others or with texts" (p.76). Thus, the reading of the narratives is not viewed as being "true", but as one possibility (Lieblich, Tuval-Mashiach, & Zilber, 1998, p.77). Therefore, I was aware that my own views, opinions, educational background, personal lack of experience with the

correctional system. In fact, social status influenced my reading of the interview transcripts and the creation and analysis of the narratives.

Approach to Coherence

According to Lieblich et al., (1998), coherence is “the way different parts of the interpretation create a complete and meaningful picture” (p.173). Coherence can be evaluated internally (i.e., how parts work together), and externally (i.e., relative to existing theories and previous literature reviews) (Lieblich, Tuval-Mashiach, & Zilber, 1998). Throughout this research study I sought to be coherent by ensuring that the participants’ narratives were coherent and reflective of the stories that were shared with me during the interviews. In order to ensure the coherence in the participants’ narratives I acquired feedback from my thesis supervisors, and the feedback focused on the content and the structure of the narratives. I also aimed to establish coherence by completing a literature review that included studies which examined the lives of criminalized women. Many of the themes and storylines that emerged from this study were consistent with findings noted in previous studies included in the literature review.

Approach to Trustworthiness

Trustworthiness refers to the evaluation of study findings by a community of researchers (Michler, 1990). It is critical to focus on trustworthiness since it shifts the validation of truth from the tradition location in the “objective, non-reactive, and neutral reality” to the social world (Michler, p. 420). The community of researchers engaged in a particular field of study may question the reliability and the connectedness of a particular set of reported findings with their own work; therefore, “the task of articulating and

clarifying the features and methods of our studies, of showing how the work is done and what problems become accessible to study” (p.423), and interpretive decisions require justification (Lieblich, Tuval-Mashiach, & Zilber, 1998). This means that “narrative work requires self-awareness and self-discipline in the ongoing examination of text against interpretation and vice versa” (Lieblich et al., p.10).

Keeping an audit trail is a critical step when conducting qualitative research. Audit trail is described as “various ways to refer to evidence that the researcher has kept track of research events and decisions in a way that can be checked by an independent auditor” (Richards & Morse, 2007, p.199). Field notes were used throughout the course of this study to document the decisions made during the pre-research stage, and the data collection stage, and became part of the overall data set. Furthermore, I forwarded the transcripts along with the reflections to my supervisors following every interview. This was done in order to ensure that the process of data collection was coherent and credible.

Ethics

Approval from ethics was obtained from the Western University’s Health Science Research Ethics Board. There are some power relations that I accounted for when working with vulnerable populations; thus, it was important to establish trust and respect with participants (CIHR, NSERC, & SSHRC, 2010). As a researcher I was considerate of participants’ particular beliefs, values, lifestyle, occupations, and family dynamics. Participants involved in this study were not placed at any physical risk. Participants were asked to recall previous experiences, and this may have caused some emotional discomfort. Prior to the interview, participants were told that they would have the right to disclose information that they felt comfortable sharing. Participants were also told that

they had the right to withdraw from the study and/or the interview at any point.

Pseudonyms were given/ chosen to hide the participants' true identity.

The ethical considerations that I employed throughout this research study were those provided by the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS)*. The following principles were considered throughout the study: protecting the autonomy of the individual by seeking ongoing consent, protecting the welfare of participants by ensuring their privacy and confidentiality, ensuring fairness and equality between all participants (Canadian Institutes of Health Research [CIHR], Natural Science and Engineering Research Council of Canada [NSERC], & Social and Humanities Research Council of Canada [SSHRC], 2010) (Tracy, 2010).

Chapter Four: Participants' Narratives

The purpose of this chapter is to illustrate each participant's experience. Included here are the unique stories of each participant involved in this study, and the narratives that were constructed (Lieblich, Tuval-Mashiach, & Zilber 1998). I have included my thoughts and reflections during the interview process (Chase, 2005). Each narrative begins with a discussion of the global impression, which is followed by the description of each individual's unique themes. The themes found across all of the participant's narratives are also included. Throughout each of the individual narratives I used italics to indicate direct quotes from participants, in order to keep the narrative as close to the participants told story as possible. Table 1 presents each participant's dominant storylines generated from the analysis of each participant's narrative.

In this chapter I will also present the similarities within the participants' stories under the cross- narratives storylines section. I will be discussing the cross-narrative storylines that emerged from the interviews. As Polkinghorne (1998) reminded us, In order to provide a full illustration a story should include "both the elements that are unique to that particular story and those that can be found, at least in essence, in other stories" (Polkinghorne, p. 167). Each cross- narrative storyline presented is discussed in terms of its unique occurrence in each woman's story, and in relation to previous literature that examined the lives of criminalized women.

Individual Narratives

Table 1: The dominant storylines generated through the analysis of each participant's narrative

Participant's Name	Dominant Storylines in Each Participant's Narrative
Ruth	<ol style="list-style-type: none"> 1. Misdiagnosis of physical injury and addiction to prescription narcotics 2. Denial of prescription narcotics and learning to cope with withdrawal symptoms in jail 3. Expecting her voice to be heard and continuity of treatment in the future
Sarah	<ol style="list-style-type: none"> 1. From foster care to young offender 2. Denial of hypoallergenic hygiene products, prescribed anxiety medications, and asthma treatments while in jail 3. The experience of solidarity: Inmates' sit-down protest 4. Self-advocacy resulting from experiencing violence in jail 5. Advocating for increased access to health professionals
Rachel	<ol style="list-style-type: none"> 1. Experiencing limited access to medical treatments while in jail 2. Frequent incarceration resulting in disruptive and limited access to treatment in jail and in the community 3. Lack of gynaecological treatment in jail 4. Consistent health care access to criminalized women in the future
Liz	<ol style="list-style-type: none"> 1. Struggling to finish school and have permanent employment 2. Lack of control due to incarceration 3. Denial of treatment in jail due to the lack of family doctor in the community 4. Health is a human right and must not be denied to criminalized women
Mary	<ol style="list-style-type: none"> 1. Delayed treatments for active health concerns 2. Ignoring health concerns in jail 3. Advocating for humane treatment from jail staff and increase health care providers in jail

Ruth

Ruth's Story

Ruth stated that she is between 40 and 50 years of age, and lived most of her life without having a criminal record. She indicated that in her 30's she was incarcerated due to drug related charges. She described her life prior to incarceration as "*normal, happy, healthy life*", and through "*series of bad*" events she "*lost everything*". Ruth's trajectory to incarceration began at her place of employment where she suffered a serious work related physical injury. Since her injury she experienced frequent incarceration in provincial jail. Ruth was prescribed narcotics to deal with the chronic pain she experienced from her injury and she became dependent on prescribed narcotics; "*I was done my prescription and I needed more, so I would buy them off the street*". As well, Ruth experienced the loss of multiple loved ones shortly after becoming injured at work; thus, drastic changes occurred in Ruth's life "*my life started to fall apart*", and Ruth "*turn[ed] to drugs to deal [with her new reality]*".

Ruth did not describe the type of illegal activities that she was involved in which led to her incarceration in provincial jail, but she did serve multiple sentences in provincial jail. During her incarceration she indicated that she was never able to access the narcotic medications that were previously medically prescribed and then self-prescribed to manage her pain. This caused her to experience severe discomfort every time she entered jail stating "*I couldn't even get off the bed, [...] It is horrible, it is horrible! Throwing up, diarrhoea, throwing up [...] you feel like you are so close to death it isn't even funny [...] I would prefer a bullet [than] to go through that [...] it's horrendous.*"

Global Impression of Ruth's Story

A series of events impacted Ruth's family life and her career, which eventually lead to her incarceration. As a witness to her story, I felt an element of surprise at how much Ruth's life circumstances changed shortly after being prescribed narcotic medications. She was of the impression that the physician misdiagnosed her physical injury and prescribed her with the wrong course of treatment. Ruth felt that the misdiagnosis resulted in her addiction to prescription narcotic medications, which was a pivotal event in her story.

Incarceration in a provincial jail negatively impacted Ruth's overall health and wellbeing (e.g., experiencing withdrawals resulting from the sudden cessation of prescribed narcotics). While in the community, Ruth felt a strong sense of social judgment (i.e., inability to find employment), which she believed stemmed from her past incarceration experience. The following is a bulleted list of the unique themes for Ruth's story.

Ruth's Unique Storylines

Three unique storylines encompass Ruth's experiences prior to experiencing incarceration, during incarceration in provincial jail, and returning into the community.

1. Misdiagnosis of physical injury and addiction to prescription narcotics

Ruth endured a workplace physical injury, which played a critical role in changing her overall health and wellbeing "*I got hurt at work [...] I was on a fork lift, and I was getting off [...] I swung myself and landed [on my back]. I could not walk for two to three weeks*". At the beginning Ruth did not think that the accident was going to

have a colossal impact on her health “[*The doctor*] took me off of work [...] for two or three weeks [and] gave me mild anti-inflammatory [...]. [*The doctor said*] ‘You just pulled a muscle or something like that and it will be fine’”. However, Ruth’s health worsened and she attributes this to erroneous medical care; her doctor did not follow the proper course of diagnosis and treatment “If [*the doctor*] would have sent me right away for the proper testing, I would have been a candidate [for] surgery [...] but they waited too long [...] and now I am not a candidate”. A secondary course of treatment was assigned to help improve her physical injury “I went for physiotherapy for three or four months, and we realized that it was not working”. Finally, another course of treatment was prescribed to Ruth that included the administration of prescription narcotics to help ease her physical pain: “after going through many, many, many appointments with surgeons [...] my doctor prescribed narcotics [...] for the pain” and this is where her life began to change: “my life started going downhill. [...] I was prescribed narcotics, which was fine, but I started abusing them”.

Ruth indicated that during that time she was also mourning the loss of loved ones “my brother died, my dad died, my stepdad died all in a matter of a year and a half”. She used prescribed and non-prescribed drugs in order to deal with the physical and emotional pain stating “that is basically where everything started going downhill. [...] I was done my prescription and I needed more so I would buy them off the street. [...] My [...] brother[’s] [death] really knocked me for a loop [so I ended up] turning to drugs”. Shortly after losing loved ones she lost her job: “I just could not heal, and I started missing time from work. [...] I ended up getting fired from my job [be]cause I did not have my medication. [...] I lost everything basically”. Ruth depended on drugs in order to

cope with the pain that she was feeling: *“I made bad choices [...] turning to drugs when [...] I should have went to therapy [...] to deal with the [death of my brother]. I lost it all, and now I am getting it back, now my life is back on track”*.

2. *Denial of prescription narcotics and learning to cope with withdrawal symptoms in jail*

Ruth indicated that she served multiple sentences in provincial jails. She was prescribed and depended on prescription narcotics when she entered an Ontario provincial jail for the first time *“I was taking [...] 90 Oxycodone 40 mg a month, plus Percocet every month [...] I was hooked on this [prescription narcotics]”*. Ruth suffered severe withdrawal symptoms while she entered jail, and she described the symptoms:

Your brain shakes inside your head, because you need [the prescription narcotics]. I [...] had hot and cold flashes [...] diarrhoea [...] throwing up. [...] I could not even get out of bed [...] you can't sleep [...] you feel like you are so close to death. [...] you are well over a week before you can finally [feel better].

The correctional officers played a critical role in controlling Ruth's access to health care services while she was in jail. She described the power that the correctional officers had, and their capacity to deny her the health care that she needed. Ruth stated that she, and other inmates, were placed in the *“hole”* (also known as the *“segregation cell”*) while suffering withdrawal symptoms. She believed that the lack of care she received resulted from the correctional officers *“not want[ing] to be bothered by [inmates]. [The correctional officers] walk[ed] by [inmates] and [saw them] laying on the floor shaking, and they [did] not care”*. As a result, Ruth *“felt [...] condemned”* not only for the

criminal charges that she was serving time for, but also for depending on prescription narcotics and being “*pill sick*”. She felt judgment and condemnation from the correctional officers “[*A correctional officer said*] ‘*If you didn’t want to lose your prescription you should not have gotten charged*’”.

Ruth described being in provincial jail “*for short bursts*”, that totalled an estimated six month period. She visited a doctor once during the multiple times that she entered provincial jail, and it took her “*five months to make an appointment [...] with a psychiatrist*” while in jail. Since Ruth was not allowed to have her prescribed narcotics while in jail, she was given replacement medications; “*the doctor judges you accordingly and give[s] you what [he/she] thinks you need. [The doctor] won’t give you what your prescription is. I think they gave me Robaxacet [...] or something that you can buy off the shelf*”. The medications given to her by the doctor in jail were not helpful since she was “*on [...] high prescription [narcotics, so there was] no way something so minuscule [was] going to help*”. Ruth “*still took [the medication prescribed in jail]*”. In order to reduce her withdrawal symptoms she smuggled “*packages [of] Lorazepam [and] Gravol*” every time she entered jail, and she “*administered [the medication] through the first week*” of incarceration. Ruth did this to cope with the withdrawal pains that she was experiencing in jail.

The “*package*” smuggled into jail by Ruth helped her gain favour with some of the inmates in jail. In order to ensure her safety, Ruth had to appease the “*right people*” while in jail, abide by the social order of inmates inside jail, and live in accordance with jail “*etiquette*”. This meant that she had to “*pay [...] respect*” to “[*one*] *girl [that ran] the show*”. As a result, some of the medications brought into jail by Ruth, to help her cope

with the withdrawal symptoms, were given to the powerful inmates in order to gain favour with them. In this case, Ruth gave the girl *“half or maybe a full Lorazepam every morning”*.

3. *Expecting her voice to be heard and continuity of treatment in the future*

Ruth indicated that when she accessed health care in the past she felt that the health care providers *“did not care”* about her health needs, and didn't listen to her. In the future, Ruth expects to be heard and *“listened to”* and be treated *“like a human, [...] and not like a piece of crap [be]cause [she] made a mistake”*. She also believes that individuals should be able to access their prescribed medication in jail; therefore, if an individual is *“prescribed something by the doctor, [...] whether it is heart medication or diabetes [medication], of pain [medication], [and] if [the individual needs the prescription] regularly, [then] it should not vary [in] jail, especially when it comes to narcotics, because [they] could die”*.

Sarah

Sarah's Story

Sarah stated that her approximate age is in the early 30's and she *“grew up with just her father raising three kids”*. During her childhood years she received counselling for the abuse that she experienced from her mother, and was later placed in foster care. In her adolescent years, Sarah began to experiment with illicit drugs, and then developed an addiction to marijuana after she *“miscarried [her] baby. [Sarah] was five months pregnant when [she] fell down the stairs [and] ended up getting into drugs because of it”*. She experienced the death of her father shortly after, and this caused her to get *“into drugs [such as] cocaine [and] needles”*. Sarah *“[got] into trouble”* and was incarcerated

for the first time when she was under the age of 16, as a young offender. During her adulthood years, Sarah attempted to overcome her drug addiction “[I tried to] slowly [get] back up again, [...] and then I relapse[d], [...] and something screws up again and I end up in jail”. She served multiple sentences in provincial and federal correctional facilities as an adult, and throughout these years she was diagnosed with many health conditions for which she needed treatments for (i.e., asthma, hepatitis C, Attention Deficit Disorder (ADD), fibromyalgia, and anxiety). Her wellbeing was severely compromised many times while serving her sentence in jail, since she was often unable to access treatments prescribed for her health conditions (e.g., asthma inhaler, & prescription narcotics).

Global Impression of Sarah’s Story

Sarah felt marginalized and disenfranchised beginning at a young age and this experience persisted throughout the rest of her life. Incarceration negatively impacted her health and wellbeing due to the continual trauma, violence, and limitations to prescribed medication and treatments she experienced while in jail. She described a lack of access to prescribed medication that almost lead to her death while in jail. This lack of care regarding Sarah’s health instigated a response by other inmates to stand up for Sarah. Sarah’s story has elements of extreme social exclusion but also some solidarity developing among the inmates in jail as a result. The following is a bulleted list of the unique themes that were extracted from Sarah’s story.

Sarah's Unique Storylines

Five unique storylines encompass Sarah's experiences prior to experiencing incarceration, during incarceration in provincial jail, and returning into the community.

1. From foster care to young offender

Sarah began her story by describing her early childhood years, and reflected on the challenges that she faced from a young age. She stated that “[she] was forced to give up [her] childhood to become an adult quicker [because her] mother use to abuse” her and her siblings “really bad[ly]”. Sarah “grew up with just [her] father raising three kids” because her mother left the family. Following this Sarah stated that she “had to go to [...] counselling, [...] like play therapy” where she “learn[ed] how to play [and be] be nice to people”. She was then placed in foster care for a number of her childhood years where she “had to become an adult really quickly, [she was] not a kid, [she] had to be an adult, that was something [she was] forced to do”. Sarah did not provide a description regarding the length of time or the experiences that she had while in foster care and therapy; however, she highlighted that both experiences had a negative impact on her childhood years.

Sarah continued her story by reflecting on her adolescent years, and described the experiences of her miscarriage, death of her father, and death of her brother as contributing to her illicit drug use and incarceration. Sarah's illicit drug use “started [when she] was twelve years old” when she “smok[ed] weed”. She then “miscarried [her] baby [at] five months when [she] fell down the stairs. [Sarah] had to give birth to the baby, [...] to a dead baby”, and she believes that the miscarriage experience

“traumatically screwed [her] up in the head” which caused her to “get into drugs [...] like cocaine [in order] to kind of numb” the pain “[but] it didn’t [...] help.” Sarah’s initial incarceration experience occurred when she was “a young offender, [...] under 16”, and it was “due to [the] drugs [that she] fell [...] really hard [...] into” to cope with the miscarriage. Shortly after her miscarriage and incarceration in juvenile detention centre Sarah’s father died and she had a failed suicide attempt. Sarah attempted suicide because she felt that she was “coming out to nothing, having nothing, no-where to live, nothing, [...] just the drugs”.

2. *Denial of hypoallergenic hygiene products, prescribed anxiety medications, and asthma treatments while in jail*

As an adult, Sarah experienced incarceration in provincial jail, and federal prison. However, all of the experiences described in this narrative occurred while she was serving her time in provincial jail. While in the community Sarah was diagnosed with and received treatments for multiple health conditions (i.e., asthma, allergies to sulphate, *Chronic obstructive pulmonary disease* (COPD), hepatitis C, fibromyalgia, panic attacks, & ADD). When Sarah entered jail she was unable to access “half of the medication that [she was] on,” such as, “Benzo [benzodiazepine], which [are] anxiety pills”.

Sarah described an experience when she was unable to access a prescribed asthma inhaler. Sarah has “really bad asthma” especially at night, and she has been prescribed a “blue Ventolin inhaler” that she is “supposed to carry [...] on [her] for emergency”; however, when she was in jail she was unable to keep the inhaler with her although inmates “are [...] allowed” to carry it with them. While Sarah “was playing basketball [she] had an asthma attack [...] and” needed to use the inhaler, and the correctional

officers had to bring her the inhaler. Sarah stated that “*it took [them] half an hour*” to bring her the inhaler, and “*If [she] didn’t know [how] to breath in a bag [she] would have probably died*. The correctional officers were not able to find Sarah’s inhaler in a short time “*because the nurse failed to put the names on the inhaler, so they were bringing [her] all these different inhalers that belong to different people.*”

Sarah was also unable to access hypoallergenic hygiene products while in jail, and consequently experienced a severe allergic reaction. Sarah is “*allergic to sulphate, [...] it is in a lot of the shampoo [and] body washes.*” Every time Sarah used the shampoo she “*was breaking out in [a] rash*” and had difficulty breathing. Sarah stated that she could have died if she used the hygiene products provided to her in jail because she “*was starting to turn purple and the [correctional officers] didn’t do [anything]*”. The correctional officers recommended for Sarah to purchase her own hypoallergenic hygiene products from the canteen, but Sarah could not “*get canteen*” because she did not “*have anyone visiting [her]*”, and did not have any family that placed “*money into the canteen*” that could be used to purchase the hypoallergenic products that she needed.

3. The experience of solidarity: Inmates’ sit-down protest

Sarah was eventually escorted to the health services in jail to receive treatment for the reaction that she developed to the hygiene products. Interestingly, she stated that the inmates played a critical role in helping her gain access to a health care provider, because the correctional officers were refusing to help her. “*There was almost a riot [where] the inmates [...] did a sit down protest in there; [...] nobody would go to their cells.*” Sarah believes that “*If it was not for*” the sit-down protest done by the inmates, she “*would not have seen the doctor*”.

4. *Self-advocacy resulting from experiencing violence in jail*

Sarah served multiple sentences in provincial jail, and she experienced a lot of violent encounters with other inmates. During her most recent incarceration in jail the correctional officers placed Sarah with “*a couple of girls*” that she had “*a lot of problems with*” while in the community. Sarah was “*basically [placed] on the range with five girls [...] that tried to jump [her]. [Sarah] ended up getting sucker punched in the face, [and] could have gotten really hurt.*” Sarah’s “*eye [was] cut open, [her] head was bleeding [...] and the [correctional officers] didn’t even do anything, [instead] they put [her] in the hole.*” As a result of previous incarceration experiences in provincial jail, Sarah described that she was willing to “*throw shoe at the judge and try to get penitentiary time, than spend a month in that jail.*”

5. *Improve health care by increasing health professionals and training correctional officers in medical aid*

Sarah described that during her incarceration in jail she was unable to see a doctor more than once or twice. She indicated that in order to improve health care access for criminalized women, inside of jail there must be an increase in the number of health care workers to meet the diverse health needs of the women. She expects to see “*more doctors in [jail], because [there are] many inmates*”. Furthermore, since correctional officers have the first contact with inmates, Sarah expects that the correctional officers “*get some sort of [...] course, [where] they recognize certain symptoms in people.*”

Rachel

Rachel's Story

Rachel indicated that she is in her early 30's, and she has *“been in and out of jail since 1996/1997”* an estimated *“30 or 40 times”*. Rachel has served a total of *“eight years [to] nine years”* in multiple provincial jails in Ontario. She has *“tried to get [her] life back together”*; however, due to her addiction to drugs she relapsed and *“blew everything up”*. She experienced a lot of violence inside and outside of jail, and the violence she endured while inside of jail often prolonged her period of incarceration. Rachel suggested that the violence was endorsed by the correctional officers who, she affirmed more than once, asked her to *“punch out”* other inmates.

Rachel has been diagnosed and treated for multiple infectious diseases and mental health problems, and spent the past 13 years in and out of jail with stays varying from *“30 days”* to *“ten months”*. Rachel often endured disruption in medication delivery while in jail. In order to receive her prescribed medication, she had to *“call the pharmacy, [...] call [her] lawyer, [...] call [her] mom, and a whole bunch of people advocating for [her].”*

Global Impression of Rachel's Story

Rachel was the only participant in the study who was on probation and residing in a half-way house during the time of the interview. Rachel's story emphasizes the tangles and the obstacles that have been created by the correctional system as inmates attempt to access health care. As noted in Rachel's story, accessing health care in jail and in the community is a never ending struggle for inmates. The following is a bulleted list of the unique themes that were extracted from Rachel's story.

Rachel's Unique Storylines

Four unique storylines encompass Rachel's experiences prior to experiencing incarceration, during incarceration in provincial jail, and returning into the community.

1. Experiencing limited access to medical treatments while in jail

During her last incarceration period, Rachel was diagnosed with MRSA (Methicillin-resistant Staphylococcus Aureus), and while she was in jail she got “*a few abscesses [that] they can take care of*” in jail; however, Rachel stated that the MRSA treatment provided for her in jail was “*not up to standards*”. She stated that when she would receive the MRSA treatment, the correctional officers (not health care providers) took her “*into this little back room and they change[d]*” the bandages. The bandages were not changed as regularly as is required, because the correctional officers did not “*take [her] down there every day like they are supposed to*”. Rachel stated that she was prescribed “*Septra [(trimethoprim and sulfamethoxazole) a synthetic antibacterial combination product]*” but she did not receive it while in jail: “*they took me right off of it without talking to my doctor*”. Rachel believes that as a result of the lack of regular treatment for the MRSA infection she developed “*two holes in [her] legs [which] didn't heal properly [because she] was in [jail] for 80 day, [and] when [she] got out they boiled again and [she] had to get them [treated] again*”.

Furthermore, before entering jail Rachel was diagnosed with “*bronchitis, so they gave [her] a puffer where [she] crush[ed] pills*” into. Rachel “*was supposed to have it in the morning, which the nurse would bring it and at lunch, and again at 2:00*”, but when she “*was [placed] in seg [segregation] they constantly [didn't] come [to] see [her]*” and

bring her the puffer, “and they would not let [her]keep it in my cell, [Rachel] would [gasp] ‘I need my puffer’, and the [correctional officers] will be like ‘you gotta wait, you gotta wait’”.

Rachel was diagnosed other health conditions that required treatment. She stated that when she entered jail she was prescribed “2 mg of Seroquel in the morning, 2 [mg] at night, 2 rits [Ritalin] in the morning and 2 [Ritalin] at night”; however, because Rachel missed “one drink [of] methadone before [she] went” into jail, the doctor “cut [her off of the] rits [Ritalin] and Clonazepam”. Rachel was on “10 mg on my methadone. [And] the whole time [she] was in there [she] was not taking [her prescribed] Seroquel”, so she was not able to “sleep at night [and got] really mad” when they do not give her the prescribed medications.

2. *Frequent incarceration resulting in disruptive and limited access to treatment in jail and in the community*

Rachel’s frequent incarceration influenced the way she accessed health care services inside and outside of jail: “I have been in and out of jail since 1996[...] I can’t even count the number of times I have been in jail, [maybe] between 30 or 40 times”. She stated that she “did a week here, a week there, just stupid little breaches. [...] But all together [she has] probably done eight years, nine years.” Rachel has “been trying to get my life back together,” and during the time of the interview she was “on methadone now, [on] bail, [and living in a] half-way house”.

Rachel was managing several health issues requiring treatment so she “would see the doctor once a month” while in the community, and a “psychiatrist [who] had filled out

two month prescription [...] of Ritalin and Clonazepam.” During one of her incarceration periods, Rachel described that she had access to her prescribed treatments for an entire year, and when she was released from jail she “went to the walk in clinic [and] they would not fill [the medication] out for [her], and the doctor there [did] not even give [her] the blister packs, [...] for a couple of days until” she was able to “get a script”. Since the “walk in clinics can’t call the health care at the jail” and she did not “have a family doctor when [she got] out” she felt “screwed.”

3. Lack of gynaecological treatment in jail

Rachel’s story indicated the lack of health care access impacted the entire inmate female population. Her story demonstrated how women in jail struggled to gain access to emergency gynaecological.

My friend [...] was pregnant, and I could hear her screaming, she ended up having to miscarriage, and she is in her cell for three days we were in lock down. [...] It was horrible. [...] Later on at night if you walked by to go to the bathroom you could smell it. [The correctional officers] just told her she [had] to wait, she got out four days later, and they [didn’t take] her to the hospital to get a D and C [Dilation and Curettage]. The [correctional officer said] ‘oh she is fine, she will be okay, she is faking’, [Rachel said] ‘she is not faking, like go take a look there is a little thing in a bag in her room’, [the correctional officers said] ‘well, keep it and show it to the hospital’. [...] It is like they don’t take you seriously, [...] and you have to go through the [correctional officers] to get to health care.

4. *Consistent health care access to criminalized women in the future*

As noted earlier Rachel needed multiple health treatments and medication, while in the community and in jail; therefore, she expects that health care access in the future to be consistent for women inside and outside of jail. She added that when inmates request to visit a doctor then “*they actually see the doctor*”. Rachel “*understands [that] in jail [inmates] lose some of [their] rights*”; however, she hopes that inmates are treated with respect by the correctional staff, and receive their medications and treatments when needed.

Liz

Liz’s Story

Liz indicated that she was in her late 20’s and at the age of 16 she moved out and lived on her own after her “*parents got divorced*”. She did not “*get along*” with her mother after the divorce, and she described experiencing depression and anxiety during this time. While living by herself, Liz continued to attend high school and work but she found it “*tough*”. During this time in her life she began to “*get in trouble*” and was “*drinking and doing drugs*”. Liz’s first incarceration experience occurred when she was 16 years old. She was charged for assault, robbery, and extortion and sentenced to a young offender facility in Ontario. She described the latter event as a pivotal point in her life “*after being in the system at 16 it felt like [...] I was always constantly getting in trouble with the law. [...] I just could not stay out of trouble*”.

After her release from the young offenders facility Liz worked different jobs, and eventually had a relationship with a guy who was “*abusive physically, mentally, [and] emotionally*”. Liz and her partner got into “*an altercation [while they were] drinking*”

which caused both of them to be charged with domestic violence, and this time she was charged as an adult and sent to jail. Liz described that her anxiety and depression worsened while she was in jail and this was due to the overall jail environment. She attempted to access health care in order to receive treatment for the depression and anxiety, and she did that by meeting with the nurse in jail; however, she *“was denied health care because [she] didn’t have a doctor”* in the community, and the nurse recommended that *“because [Liz] was not going to be in [jail] for a long period of time, [she should] just wait until [she] got out and go make an appointment to go see a psychiatrist”*. Liz’s anxiety and depression *“sky rocketed”* and she resorted to using other inmates’ prescription medications to cope with her condition while in jail *“a few times a couple of the girls would get Seroquel or Trazodone at night”*.

Global Impression of Liz’s Story

Liz described how she became independent by a young age, and how her health and wellbeing were greatly impacted as a result. While Liz attempted to live independently she struggled to complete her secondary school education, find meaningful employment, and to stay out of trouble with the correctional system. Liz reflected on her struggle with mental health issues, and how those issues were often a critical to her incarceration. While incarcerated, Liz’s mental state deteriorated further; yet, she was unable to receive the proper treatments because she did not have a family doctor in the community.

Liz's Unique Storylines

Four unique storylines encompass Liz's experiences prior to experiencing incarceration, during incarceration in provincial jail, and returning into the community.

1. Struggling to finish school and have permanent employment

Liz's "parents got divorced when I was 13, [and] after the divorce" she began to get in "troubled, [she was] drinking and using [...] marijuana. Liz "moved out at 16 [...] on [her] own going to school" while working different types of jobs such as cleaning and waitressing. Liz tried "to graduate from high school", but found that it "was kind of tough". Her "first charge was [for] assault, robbery, and extortion" where she spent "three months, 90 days in a young offender custody facility." Shortly after serving her time as a young offender, she met a man that she had a relationship with for four years. Liz described her partner as "abusive, physically, mentally, [and] emotionally", and the domestic violence contributed to her worsening depression and anxiety "I was going through a lot of depression, [and] anxiety, [and] my body was really achy and [the] aches and pains [were] from being depressed".

2. Lack of control due to incarceration

Liz's depression and anxiety worsened while she served her sentence in jail, and she believed this to be linked to the lack of control, disempowerment, and fear that she felt upon entering jail for the first time. "Being in [the jail] environment [was] stressful enough", and Liz described it as "the worse situation [she has] been in." She felt "helpless and hopeless" because she could not "do nothing". She was not able to "do what [she] normally [did] on the outside", which made her feel that she was "not in

control in there of [herself].” The feelings of disempowerment and lack of control made Liz feel “*helpless, [...] really scared sad, and depressed.*” She coped with the worsening of her depression and anxiety while in jail by keeping to herself, and since she is “*an artist [and] love[s] drawing*”, she would “*just sit and draw, and a couple of the other inmates notice that, and they liked [her] drawings*”. Liz was able to “*earned extra food and stuff*” by drawing images to other inmates who were sending letters to their loved ones.

3. *Denial of treatment in jail due to the lack of family doctor in the community*

Because Liz’s depression and anxiety “*sky rocketed, it was really bad, it was hard to sleep, [and she] could not sleep at night*”. Liz requested an appointment with a health care provider in order to receive treatment while in jail, to “*help [her] sleep or calm down or to relax*”. However, she described that she was “*denied health care*” while she was in jail because she did not have a family doctor in the community. Liz “*asked the [correctional officers] a few times to see the nurse,*” but she “*never got to see the nurse, the only time [she] got to see the nurse was one time*” during her incarceration. The nurse was not able to provide Liz with any type of treatments to help with the elevated anxiety and depression, instead the nurse recommended that Liz should “*just wait until*” her release then “*make an appointment to go see a psychiatrist.*” In order to cope with the lack of health care and the elevated depression and anxiety that she was feeling, Liz used other inmates’ prescribed medication. Liz stated that “*some of the girls were nice enough to give [her] something that could help [her] sleep,*” and some of the medication that she was receiving from other inmates included “*Seroquel or Trazodone at night*”.

4. *Health is a human right and must not be denied to criminalized women*

Liz indicated access to health care is her right and as a Canadian she is entitled to “health care [inside of jail, and] outside of [jail]”. In the future the rights of criminalized women must be protected, and since she was “denied health care [in jail]”, she suggested jails “should have nurses, doctors, psychiatrists [...] since a lot of people that are in and out of jail have [...] mental issues and health problems”. Liz expects that by increasing health care providers in jail, criminalized women will have improved access to health care, and this is especially important since “jail is over packed”.

Mary

Mary’s Story

At the time of our interview, Mary indicated that she was in her 20’s. Mary stated that growing up she was “never like a troubled child”, and she was “kind of quiet, [and] didn’t really talk”. She had a dependency on illicit drugs and “was in and out of rehab [institutions]”. Mary’s first arrest occurred a couple of year ago; however, it is not clear the number of times that Mary served time in provincial jail. Mary struggled with mental health issues prior to incarceration, and she described that her mental health status further deteriorated while in jail “I was always [...] over paranoid [in jail], I could not sleep at night time at all”; the latter was a direct result of from being in the jail environment.

Mary had multiple health issues requiring treatment when she entered jail, and they included a skin abscess on her arm, lung cavity resulting from “living in [an] apartment that [...] had bad mould problems, [which] caused [Mary] breathing problems”. She also stated that she had physical pain from an unknown cause. When serving her sentence, Mary was not able to access health care services as frequently as

she needed, and this caused her to have feelings of anxiety and fear. She often asked to visit a medical care profession in jail but “[the correctional officers] would not let [her] see the doctor, [...] and every time [she] tried asking them, [...] they just ignored [her], [...] and didn’t listen to [her]”. Mary was often afraid that she may die in her sleep due to the extensive breathing problems that she had. She often felt that “[the jail staff] didn’t care for anybody, and [they saw the inmates] as criminals, [...] and they don’t really matter, [...] so [the inmates] don’t deserve to get the proper health care that [they] need”. As Mary continued to tell her story she expressed that “a couple of girls that [she] knew in [jail]” helped protect her from other girls, and this helped ease the anxiety and fear.

Global Impression of Mary’s Story

Throughout Mary’s story she expressed many times where she felt ignored and neglected, which often made her feel in despair. She spoke about her struggle with mental health issues which began while living in the community, and she described in detail how her mental health status deteriorated when she served her jail sentence. Mary emphasized throughout her story the way others treated her when she accessed health care as an inmate, and how that impacted her health. Mary often felt mistreated by the correctional officers and health care providers in jail; furthermore, she felt that she was not treated with the dignity and respect that she deserves as a human being. She concludes her story by advocating for improved treatments of inmates in jails.

Mary's unique themes

Three unique storylines encompass Mary's experiences prior to experiencing incarceration, during incarceration in provincial jail, and returning into the community.

1. Delayed treatments for active health concerns

Mary accessed health care services frequently, while in the community, because she received treatments for multiple health condition. She has *"been in and out of rehab [...] and at the time"* of her arrest she *"was using"* illicit drugs, and had *"a lung cavity, [...] from living in [an] apartment"* that had *"bad mould problems"*. Mary did not seek health care while in the community for the lung infection right away, and she *"left it too long"* which caused her *"a lot of breathing problems."* Mary also experienced physical pain in her side, and she was prescribed medications for it shortly prior to her initial incarceration experience. She indicated that health care providers were not able to *"figure out"* the cause of the pain, but *"the doctor"* prescribed her *"pills for the pain"*; yet she *"still [has] a problem with [her] side."*

2. Ignoring health concerns in jail

In jail, Mary *"could not sleep at night"* because of the physical pain that she was feeling, for she has been prescribed medication for while living in the community. She was able to see a medical doctor one time during her incarceration in jail, and had an appointment with the doctor *"for like maybe five minutes"*. Mary said that the doctor *"didn't really let [her] explain anything"* during her visit, and *"prescribed [her] Flexeril, or something like that, which is what they prescribe everybody apparently in there."* She was not able to take the medication *"because it made [her] legs go numb, and [she]*

didn't like it.” Mary “*tried telling*” the health care staff in jail this, but “*they didn't listen*”.

Mary attempted to schedule follow-up appointments with the doctors in jail, but she was not able “*to see [a doctor] after that*”. Furthermore, every time she “*complained about*” the pain that she was feeling, she was told that she was placed “*on a list to see the doctor*”, and that she had to wait. Mary indicated that when she was scheduled to access health care it was always after her a court hearing, but she would never return back to jail; thus, she would not receive care. As a result of being ignored and not listened to, Mary “*stopped asking*” to see a health care provider while in jail, and instead she pleaded guilty to “*two charges*” because this way she was able to do less time in jail. Mary was not “*able to handle more time, because it was just [...] ridiculous in there*”.

3. Advocating for humane treatment from jail staff and increase health care providers in jail

Mary's future expectations is that there will be “*more doctors, more nurses, and more staff*” to address the needs of women in jail. She also indicated that health care providers in jail “*should listen to the inmates instead of pushing them off right away [...] because some people actually tell the truth*”. She also described that women inside of jail deserve to be treated humanely by the jail staff, especially the correctional officers since they “*are not just people that are coming in off the street for whatever reason, [criminalized women] are actually people, just like [the jail staff] underneath their uniforms*”.

Cross Narratives Storylines

1. Low socio-economic background and compromised health and wellbeing prior to incarceration

The first common storyline found across all of the narratives is that the participants described their health and wellbeing as already compromised prior to their entry into jail. Participants indicated having a troubled family history, which was often coupled with mental health conditions (e.g., depression, thoughts of suicide, addiction to illicit substances, bipolar disorder, and anxiety). Participants described having difficult experiences during early childhood and adolescent years; for example, spending childhood years in between home and foster care, leaving home during adolescence while attempting to attain an education and have meaningful employment. The participants' narratives illustrated how their lack of social support from a young age resulted in compromised mental health and wellbeing while living in the community.

Another common storyline within the participants' narratives showed that the women frequently experienced unemployment, and a lack of permanent accommodations. Participants reflected on the social and economic inequalities experienced prior to incarceration, and how such experiences often resulted in further deterioration of their financial situation, which directly impacted their health and wellbeing. In order to deal with the worsening of health status and deterioration in financial and social situations, participants described resorting to the use of illicit drugs in order to deal with their particular issues. As a result, all of the participants indicated developing addictions prior to incarceration.

2. Limitations to health care access in jail resulting in worsening of health

The second cross narrative storyline found in the participants' narratives showed that the inmates faced multiple limitations and challenges when attempting to access health care in jail. All of the participants involved in this study discussed the limitations they faced when attempting to access prescribed treatments/medications provided to them prior to incarceration. This included limited access to prescribed narcotics, asthma medication, psychotropic treatments, pain-killers, and anxiety medication. Participants emphasized the critical role of the correctional officers in limiting their ability to access health care in jail. The study participants described the power that correctional officers had in controlling inmates' ability to access to health care in jail. The correctional officers often denied inmates health care access because the correctional officers (not health care professionals) determined that the inmates did not require care.

Participants spoke about the relationships formed between inmates in jail, and described the importance of such relationships as a way to overcome the limitations to health treatments in jail, and helped to secure access to health care. Some of the methods used to help other inmates cope with the lack of health care access involved sharing of prescription medications and other illicit drugs. Participants described that the inmates cared for each other's health and wellbeing, and often advocated for each other when an inmate was attempting to access health care in jail, even if inmates risked being punished by the correctional officers.

3. Inadequate living condition in jail resulting in deterioration of health

Participants described that the jail environment had a critical impact on their health and wellbeing. The jail's environment had a great influence on the health of participants, leading to poorer mental health and feelings of hopelessness and helplessness, while increasing feelings of anxiety, depression, and stress. Participants described that being placed in a segregation holding cell, also known as "the hole", for an indefinite amount of time caused them to feel increased anxiousness and paranoia, which made them feel even more powerless. The participants noted that their health and wellbeing was compromised as a result of experiencing long periods of lockdown in poor living conditions.

Participants indicated a reduced ability to care for their health and wellbeing while in jail, and this was partly due to their inability to access adequate hygiene products, clean clothes, healthy food, and necessary cleaning products. Participants also described that the only type of food served in jail was high fat processed food, which caused rapid weight gain

4. Advocacy for improved treatment of criminalized women

Participants in this study advocated for improved access to health care services in jail, and further added that the medical staff must view inmates as humans, and provide them care accordingly. The findings of this study reflected that women in jail experience inhumane treatment from the correctional officers and other facility staff. In this study all of the participants reported feelings of disrespect, lacking power, and dehumanized as a result of the treatment of the jail staff. Participants described being treated like animals in a cage while in jail, and not as humans. A common storyline among all of the participants' narrative was their advocacy for respectful treatment, and for their requests

to access health care in jail to be taken seriously and not ignored or viewed as deceptive. Participants recommended that jail staff, particularly correctional officers should receive some type of primary medical training in order to response properly during cases of emergency.

Chapter Five: Discussion and Conclusions

The focus of this critical narrative study was to collect the stories of women who served in Canadian provincial/territorial jails and explore their health care experiences and their future expectations regarding health care access in jail. In the previous chapter, the women's narratives were presented to illustrate the unique stories of each participant, and the cross narratives themes and findings based on each participant's individual story. In this chapter I will integrate previous literature on criminalized women and health access, in order to discuss the potential similarities and contrasts between the stories from this study and previous research. Also, I will discuss the areas where further research is needed, particularly the role of women's life contexts (i.e. gender, and social/economic status) in relation to incarceration. I will conclude the chapter with the final considerations and the limitations of the study. Lastly, I will reflect on the new insights that I have gained as a result of conducting this research project, and relate it to my personal story.

1. *Consequences of a fragmented health care system*

Researchers have recognized that criminalized women experience movement in and out of jail/prison, and this leads to fragmentation in their access to health care (Sered & Norton-Hawk, 2008). Criminalized women experience a lack of coordination among healthcare services, and this is due to the place-bounded nature of prison/jail. “Place-bound” refers to the specific spaces, relationships, and cultural practices in which operations are carried out (Hess, 2004). Incarceration bounds individuals to a particular space to well defined physical and social boundaries. As a result, criminalized women with short sentences are not able to go back and visit a health care provider in prison/jail after their release, nor are able to visit their health care provider in the community while incarcerated (Sered & Norton-Hawk). Participants in this current study who described being incarcerated multiple times, within short periods of time, struggled to receive their prescribed treatments/medications while in jail and after their release; consequently, causing participants to experience adverse health outcomes related to their physical and mental wellbeing.

The lack of care continuity, experienced by the women in this study, is consistent with the study findings on the challenges of ‘transitions’ in care from one setting to another; for example, transition of individuals from acute care hospitals to home care (e.g., private residence of client) (Naylor, & Keating, 2008; Naylor, 2004). Literature on ‘transitions’ in care describes that individuals receive care from multiple providers when hospitalized; however, individuals experience a breakdown in care upon transition into home care. The literature also describes a great need for translational care services in order to ensure that the experience of transition does not lead to adverse events, increases

the satisfaction of care, and lowers the rates of rehospitalisation (Naylor, & Keating; Naylor).

While in jail, women lose their freedom and autonomy, and their ability to self-care is reduced (Sered & Norton-Hawk, 2008). The same context was described by participants in this study. In order to reduce the impact of the fragmentation in health care access experienced (i.e., in the moving between community and jail settings), the women in this research described engaging in criminalized activities that included purchasing illicit substances while in the community, and/or smuggling, using, and distributing illicit drugs/prescribed medication with other inmates in jail. The women noted that engagement in such activities caused their health to worsen, but was perceived as a feasible method to maintain continuity of care across settings and self-manage their personal care in a system that is so fragmented.

2. Moral economy of jail

An ethnographic study conducted among homeless heroin addicts in the city of San Francisco explored street-base income production initiatives (e.g., panhandling, recycling, day labour, shoplifting, street-level heroin selling, & warehouse burglary), and the moral economy of the social networking between homeless drug addicts. The study described that the sharing of drugs among homeless heroin addicts invited moral and economic debt for future exchanges of drugs, which was described as an investment in a “complex gift giving economy” (Bourgois, 1998, p. 2331). The author described that the participants in the study shared “ancillary paraphernalia” (i.e., water from the same cup, same heating/mixing containers, same cotton filters) when injecting heroin; furthermore, a single participant rarely had enough money to buy one “bag” of heroin, and this

resulted for the sharing of heroin to be limited to the “ancillary paraphernalia” (Bourgois, p. 2330). According to Marcel Mauss, “reciprocal gift giving distributes prestige and scarce good, and services among people living in nonmarket economics” (Bourgois, & Schonberg, 2009, p. 6; Mauss [1924] 1990). Participants in that ethnographic study were middle-aged males, primarily white, homeless, and addicted to drugs (Bourgois). The participants in the ethnographic study constructed themselves as being dependent on each other for many reasons, and through their engagement in drug sharing practices, participants described that their support network with other homeless heroin users was strengthened, and these relationships increased their ability to survive the street environment (Bourgois).

The women in the current study spoke about smuggling illicit drugs and prescription medication into jail. The smuggled substances were used as currency in jail, and were exchanged between inmates. The sharing of drugs subsequently caused the formation of supportive relationships between inmates, which sometimes helped balance the power between the inmates and the correctional officers. Establishing good rapport with other inmates in jail, through the sharing of drugs and medication, was critical since it allowed for participants to depend on one another and help overcome the fragmentation and limitation experienced in health care access. For example, the formation of a strong relationship between inmates helped to contest the power difference between the inmates and the correctional officers in jail. Study participants described that the correctional officers had complete authority and power to allow or disallow inmates from accessing health care services. However, the solidarity between inmates and their dependency on one another allowed inmates to establish and utilize their own social network in order to

circumvent decisions made by the correctional officers. The solidarity between inmates did help ensure access to health care for inmates sometimes.

3. *A single narrative to describe criminalized women: neglecting to acknowledge the complexity of criminalized women's experiences*

3.1 *Criminalized women as offenders*

A single narrative has been constructed and used by the criminal justice system to describe criminalized women which portrays them as irresponsible, irrational and dangerous to others around them (Franklin, 2008). This narrative has been used by the justice system to punish women, especially those who have been victimized and abused by their intimate partners (Franklin). As a result, the correctional system often neglects to consider the gendered context of violence experience by criminalized women (Franklin). The construction of a single narrative to describe the lives of criminalized women is problematic; their life complexity is illustrative of many women in violent relationships who are arrested for domestic violence charges. This is critical since many criminalized women, who are often victims of violent relationships, lose protections offered to victims by the justice system (e.g., safe transport from a violence home, and access to shelters) (Franklin). In the current study, Liz's incarceration was linked her role as an offender in a domestic violence situation. The correctional system classified Liz as an offender without taking into considerations other factors that are linked to her engagement in violent behaviours. This provides an example of how a single constructed narrative has been used to describe criminalized women as offenders by the criminal justice system.

Another factor contributing to the single narrative, which constructs criminalized women as offenders, occurred during the 1980s and the 1990s. During this time the media began to communicate a single story which focused on portraying the pregnant criminalized woman as irresponsible, addicted to drugs, incapable to taking care of herself, and a serious threat to her child(ren) (Franklin, 2008). Such portrayal of criminalized women in news reports exposed the public to the mental and physical consequence of drug use on the baby. As a result, public prosecutors began to find various ways to prosecute pregnant criminalized women (e.g., child abuse, neglect, manslaughter, drug trafficking) (Franklin). Judges used harsher sanctions on pregnant criminalized women, addicted to drugs, as a way to protect the unborn child. However, this has been done with a lack of consideration to the chaotic context of women's lives, health needs and the type of health care available to them in prison/jail (i.e., prenatal care, drug treatment services) (Franklin).

3.2 Offenders who are irrational and deceptive

Other element that add to the single narrative that constructs criminalized women as offenders, is their portrayal as individuals who are irrational, deceptive, and in need of reform (Kitly, 2012). The women in this study described being denied access to health care in jail because the correctional officers viewed their health concerns as deceptive, over exaggerated, or attention seeking methods. The distrust in and the de-legitimatization of the health care needs of criminalized women is rooted in sexist stereotyping of criminalized women, who have been portrayed as generally morally deviant (Franklin, 2008). Society's distrust of criminalized women also stems from the notion that these women are classified as "problematic" and have fallen outside the

traditionally accepted gender roles; thus, being classified as less respectable and deemed unworthy of protection (Franklin). There have been multiple reformation efforts, designed to (re)shape criminalized women into a socially acceptable feminine mould in order to fit the prevailing normative gender role (Chesney-Lind & Pasko, 2004; Chesney-Lind & Shelden, 2004; Humphries, 2003). Many criminalized women who do not conform to the accepted gender role have been deemed as lacking standards of femininity, and punished more relative to those that conform to feminine gender roles (Franklin).

3.3 Challenges against the common narrative

Research evidence confirms that relative to non-criminalized women, criminalized women are more likely to have been placed in child care, run away from home during adolescent years, and endure an absence of normative childhood experiences (Condon, Hek, & Harris, 2008; Orchard, Farr, Macphail, Wender & Young, 2012; Orchard, Farr, Macphail, Wender, & Wilson, 2014). Prior to incarceration, many criminalized women are disempowered, experience social exclusion, lack permanent housing, are 10 times more likely to be unemployed, experience domestic violence, and be sexually abused at some point in their life (Condon, Hek, & Harris). The findings of this study concur with previous literature as the participants described very troubled family histories. However, it is critical to note that criminalized women's lives have a great deal of complexity, where their roles as the victim and the offender often overlap (Franklin, 2008). Liz's story embodies both elements of offender and victim. She left home at the age of 16, and lived on her own while attempting to attain a secondary school degree. She described multiple health challenges particularly to her mental health status.

However, part of Liz's story indicated that she was incarcerated due to engaging in violent activities within a domestic partnership, where she was both the offender and the victim.

Evidence from the research literature supports the continuum of "victim" and "offender" found in the criminalized women in the current study, as this leads to blurred boundaries. The concept of blurred boundaries emerges in the literature exploring "women's pathway to crime", and many criminalized women characteristically experience trauma including abuse, maltreatment, and violence at home (Franklin, 2008); thus, "potentially providing a catalyst for a life of crime through self-medication, and drug use" (Franklin, p. 347). Moreover, women who have been battered and abused, both physically and sexually, are likely to fight back/kill their domestic partners (Chesney-Lind & Pasko, 2004; Franklin; LaViolette & Barnett, 2000). Currently the criminal justice system often arrests these women as perpetrators of family violence (Chesney-Lind & Pasko; Franklin; LaViolette & Barnett). The concept of blurred boundaries is critical since it aims to reconstruct the accepted common narrative of the criminalized women being classified solely as offenders. The concept of blurred boundaries describes that there are multiple social and cultural factors that shape criminalized women's lives, and contextualizes their behaviours accordingly; for example, the criminalized behaviours of the participants' in this current study cannot be separated from the disempowerment, violence, mental health issues and injustices that she endured throughout her life. The reconstruction of the common narrative challenges the accepted classification of criminalized women, as individuals who committed a crime and require reformation. The new narrative must assist in portraying criminalized women's lived

holistically by including the inequalities and violence that many of them experience prior to incarceration.

3.4 Narrative of resistance

The criminal justice discourse has often focused on law breaking stories which emphasize a personal responsibility by placing the cause of the criminal behaviour on the individual (Pollock, 2003). This is done by presenting women's experience through individual interviews, which decontextualize their stories and ignore multiple social and economic factors (e.g., gender, & ethnicity) (Pollock). As illustrated through the findings of this study, criminalized women have complex lives and experience similar difficulties; for example, many criminalized women experience admission into children's services, juvenile delinquency, high level of unemployment, lack of education, and physical/sexual abuse. According to Mandriz (2001), bringing together women who share a common oppression is critical since it allows for the development of counter narratives, which exposes multiple levels of oppression and how the women resist or deal with the experience of oppression (Pollock). Furthermore, women who share a common oppression often develop a collective identity linked to the illegal behaviour, and the "desire for independence and resistance to the state-enforced dependence" (Pollock, 2003, p. 469). In the case of this study, participants talked about the various methods used to self-care, and increase their agency while in jail and in the community. For example, the participants described smuggling illicit drugs into jail, and sharing the drugs with other inmates in order to cope with the lack of health care available to them.

4. *Privatization of jail and self-care*

Participants described experiencing lack of power to take care of themselves while in jail, which resulted in further deterioration of their health. Participants' limited ability to self-care was reduced partly because hypoallergenic soaps/shampoos, and some essential health products for women had to be purchased by inmates while in jail. The experiences described in the women's narratives in regards to their inability to access essential health products represents the lack of choice, the lack of opportunity, and inequitable access to care. Participants also described that the only type of food served in jail was high fat processed food, which caused rapid weight gain. The experiences of limited access to essential health products, narrated by the participants, are reflective of neo-liberal policies through privatization initiative of the jail/prison system (Sinden, 2003). A rapid expansion in the incarcerated population occurred in the USA from the year 1972 onwards. The increase of the incarcerated population resulted directly from "get tough" on crime policies, repeat offender provisions, and the war on drugs (Sinden). As Sinden shows, these policies began to emerge during the 1960's and peaked during the 1980's under the administration of US President Ronald Reagan. The growth of prison population caused a swift increase in the cost of correctional services. This trend amplified the interest of private companies in the penal economy, and private companies became responsible for providing food, health, education, drug treatment, laundry, garbage collection, and communication services for prisons/jails in the USA and Canada (Sinden).

"Incarceration is an inherent function of the government and the government should not abdicate this responsibility by turning over prison [and jail] operations to

private industry” (Sinden, 2003, p. 44). The increased involvement of private industry in prison/jail operations has stimulated a heated debate, and many have questioned whether it is legal for the government to source out services within the correctional system (Sinden). An important characteristic of the modern nation state is “its monopoly on the legitimate use of violence and coercion in society” (Sinden, p. 44), this means that only the state can detain, arrest, and punish individuals. In order to maintain its legitimacy and moral significance, the state must remain as the sole authority responsible for depriving citizens of their liberty (Sinden). With the gradual increase of privately delivered services in jails and prisons, some critical questions emerge: what extent of privatization of services will the Canadian correctional system experience? Will Canada experience further emergence of private prison industry, where the provincial and the federal governments delegate the task of imprisonment to private, for-profit parties?

The increased privatization of services in jails/prisons in the United States has negatively impacted the health and rehabilitation of inmates (Sinden, 2003). Private jails/prisons, similar to other for-profit businesses corporations, are concerned mainly with increasing the profit of their stakeholders, which often means cutting spending on essential service (i.e., security, & health care); moreover, the failures and shortcomings of private jails/prisons in providing health and rehabilitative services is more difficult to detect than public prisons/jails (Sinden). It is true that both public and private prisons/jails in the USA are not open for citizen scrutiny; therefore, there is always a risk of that correctional staff and managers abusing their power. However, the risk of misusing public funds is more likely to occur in a private prison/jail. For example, if the official in charge of a private corporation saves money from a government contract by

failing to provide health care staff, and those failures go undetected, the corporation will profit and those profits are more likely to benefit the manager. In the case of public jails/prisons, it is difficult for officials to transform public funds to serve their personal benefit (Sinden).

5. *Lack of rehabilitation and community reintegration*

5.1 *Mental health care and incarceration*

According to Correctional Services Canada (CSC), during the intake process, an assessment of the inmates' health is conducted by a nurse within the first 24 hours of arrival which includes mental health screening (CSC, 2012). This is in accordance with the following policies: a. CD 800- Health Services, which aims to ensure that inmates have access to essential medical, dental, and mental health service in keeping with generally accepted community practices (CSC); b. CD 843-Management of Inmate Self-Injurious and Suicidal Behaviours, focus on ensuring the safety of inmates, who are self-injurious or suicidal, using the least restrictive measures in order to prevent bodily injuries while maintaining the dignity of the inmate (CSC); c. CD 850-Mental Health Services, which intends to ensure that the Correctional Service of Canada (CSC) provides inmates with essential mental health care, and reasonable access to non-essential mental health care which is designed to contribute to the inmates' rehabilitation and successful reintegration into the community (CSC). According to CSC, CD 850- applies to individuals who experience "disturbances of thought, mood, perception, orientation or memory that significantly impair judgment, behaviour, capacity to recognize reality or meet the ordinary demands of life" (CSC). The purpose of this policy is to ensure that acute and long-term mental health care services are provided for inmates that need it

(CSC). CD-850 was produced in May 2002, but revised and updated on March, 13th, 2012 (CSC). The revisions and updates were conducted in order to fulfil the recommendations found in the Correctional Service of Canada's response to the Office of the Correctional Investigator's Death in Custody Study and the recommendations of the Policy Review Task Force (CSC). Although only two participants were incarcerated when the revisions to CD-850 were made, and participants reported the lack of adherence by correctional officers and health care workers to the principles, recommendations, and guidelines mandated through the revisions of the policy.

There is an emerging debate about the extent to which psychiatric deinstitutionalization has led to an increase in the number of mentally ill individuals to be incarcerated (Diamond et al., 2001; Etter et al., 2008; Lamb & Weinberger, 2005; Metraus & Culhane, 2006). Psychiatric deinstitutionalization began to occur in Canada in the latter part of the 20th century, and it allowed individuals with mental health issues to receive mental health care in the community supplemented by hospitalization for acute cases (Read, 2009). This was done in order to empower mentally ill individuals and help integrate them into their communities (Read, 2009). In Canada the number of women diagnosed with mental health issues who were incarcerated in federal prison increased by 65% from the year 1967 to 2004. As stated previously, literature describes an intersection of marginality, poverty, homelessness, and addiction that many criminalized women in Canada face (Sapers, 2009; Sinha, 2009). The availability of publically funded community services has slowly eroded since 1995 when the Progressive Conservative party came into power in Ontario, under primer Mike Harris. The platform for Harris' campaign emphasised 'common sense', during which marketization and privatization of

public services became widespread (Keil, 2002). The lack of community services has led many women to engage in cyclical drug and alcohol use, homelessness, sex work, and short term incarceration in local jails (Kilty, 2012). While in jail, many of these women are over-medicalized and are prescribed psychotropic medication, during the intake process, to address various mental health issues. Prison/jail health care staff often do not abide by the recommended period of observation required to make a psychiatric diagnosis before prescribing psychotropic medication. This is an indication that correctional systems' main concern is not to provide mental health care to inmate, but to maintain institutional security by eliminating the risk to harm the self and harm others (Kilty). Participants in the current study described having existing mental health issues prior to incarceration, and disclosed their limited access to a nurse or any other health care provider within the first 24 hours of intake. Participants in this study also indicated being encouraged to take psychotropic medication (Seroquel) while incarcerated, and experienced delays or no access to mental health services in jail. One participant noted being placed under suicide watch, in order to maintain jail security. The basic principles of jail/prison security are to prevent incidents of any kind, and ensure that staff, visitors, and inmates are provided with the highest possible level of security. Maintaining jail securing and eliminating risks of self-harm or harm to others are often done to the detriment of the women's health needs (Hannah-Moffat, 2001; Kilty); as described by the women in this current study.

5.2 Are jails reformative and rehabilitative institutions?

In the year 1996, the provincial government in Ontario introduced new policies to modernize the correctional system. The Arbor Commission (1996) was used in the

modernization of the correctional system, specifically policies under the Commissioner's Directives, Regional Instructions, Standing Orders, Post Orders, Manuals/other written policies, and operational policy (i.e., yard access). The Arbor Commission states that:

Individuals are sentenced to a period of imprisonment as punishment. Engaging in amplified punitive practices (i.e., austere settings, corporal punishment, denial of right, dignity etc.) with those already confined oversteps the boundaries of the sanction set out by the court. (Moore, Burton, & Hanah-Moffat, 2003, p. 161)

The slogan for the modernized changes was “‘safe’, ‘secure’, ‘efficient’, and ‘effective’ corrections with ‘no frills’” (Moore, Burton, & Hanah-Moffat, 2003, p. 155). As a result, Ontario jails cut virtually all programming. Prior to this, inmates had access to various recreational, life skills, educational and social related programmes. The cut in programmes is linked to inmates experiencing prolonged periods of locked down in their cells from 16 to 23.5 hours every day, and have no access to any existing facilities within the detention centre; for example, decommissioning gymnasiums into dormitories (Moore et al.). Furthermore, gymnasiums have been turned into dormitories in order to accommodate additional inmates serving intermittent sentences. The correctional renew has another critical influence on the rehabilitative process of inmates, as it changed their day-to-day work programmes. Instead of engaging inmates in work programmes that would provide them some marketable work skills, inmates incarcerated in Ontario were now engaging in mundane work (i.e., picking up trash by the side of the highway) (Moore et al.). The women in this study described multiple challenges throughout their community reintegration process. The women described a lack of educational and practical skills to find meaningful employment after their release from jail, which negatively influenced and hindered their reintegration into the community.

According to the UN's Standard Minimum Rules (SMRs), the intended objectives of a sentence of imprisonment are:

to protect society against crime. This end can only be achieved if the period of imprisonment is used to ensure, so far as possible, that upon his[and her] return to society the offender is not only willing but able to lead a law-abiding and self-supporting life. (Moore, Burton, & Hanah-Moffat, 2003, p. 156)

The United Nations commands that punishment be forward-thinking by offering inmates developmental opportunities. It is clear that the correctional renewal in Ontario has rejected these orders, and created a correctional system that fails to provide real rehabilitative and developmental opportunities for inmates; for example, inmates are stripped of personal effects upon incarceration, are made to wear jail/prison clothes in public (i.e., to medical & dental appointments), are subject to random drug-testing, and inmates hoping to be released face extremely restricted parole policy and increased community surveillance (Moore et al.). Furthermore, the correctional renewal in Ontario has subscribed to the use of punitive methods which are dehumanizing and demoralizing to inmates (Moore et al.); this was described by the participants in this study.

Methodological Considerations, Limitations and Future Directions

In this section I will discuss the areas where further research is needed. I will add the final considerations and the limitations of the study. Lastly, I will reflect on the new insights that I have gained as a result of conducting this research project, and relate it to my personal story. The results of this study support the knowledge found in previous research, it also adds to the current discourse concerning the experiences of criminalized women's health care access in provincial jail. The current study provides the narratives of women who have been incarcerated in Ontario jail, and provides their future expectations

when accessing health care in the future. I hope that the findings of this study will present health care providers outside and inside of jail, correctional officers, and researchers a unique insight into the realities of criminalized women's lives, especially when attempting to access health care services.

There is a significant need for further research which examines the complex context of criminalized women's lives and its relation to incarceration. Further research is needed in order to provide in depth explanations regarding criminalized women's complex lives and help shift public perceptions. Further research should integrate various methodological approaches. The use of qualitative visual methodologies may be useful when conducting research with criminalized women (e.g., body mapping & photo voice), and help overcome many obstacles (i.e., literacy level, language barriers, and scheduling issues); moreover, ethnographic research methodologies may also be useful in unpacking the complex experiences of criminalized women. For future consideration, it will be helpful to employ a gender lens when studying the lives of criminalized women. It is critical to expand the body of knowledge available on the experiences of criminalized women, and bring evidence informed changes in policy and practice.

According to the World Health Organization (WHO), health promotion is: "the process of enabling people to increase control over their health and its determinants, and thereby improve their health" (WHO, 2005, p. 168). In light of this definition, the results of this study indicate that health promotion among criminalized women in Ontario is severely limited. The limitations experienced by criminalized women are not only due to incarceration, but also to the various social, economic, and gender barriers that these women face; consequently, restricting their ability to have adequate control over their

own health and wellbeing. Many criminalized women are disempowered during early stages of life, and their ability to have control over their health is compromised as a result.

Narrative inquiry study may employ various methods and approaches in order to explore people's experiences. The findings of this study are limited by the methodology chosen to examine the experiences of criminalized women when accessing health care services in provincial jail. Different methodological perspectives may have provided different layers and insight into the experiences of criminalized women, again, specifically methodologies that employ a gender lens. Furthermore, the narratives captured and presented in this study are confined by the characteristics of the particular participants involved in this study. Finally, due to the complexities in the participants' lives, only one interview was conducted with each participant, which might have limited the richness of the data collected.

Final Considerations

The purpose of this study was to explore the experiences of criminalized women when accessing health care in provincial jail and their expectations when accessing health care in the future. By using a narrative inquiry methodological lens I was able to explore the experiences of five women who served multiple sentences in provincial jail. I situated this study within a Critical Theory paradigm framework, which allowed me to investigate how participants' narratives were shaped by the power relations embedded in social, political, and historical contexts. The approach used in this study allowed me to bring to light the experiences and the voices of criminalized women when accessing health care in jail. Therefore, from a health promotion perspective, this study advocates for the

broadening of the discussion on the lives and experiences of criminalized women, and the inclusion of their stories and views in the construction of various health and rehabilitative services within the Canadian correctional system. The criminal justice practices could be improved by addressing women's complex pathways into the criminal justice system, and distinguish their patterns of offense and their experiences in the justice system from male offenders. Furthermore, improvement in the availability of programming for women is needed, specifically recovery programs that take into account trauma, child-care issues, inadequate social support, lack of financial support, and gynecological issues (Covington, & Bloom, 2003).

Lastly, I have gained some insight on the lives and experiences of criminalized women serving time in Canadian provincial jail, as a result of conducting this research project. My knowledge about the lives of criminalized women in Canada was very limited when I began this research process. I had multiple assumptions about the lives of women who serve time in jail/prison, and assumed that everyone is a product of the choices made by them; thus, I was aiming to examine the lifestyles of criminalized women and their experiences with infectious diseases. My assumptions were challenged by my thesis supervising committee, who recommended that I volunteer at a community organization that provides services to criminalized women. As a result of volunteering at the community organization for about a year, and by conducting this study, my assumptions about the lives of criminalized women greatly changed. I now have an improved understanding of the complex lives that many of them experience from a young age, and I became aware that the choices available to me are not necessarily available to

them. The single narrative that was previously constructed in my mind was challenged and altered.

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Appendix A: Information Letter

Project Title: The Lived Experiences of Criminalized Women Accessing Health During Incarceration

Principal Investigator

Dr. Lilian Magalhães, MEd, PhD
Candidate 2014

Associate Professor
School of Occupational Therapy
Sciences

Faculty of Health Sciences

Western University

Elborn College, [REDACTED]
[REDACTED]

Co-Investigator

Shamiram Zendo, MSc.

Student Researcher
Health & Rehabilitation

Faculty of Health Sciences

Western University
[REDACTED]

Letter of Information**Invitation to Participate**

You are invited to voluntarily participate in a research study that explores the lived experiences of women who accessed health care services while incarcerated in a provincial/territorial jail. The purpose of this letter is to give you the information you need to make an informed decision about whether or not you would like to participate. It is important that you know of what the research involves. Please take the time to read this carefully and ask questions if you would like to understand some part of it better. You should feel free to ask any questions you may have at any time. You will be given a copy of this Letter of Information and Consent Form once it has been signed. Please be aware that the interview will be audio-recorded to facilitate the data collection.

Purpose of the Study

The purpose of this research project is to explore the experiences of women who have accessed health care services while incarcerated in a provincial/territorial jail. During this study you will be asked to participate in an interview

What are you being asked to do?

Volunteering to participate in the study involves participating in an interview to tell your experiences regarding access to health care services in provincial/territorial jail. The interview will be approximately one hour long, and will be done at a mutual location, and time of your choosing. The interview will be audio recorded and the researcher may take notes during the interview.

Who is Included in the study?

You are invited to participate in the study if you are a woman over the age of 18, served time at a provincial/territorial correctional facility, fluent in English, and needed to access health care services while in jail. The interviews will be audio recorded. If you do not wish your story to be audio recorded, you will be excluded from the study.

Possible Benefits

Your participation in this study will help us understand and increase our knowledge regarding the health experiences of criminalized women while serving time at a Canadian jail.

Possible Risks and Harms

There are no known or anticipated physical discomforts associated with participating in this study; however, you may experience physical or emotional discomfort when remembering experiences in jail. Also, you will be asked to revisit and communicate possible unpleasant times in your life, and this may cause you to feel upset and/or uncomfortable.

Compensation

If you decide to participate in this study you will be compensated with a \$30 stipend prior to the interview.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no consequences or harm to you.

Confidentiality

1. You are volunteering to participate in the study and you can leave it any time. If you experience any discomfort during the interviews or if you feel at risk at any other time for the duration of the project, you can always withdraw from the study with no negative consequences to you. You may also refuse to answer any questions that you do not want to answer.
2. If participating in these interviews brings difficult memories or emotions to you, a list of counselling services will be provided to you.
3. Any information that is obtained as part of this study will remain confidential and accessible only to the researchers. If any information is published, a pseudonym (fake name) will be used and any potentially identifying information will be removed.
4. Please understand that I (Shamiram Zendo) have the legal obligation to report any allegations of abuse and/or neglect that you may have endured while serving at a correctional facility.

5. Please understand that certain information cannot be guaranteed confidentiality and I (Shamiram Zendo) have the responsibility to report the following information:
 - a. Under the Child and Family Services Act, it must report to the children's aid society if the researcher suspects a child under 16 has suffered abuse.
 - b. Situations where there are reasonable grounds to believe that you intend to seriously harm another individual. Confidential information may be disclosed in order to warn a third party.
 - c. If you pose a threat to yourself or others, you may be referred to a health professional for an examination.
6. Any information collected from the interview will be securely stored on a computer using an encrypted file and password protection. All information collected will be destroyed after five years.
7. You will have the opportunity to have access to the results of this study. You can also request a final copy of the research report by contacting the research team.

■ If you have questions regarding your rights as a research participant that the research team did not address to your satisfaction, you will be able to contact: Office of Research Ethics, the University of Western Ontario ■; ■
 ■

For Further Information and Publication

If you require any further information regarding this research project or your participation in the study you may contact Dr. Lilian Magalhães, or Shamiram Zendo. If you would like to receive a copy of any potential study results, please contact:

Principal Investigator

Dr. Lilian Magalhães, MEd, PhD
 Candidate 2014
 Associate Professor
 School of Occupational Therapy
 Sciences
 Faculty of Health Sciences
 Western University
 Elborn College, ■
 ■

Co-Investigator

Shamiram Zendo, MSc.

 Student Researcher
 Health & Rehabilitation

 Faculty of Health Sciences
 Western University
 Elborn College, ■
 ■

This letter is yours to keep for future reference.

Appendix B: Consent Form

Project Title:The Lived Experiences of Criminalized Women Accessing Health Care Services During Incarceration

Study Investigator's Name: Dr. Lilian Magalhães and Shamiram Zendo

I have read the Letter of Information, I agree to have the interview audio recorded, and I have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

Participant's Name (please print):

Participant's Signature:

Date:

Legally Authorized Representative/ Witness to Consent (if applicable) Print: _____

Legally Authorized Representative/ Witness to Consent (if applicable) Sign:

Legally Authorized Representative/ Witness to Consent (if applicable) Date:

Person Obtaining Informed Consent (please print):

Signature:

Date:

Appendix C: Recruitment Poster

Text appearing on all study-related recruitment forms:

**PARTICIPANTS NEEDED FOR
RESEARCH Regarding Health Care Access in
Provincial/Territorial Jail across Ontario**



**We are looking for volunteers to take part in a study regarding
Access to Health Care Services in Provincial/Territorial Jail**

You are invited to participate in this study if you:

**Are you a woman over the age of 18
Have you served time in a provincial / territorial jail
Accessed health care services while in jail
And are fluent in English**

**As a participant in this study, you will be asked to
take part in an hour long interview at a mutually convenient location
All interviews will be audio recorded**

Participants will be given \$30.00 compensation for their time

**For more information about this study, or to volunteer for this study,
please contact:**

Lilian Magalhães (Principal Investigator)



OR

Shamiram Zendo (Master's Student)



Appendix D: Interview Guide

Semi-Structured Interview Guide

I would like to hear about your experiences in provincial/territorial jail as they relate to your health care there. There is no “right” way to tell your story. I will interrupt as little as possible, but I may ask for clarification throughout our conversation.

1. Thank you for coming today. I appreciate your participation. After reading the advertisement for this and speaking with the gatekeeper, what made you decide to call and meet? How are you doing currently?
2. Can you describe how long ago you were in jail and how long you have been back in the community? Are you on parole? Was this the first time you have been in jail? If no, then how many times have you been in jail? What age were you when you were in jail for the first time, subsequent times, and most recently?
3. Can you describe your health or health concerns before you were in jail (the last time) and the types of health care services you used? How often did you access health care services before you entered provincial/territorial jail?
4. Can you describe your health or health concerns while you were in jail (the last time) and the health care services that were available to you? What were your experiences like when you accessed health care while in provincial/territorial jail?
5. How often did you access health care services while you were in provincial/territorial jail?
6. What are your personal views on health care access in provincial/territorial jail?
7. How did the experience of incarceration influence your ability to access health care services while in provincial/territorial jail?
8. What suggestions do you have, for the jail you were in or for the jail system, to improve the health care services that you were provided with in provincial/territorial jail?
9. How would you compare the health services in the community to health services in jail?
10. Who would you like to read this research when it is published? Or who do you think should read it?
11. Thank you for your participation in this interview. Before we end today, is there anything else that you would like to talk about, or do you have any comments?

Potential Prompts

1. “How do you think your experiences when accessing health care services in provincial/territorial jail differs from other people’s experiences?”
2. “How do you think your experiences when accessing health care services in provincial/territorial jail might be similar to other people’s experiences?”
3. “Tell me more about ...”
4. “I’m not sure what you meant when you said ... Can you give me a concrete example?”
5. “How would you describe that to someone who knew nothing about it?”
6. “Can you go through that again giving some examples/different examples?”

Appendix E: Debriefing Form
Debriefing Form

**The Lived Experiences of Criminalized Women Accessing Health While
Incarcerated**

Questions to discuss during and at the end of the interview:

1. Are you comfortable participating in this interview? Please, let me know if you need to take a break from the interview.
2. Please remember that I (Shamiram Zendo) am here to listen to your story and explore your experiences while you served time at a Canadian provincial/territorial jail. Please note that your story is very important to me (Shamiram Zendo) and I want you to feel well about your participation.
3. Please, let me (Shamiram Zendo) know if you need the interview process to go slower or if you need to change the order of the interview.

Questions to discuss before leaving:

4. How are you feeling? Is there anything else you want to add or review?
Thank you so much for your participation.

Appendix F: Ethics Approval



Use of Human Participants - Ethics Approval Notice

Principal Investigator: Dr. Lilian Magalhaes
 File Number: 104713
 Review Level: Full Board
 Protocol Title: The Lived Experiences of Criminalized Women Accessing Health During Incarceration
 Department & Institution: Health Sciences/Occupational Therapy, Western University
 Sponsor:
 Ethics Approval Date: March 17, 2014 Expiry Date: August 31, 2014

Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Other	Received Nov 23 2013. Appendix A - Tables and reference list	
Other	Received Feb 20 2014. Appendix B - Debriefing form	2014/02/19
Recruitment Items	Received Feb 20 2014. Appendix C - Recruitment poster	2014/02/19
Instruments	Received Feb 20 2014. Appendix D - Interview guide	2014/02/19
Letter of Information & Consent	Received Feb 20 2014. LOI & Consent	2014/02/19
Western University Protocol	Received Mar 16 2014.	2014/02/19

This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above named research study on the approval date noted above.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information.

Members of the NMREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussions related to, nor vote on, such studies when they are presented to the NMREB.

The Chair of the NMREB is Dr. Riley Hinson. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 0000941.

Signature

Ethics Officer to Contact for Further Information

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This is an official document. Please retain the original in your files.

Curriculum Vitae

Name: Shamiram Zendo

Post-secondary Education and Degrees: Master of Science Candidate, Health Promotion
Faculty of Health Sciences, University of Western Ontario
London, Ontario, Canada
2012-2015

Honours Bachelors of Science in Health Science
Faculty of Community Health Sciences at Brock University
St. Catharines, Ontario, Canada
2005-2012

Honours and Awards: Teaching Assistant
The University of Western Ontario
2012-2015

Western Graduate Research Scholarship
2013

Western Graduate Research Scholarship
2012

Related Work Experience: Teaching Assistant at Western University
2012-2014