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At a Crossroads: Reentry Challenges and Healthcare Needs among Homeless Female Ex-Offenders

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Abstract

The exponential increase in the number of women parolees and probationers in the last decade has made women the most rapidly growing group of offenders in the United States. The purpose of this descriptive, qualitative study is to understand the unique gendered experiences of homeless female ex-offenders, in the context of healthcare needs, types of health services sought, and gaps in order to help them achieve a smooth transition post prison release. Focus group qualitative methodology was utilized to engage 14 female ex-offenders enrolled in a residential drug treatment program in Southern California. The findings suggested that for homeless female ex-offenders, there are a myriad of healthcare challenges, knowledge deficits, and barriers to moving forward in life, which necessitates strategies to prevent relapse. These findings support the development of gender-sensitive programs for preventing or reducing drug and alcohol use, recidivism, and sexually transmitted infections among this hard-to-reach population.

Keywords

Female ex-offenders; healthcare access; homelessness; physical and psychological needs; recidivism; substance use; transition into community life

Female offenders are the fastest growing population in the criminal justice system (Browne, Miller, & Maguin, 1999; Leukefeld et al., 2009; Richie, Freudenberg, & Page, 2001; Sheu et al., 2002; Zust, 2009). In the last decade, the numbers of women in prison have grown by 25% (Garcia & Ritter, 2012). In the State of California, nearly one third of women offenders in prison are between the ages of 25–34 years (California Department of Corrections and Rehabilitation, [CDCR] 2009). Women make up 24% of the probation population, while 12% of the parolee population (Glaze & Bonczar., 2006).

Although there are similarities, pathways to criminality among women differ from men; in particular, predictors form a triad and they are composed of survival from abuse, poverty, as well as, substance use (Blasiolo, Shinkunas, Labrecque, Arnold, & Zickmund, 2006). The combination of substance use and recidivism threaten the fabric of successful reentry for women offenders post prison release. When first paroled, female offenders are more likely to recidivate within one year due to possession of a controlled substance (CDCR, 2008a). Furthermore, 44% of female parolees are returned to custody within 1 year for drug-related violations (CDCR, 2008b). Compared with incarcerated males, female offenders have a higher rate of being sentenced for drug crimes (32% vs 21%) (Leukefeld et al., 2009).

Garcia and Ritter (2012) argue that reentry programs for women are often modeled after programs for men; yet, women have unique gendered needs that are not being addressed,

especially as it relates to post release. Some authors argue that the national discourse of human immunodeficiency virus (HIV) prevention does not consider women who have histories of incarceration (Kramer & Comfort, 2011). Data suggest that women who are incarcerated are at heightened risk for sexually transmitted infections (STIs) (Nijhawan, Salloway, Nunn, Poshkus, & Clarke, 2010; Stein, Caviness, & Anderson, 2012), hepatitis B virus (HBV), and hepatitis C virus (HCV) infections (Macalino, Vlahov, Dickinson, Schwartzapfel, & Rich, 2005; Martin et al., 2005), and HIV infection (Baillargeon et al., 2008; Hammett & Drachman-Jones, 2006). There is similarly a high prevalence of mental health issues (Hatton & Fisher, 2008), and substance abuse (Guydish et al., 2011); all of which may contribute to both homelessness and a history of incarceration.

The purpose of this descriptive, qualitative study conducted with focus group methodology is to understand the unique experiences of homeless female ex-offenders post prison release in order to understand the healthcare needs, health services sought, and barriers to attaining future health and life goals. The voices and reflections of female ex-offenders will inform future health promotion interventions in an effort to provide effective bundled services and improve successful reintegration in hopes of trumping recidivism, mismanagement of chronic disease processes, and communicable disease transmission.

Traumatic Life Experiences

Many female offenders have experienced traumatic life events (Weir et al., 2009), some of which include physical and sexual abuse (Brewer-Smyth, 2004), rooted in childhood and adolescence (Browne et al., 1999) domestic violence as an adult (Zust, 2008) and violence originating from family (Browne et al., 1999; Zust, 2009). Intimate partner violence, defined as violence which may involve boyfriends, former boyfriends, spouses or girlfriends (Rennison & Welchans, 2000) is a significant life event among incarcerated women. In one study, severe physical violence by intimate adult partners was reported by 75% of incarcerated women, 35% had experienced marital rape, and 62% had sustained physical injuries (Browne et al., 1999). However, physical and sexual violence (e.g. raped, knifed, shot, threatened, etcetera) does not only occur by intimate partners, as 77% of incarcerated women had also experienced this life event by non-intimates (Browne et al., 1999). Given that a large proportion of incarcerated women have had these experiences, it is not surprising that there is a higher incidence of depression among female offenders (Bloom & Covington, 2008; Zust, 2009) making it one of the most frequently diagnosed conditions (Center for Substance Abuse Treatment, 1998; Lewis, 2006).

Substance Abuse

Substance use is highly prevalent among women offenders (Bloom & Covington, 2008). When compared with men, female state offenders are more likely to report drug use one month before an offense, and they are more likely to report methamphetamine use (15% vs. 10%) (Mumola & Karberg, 2006). Among women with substance abuse problems (n=1404), Grella & Greenwell, (2007) found that common drugs used prior to incarceration were cocaine/crack (49%), amphetamines (41%), marijuana (40%), and opiates (21%). In another study focused on female offenders (N=804), both alcohol dependence and cocaine (30%, respectively) were the two most prevalent substance use dependencies (Proctor, 2012). Women were more likely to use methamphetamine when compared to men (15% vs. 10%) (Mumola & Karberg, 2006). In fact, women in state prison are more likely to meet the criteria for drug use dependence when compared to men (60% vs. 53%) (Mumola & Karberg, 2006) and represent a larger majority of those incarcerated (29.7% vs 19.9%) (CDCR, 2008a).

Communicable Diseases a Growing Concern

Among incarcerated women transmission of Hepatitis B and Hepatitis C may be a significant concern (Macalino et al., 2005); with singular attention to HBV, the prevalence has been found to be 36%, while HCV infection was 34% (Macalino et al., 2005). Furthermore, HIV transmission continues to be a particular challenge for those in prison and has become an urgent public health issue among female offenders (Leukefeld et al., 2009). Drug use places women at heightened risk for HIV transmission when compared to their male counterparts; further, the prevalence of HIV among female offenders appears to be higher than among their male counterparts (Leukefeld et al., 2009). In fact, HIV rates vary among incarcerated women (3% to 35%) (Fogel & Belyea, 1999). Data suggest that high rates of STIs and HIV infection may be due to engaging in high risk sexual behavior, namely, promiscuity, and exchanging money for sex (Fogel & Belyea, 1999). Upon release from prison, women may be at continued risk for acquiring HIV infection; thus, adequate screening should be utilized during this period of time (Leukefeld et al., 2009).

Challenges with Housing and Employment

Women who are reentering the community face a slew of challenges which may affect their ability to obtain housing and employment, inhibiting successful reintegration into the community (McLean, Robarge, & Sherman, 2006; Pogorzelski, Wolff, Pan, & Blitz, 2005; van Olphen, Eliason, Freudenberg, & Barnes, 2009). In 2005, Pogorzelski et al. reported that ex-offenders experienced challenges for reentry which related to personal, civil, legal and health-care access. In a qualitative study among 17 women who recently left jail, reported challenges to transitioning to the community included stigma due to drug use, inability to find jobs and housing, access to treatment services, and difficulty reconciling with family and loved ones (van Olphen et al., 2009). The most prevalent concerns for women was earning income and locating safe housing; further, for many women, family reunification and being a good role model for children was imperative (van Olphen et al., 2009). Other studies confirmed that housing was a challenge for newly released offenders. In fact, McLean et al. (2006) found that 25% of women (n = 148) released from jail did not know where they were going to live when they left jail.

Although time spent in the correctional system provides an opportunity to address these risk factors, oftentimes, unmet needs continue pervading this period, and inhibit successful transition into the community, which precipitates recidivism. Accordingly, once released, female parolees and probationers must contend with lack of care, and linkage to services that encourages reincarceration. The following paper aims to highlight community reentry needs for women offenders.

Methods

Design

This qualitative, descriptive study collected data homeless women who were on parole or probation and living in a residential drug treatment (RDT) facility using focus group methodology. Focus groups, which may be considered “staged conversations”, and generally enable pedagogy, politics and interpretive inquiry to cross-pollinate (Kamberelis & Dimitriadis, 2005). Furthermore, this method offers the process of discussion of real-world problems (Bourdieu & Wacquant, 1992), and collective testimonies that produce interactions between people, which would seldom occur individually and may validate (Kamberelis & Dimitriadis, 2005) and corroborate experiences.

The collaborative approach of community-based participatory methods (CBPR) heavily influenced this research process; in particular, CBPR enables the community and academic partners to build on knowledge in an effort to serve community needs. Multiple informants influence action researchers (Dick, 2007); in particular, our community partnership consisted of both the Vice President and Director of the RDT, along with the research team. Specifically, this research process enabled women who were enrolled in a RDT program to become participants of the focus group sessions and to discuss their physical and psychological needs. The selected RDT houses men and women in two- and three-bed dorm-style rooms and utilizes a therapeutic milieu, which is composed of seminars, workshops and groups in order to reduce substance use and behavioral challenges. All interviews were audiotaped and transcribed; furthermore, pseudonyms were used to protect the confidentiality of the participants.

The long-standing relationship with the leadership of the RDT enabled the development and construction of the semistructured interview guide (SSIG) which directed the researchers to the areas of focus. The SSIG was devised by the Principal Investigator (PI), the research team and the extant literature and focused on the following: a) types of healthcare needed; b) resources for sobriety and/or abstinence; and the need for c) future access to care. In addition, sociodemographic data were collected by a structured questionnaire assessing age, education, race/ethnicity, educational background, marital status, and history of homelessness.

CBPR encourages equal partnership between academia and the community, thereby empowering both in an effort to develop initiatives aimed at affecting policy (Israel, Schulz, Parker, & Becker, 1998; O'Fallon & Dearth, 2002). In this study, the housed residents brought the research questions to the researchers, and, along with the facility leadership, assisted in the clarification of the question, the recruitment plan, and recruitment activities. The study was approved by the University of California Los Angeles Human Subjects Protection Committee.

Sample and Site

A sample of 16 female parolees and one probationer were screened for eligibility; however, 14 met eligibility criteria which included being: a) age 18–60; b) on probation or parole; c) a participant in an RDT program; d) considered to be homeless prior to discharge from prison, and e) at the site for at least 2 weeks.

Procedures

In preparation for the focus groups, the Director and staff met weekly in order to review the content of the questions, logistics, protocol and IRB documents. Approved flyers were posted at the RDT site, highlighting the nature of the study. Interested female parolees and the probationer residing at the site met with a research staff, one-on-one, to receive details about the study. If interest continued, potential participants were screened for eligibility criteria in a confidential office at the site. Subsequently, the research staff obtained informed consent and a brief 2-minute structured questionnaire related to sociodemographic characteristics. All respondents who had completed the screening received \$2. Two focus groups were conducted with five to seven female ex-offenders in each group. Each focus group lasted about 1 hour and was conducted by a well-trained, senior qualitative researcher and her junior counterpart. The focus groups were audiotaped and participants selected their pseudonym. One researcher led the focus groups as guided by the SSIG and the junior-level researcher took extensive field notes and captured the emotions and nonverbal activities in the room. Those who participated in the focus group were compensated an additional \$8.

Content Analysis

Audio files were transcribed and transcriptions were coded line-by-line and analyzed using the grounded theory methods of (Strauss & Corbin, 1990). Trained staff searched for repeated words and phrases that indicated the participants' perspectives. Major dimension themes were identified and their linkages were examined by the team. After the coding schedule was developed, intercoder reliability was assessed by another coder who had expertise with women on parolees/probation, substance use, and content analysis. Research staff was well trained in content analysis by the PI and coinvestigators, who have conducted qualitative and quantitative research and content analysis for many years. The PI and coinvestigators met and reviewed the coding during the period of content analysis.

Trustworthiness of the data was safeguarded by four means which include credibility, transferability, dependability, and confirmability. Credibility of the data was established by qualifications of the senior level researcher, developing early familiarity with the culture at the RDT site, and debriefing between the PI and other researchers (Shenton, 2004). Next, transferability was established by describing the context and setting as well as providing sufficient information related to the study in order for other investigators to make comparisons (Shenton, 2004). Dependability was established through saved taped recordings and transcriptions to affirm the consistency of interpretations. Confirmability involved reflexive examination, discussion between researchers related to the data, commentaries, and an audit trail.

Results

Sociodemographic Characteristics

Among the 13 female parolee and one probationer, the average age was 42 and the mean education level was 12 years (see table 1). In terms of race/ethnicity, the majority were African American (79%), followed by White (14%) and Hispanic/Latino (7%). Nearly one-third (29%) of the women said that they were currently in an intimate relationship. It is important to note that over three quarters (79%) reported having children.

Female parolees and those on probation identified several barriers to obtaining necessary healthcare and reported deficits in knowledge and barriers to moving forward. Further, they indicated the need to learn new skill sets, seek additional resources and the need to stay connected to the post-residential care facility in an effort to maintain sobriety.

Healthcare Challenges

For female ex-offenders who resided in this RDT program and preparing to transition into the community, one central theme that was pervasive throughout the focus group sessions was the challenge to access health care. These challenges included long wait times, lack of transportation, the need for on-site healthcare providers at the RDT, knowledge deficits in terms of prevailing healthcare issues and lack of health insurance. The participants indicated that they were unable to get dental care, mental health care, women's healthcare including prenatal care and sexually transmitted infection (STI) testing, that is, chlamydia and HIV. The women believed lack of access to care was due in part to the lack of ability to make healthcare appointments.

In terms of dental care, participants shared that they had to arrive at public facilities early and wait for long periods of time to see the dentist; however, waiting in line did not guarantee being seen by a provider. As one woman expressed, "...you just go get a number and you go up and it's like not first come first serve. They would only take so many people." Thus, lack of access was also related to only having a few available appointments at public

facilities and limited specialty services were present, such as dental care, which was further exacerbated by the lack of transportation available in the RDT program. Another woman indicated, "That stuff gets expensive so it's not like I can call a doctor and make an appointment." Mental illness was another prevailing concern among the women, as well as, other comorbidities which included, "asthma...a kidney disorder... high blood pressure and a heart problem."

Lack of understanding related to not knowing how to care for chronic health conditions was similarly problematic. Specifically, one woman described not knowing how to control her high blood pressure and diabetes while living in a residential facility which made it increasingly difficult to eat right. For instance, she said, "...high blood pressure, sugar... gets out of control and we don't know how to control it." Other knowledge deficits included not knowing their bodies, not knowing how to conduct self-breast examinations, and how to care for themselves with respect to taking medications.

Not only did women want to know how to care for themselves, they were equally concerned about caring for other women in the RDT program and shared that they did not know how to care for other residents in the facility. One woman stated,

I'm kind of like I'm nervous you know because she's a diabetic and I don't know if she's sick. And if something happens to her, I need to know where I can get helpful to help her, you know.

Not having adequate dental care placed female offenders at risk for poor nutrition, even if food was available. One woman shared that "not having teeth was hard for [her] to eat salads." Other issues included not knowing how to eat right and, for women who have diabetes, not having proper assessment equipment, which led to not being able to control blood glucose levels.

Equally important, not having the right support staff, that is, nurses or psychologists, at the RDT program was described as a barrier. Some women shared that they would prefer to have clinicians, specifically nurses, on-site in order to ask questions, learn about healthcare issues, and participate in health care discussions. Other women also reported that due to the lack of health insurance, the emergency room is the first place where healthcare is sought.

As one woman summarized, "personally I don't have income and so really I deal with the emergency room....If I get sick I got to go to the emergency room in the ambulance."

Challenges to Moving Forward in Life

For some female parolees and those on probation, challenges to reintegrating into society included having a felony record, which often disrupted goals to pursue certain professions; in particular, for women, having a record equated not being able to pursue a career.

Illustrative of this theme is when one woman stated,

You can't go be a vet tech. You can't go be a pharmacist. The things I wanted to do, nursing, pharmacist, vet tech, I was even going to school to be a Highway Patrol and I messed that up you know.

Correspondingly, not having adequate identification, that is social security paperwork, birth certificate, or proof of residence, likewise created a challenge to successful reintegration and even eligibility for health insurance. Other challenges to moving forward in life after RDT included moving back to past neighborhoods and spending time with past peer groups and social networks. Women felt that finding a new environment prevented relapse and helped women avoid boredom. One woman shared,

And when I get out of here, I want to move to a better environment also but I still want to have something to do in the meantime because see if I don't have anything to do, my Mind gets bored

Thus, preventing relapse was another critical issue for these participants.

Preventing Relapse and Program Seeking

Female offenders emphatically shared how they wanted to stay sober and felt that strategies to remain clean included being empowered, having a job, going to narcotics and alcohol anonymous meetings, and having access to housing. Job skills, in particular, included massage classes, child development, as well as parenting, culinary, and janitorial skills. Other women reported the need to receive a GED, as well as, classes in grammar and punctuation.

As one young woman expressed, “[I] want to do stuff with [my] life like I don't want to just sit here and do nothing.” In essence, avoiding criminality meant keeping busy. As one woman revealed,

... I don't want to do this no more you know. So I want to do something constructive for me that will keep me busy going through the day.

When discussing next steps, women shared that part of preventing relapse included finding and locating housing. In fact, obtaining housing was frequently cited as a challenge. In particular, one woman indicated,

Like a place to live too... here a lot of people take off with the men and then they don't have nowhere to go you know and then they end up using drugs again. But like if there was somewhere to go you know or some help...

An aftercare program after the RDT facility was also an important resource for female parolees and probations to remain connected, develop a supportive network, prevent relapse, and stay in touch. One woman said, “...to have a number where I can call and talk to somebody and they could just help me stay on that, the right road instead of hanging off of it.” A few women indicated that having a hotline number to call was essential to preventing relapse and recidivism. Assuredly having a person to call was a critical element when trying to maintain sobriety.

In fact, one woman said, “I need somebody to stay in touch to being able to focus and I need a lot of support.” Staying in touch with one another was an important component of preventing relapse. All things considered, homeless, female ex-offenders articulated that they needed to use existing skills, obtain other skills, ensure job placement, secure medical help which included physical and psychological care, and obtain positive social support, coupled with housing in order to successfully reintegrate into society.

Discussion

The rapidly growing cohort of women parolees and probationers in the United States, along with an aging offender population, is a substantial issue facing policymakers, healthcare providers and academicians alike. Yet, there is limited data on women who are both homeless and on parole or probation. Preliminary findings of these focus groups indicate that unmet physical and psychological needs abound especially during the period of post-release. To enumerate the findings, female ex-offenders indicated that they have to manage multiple chronic conditions and do not have adequate resources, health care providers, as well as transportation to and from facilities.

Not only was lack of access to care frequently cited, but the need to have healthcare providers at the RDT site was dually noted. Female ex-offenders felt that having a psychologist and nurse on site to provide health education and answer health-related questions would be beneficial. Another significant issue is the fact that many women in our sample do not have adequate insurance which led to the use of emergency room services. Data suggest that having a history of incarceration independently predicts lack of access to care and subsequent health disparities (Kulkarni, Baldwin, Lightstone, Gelberg, & Diamant, 2010). This is especially true for female parolees and probationers and communities of color.

Our findings revealed that healthcare challenges include being unable to manage comorbid conditions such as hypertension, diabetes, as well as, asthma. When compared with the general community dwelling population, those in the correctional system have an unequal distribution of the burden of communicable and chronic diseases (Wilper et al., 2009). In particular, prisoners have been found to have higher percentage of chronic medical conditions, such as, diabetes mellitus, hypertension, prior myocardial infarction, persistent hepatitis, as well as HIV (Wilper et al., 2009). For those with a history of incarceration, data suggest access to medical and dental care was more challenging when compared to their non-incarcerated counterparts (Kulkarni et al., 2010). In our study, female ex-offenders shared that primary health education measures may help address gaps in care; for instance, providing educational sessions on nutrition, cancer, diabetes, cardiovascular disease, and breast self-examination training would be beneficial.

Other healthcare challenges that were cited by the participants included not having certain types of allied health services, among this sample, lack of dental care was frequently cited as a problem. Women shared that long wait times, in addition to not being able to be seen by a provider, were the main barriers, and this finding is consistent with other studies (Baum et al., 2008; Daly, Newton, Batchelor, & Jones, 2010). Data suggest that homeless adults in Los Angeles are in dire need of a compendium of dental services which include, but are not limited to, restorative and surgical procedures. In fact, methamphetamine users have higher rates of dental disease (Shetty et al., 2010). In the perimeter surrounding this RDT, dental services for the homeless are strained; thus, making it challenging to obtain prompt care. Conte et al. (2006) found that among homeless adults in New Jersey, only 28% had a dental visit in the previous year; furthermore, oral health impacted eating, smiling and talking. Another study found that among homeless adolescents and young adults, 52.6% reported sensitive teeth and 38.5% reported a toothache (Chi & Milgrom, 2008).

Authors maintain that women offenders are at heightened risk for substance abuse, as well as co-occurring mental health issues (Batkı, Canfield, & Ploutz-Snyder, 2011). Likewise, among both jail and prison inmates, there are nearly one million who have mental illness (Kinsler & Saxman, 2007). Over the last several decades, the re-institutionalization of those with mental illness into our state prison and jail systems is striking and many authors argue that mental illness has been recriminalized (Kinsler & Saxman, 2007). Our findings indicate that upon reentry into the community, mental health access continues to be a challenge due to lack of access to care, long wait times and for those who have a diagnosis, lack of access to medication.

Our findings further suggest that, for female offenders who are exiting prison, there are a throng of challenges in locating appropriate housing, health services, and avoiding drug use. Our data suggests that recidivism is driven by the lack of secure housing and job skills, which are considered the greatest sources of stress among women preparing for reentry and may contribute to recidivism, migration back to problematic relationships, and drug/alcohol use. In fact, several women questioned where they would live upon completing the RDT

facility. Homeless female ex-offenders cited wanting to start a new chapter in their lives and become positive role models for their families and children. Equally important, these women strived to stay clean and were seeking a different lifestyle. One solution that was proposed during the focus groups included staying connected and developing supportive networks. The ability to stay connected by developing trusting friendships and having a hotline number to call in case of relapse is being considered for a future CBPR intervention.

For many women who are doing their utmost to transition into the community, lack of job skills and employment opportunities encourage relapse and recidivism. Our findings found that earning a stable income was a constant and prevalent concern. Findings from our focus groups suggest that while ex-offenders would prefer to utilize existing skills sets, they are aware that some employment opportunities are no longer available to them due to their criminal record. As discussed previously, women feel that certain careers are not possible due to criminal histories, despite this belief; hopes remain fervent that a new chapter in life will begin. However, challenges with job skills and obtaining substance abuse treatment persist. For many women ex-offenders, recidivism may become a reality; therefore, it is imperative that these women obtain job skills and employment opportunities in an effort to sustain their income and livelihood.

Conclusions

The collective voices of homeless female ex-offenders are both unified and emblematic of a population which continues to struggle and is at a crossroads. In particular, successful reintegration amidst a storm of healthcare barriers, relationship challenges, substance use and addiction, as well as lack of education and job skills is the reality for many women. The study findings emphasize the need to understand that successful post-release supervision necessitates adequate linkage to healthcare (physical and psychological), job skills and opportunities for employment, stable and safe permanent housing. Successful community reintegration is composed of providing physical and psychological services, as well as substance abuse treatment, job skills and employment opportunities. For clinicians working with homeless women on parole or probation, it is imperative to understand that this population has experienced victimization, traumatic life conditions, and may continue to be faced with potential substance abuse issues. Furthermore, clinicians need to take into account the fact that this population struggles with meeting basic necessities; thus they need to develop chronic disease treatment plans to facilitate transportation, appointments, and care. Another strategy which can be employed is that providers of RDT facilities can collaborate with nurses and primary care practitioners in order to help facilitate mental health services, dental and other allied health services for this population.

Limitations

There is a scarcity of research which focuses on the reentry needs of women offenders who are homeless. Despite the benefits of these study findings and being able to ascertain experiences from a hard-to-reach population, several limitations must be considered. The aim of this study was to understand the needs of female ex-offenders; thus, the results do not reflect experiences of homeless men who are on parole or probation. Furthermore, this study utilized a convenience sample from one RDT and the sample was mixed (parole and probation). We recognize that both parolees and probationers, may have different needs, and we may not have been able to address those needs completely in this paper. Thus, these findings should be used with caution in terms of extrapolation to a larger cohort. Despite this understanding, these findings are rich with data and enable clinicians to gauge some of the challenges which this hard-to-reach population faces ultimately enabling the development of a future CBPR intervention.

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Table 1

Sample Characteristics (N = 14)

Characteristics	Mean	SD	Range
Age	41.9		20–60
Education	12.2	2.1	6–14
	N	%	
Race/Ethnicity:			
Black (not Hispanic)	11	78.6	
White	2	14.3	
Latino	1	7.1	
Relationship Status (Intimate relationship):			
Yes	4	28.6	
No	10	71.4	
Children:			
Yes	11	78.6	
No	3	21.4	
Religion:			
Protestant, Baptist, Methodist	12	85.7	
Catholic	1	7.14	
Jehovah's Witness	1	7.14	

Table 2

Sample Questions from Semi Structured Interview Guide (N=14)

1	Please tell us what health services you have sought in the last few years?
2	If you ever had a time when you had a health problem but did not seek care for it, what got in the way?
3	Which kinds of care do you or your friends like to use or feel you need?
4	What are the barriers you experience to receive care?
5	Do you think you or your friends would be willing to receive care?