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PRINCIPLES & PRACTICE

Evaluation of the East Bay Community Birth Support Project, a Community-Based Program to Decrease Recidivism in Previously Incarcerated Women

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ABSTRACT

The East Bay Community Birth Support Project provides entry into the health professions for previously incarcerated women and enhances access to culturally appropriate doula support for low-income communities. Sixteen women of color were trained as doulas: eight were identified as low-income and eight were previously incarcerated. Qualitative focus group data from program participants showed an increase in empowerment, improved assessment of skills, and confidence in perceived ability to provide doula support. To date, no incidents of recidivism have occurred.

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The East Bay Community Birth Support Project (EBCBSP) is an innovative public health program based in Alameda County, California that was designed to provide access into the health professions for previously incarcerated women and to enhance access to culturally-appropriate doula support for low-income communities. The EBCBSP was formed when members of the Birth Justice Project (BJP) and Black Women Birthing Justice (BWBJ) agreed to collaborate to improve doula support and services for low-income and previously incarcerated women. The purpose of this article is to describe the program to encourage replication and dissemination of results.

Background

Durose, Cooper, and Snyder (2014) studied the recidivism of prisoners released in 30 states in 2005. They found that overall, 67.8% of the 404,638 state prisoners released in 2005 in 30 states were arrested within three years of release, and 76.6% were arrested within five years of release. Among prisoners released in 2005 in 23 states with available data on inmates returned to prison, 49.7% had a parole or probation violation or an arrest for a new offense within three years that led to imprisonment, and 55.1% had a parole or probation violation or an arrest that led to imprisonment within five years (Durose et al., 2014).

Despite the fact that women in the United States are arrested for only about 25% of crimes committed, incarceration rates for women are increasing (Federal Bureau of Investigation [FBI], 2010). In 2011, California was mandated to reduce its jail and prison populations, and funding was allocated to the 58 counties to develop innovative and novel programs to support incarcerated individuals (Brown vs Plata, 2011). Two-thirds of incarcerated women in California are parents compared to only half of incarcerated men, and of incarcerated mothers, two-thirds were the sole custodial parents prior to incarceration (Morris, Sumner, & Borja, 2008). For men who lived with their children prior to incarceration, 90% of the children remained with the mothers during incarceration. For mothers who are incarcerated, more than half of their children are placed with grandparents. Further, the likelihood of a child being placed in foster care during a parent's incarceration is five times greater when the incarcerated parent is female (10% for women, 2% for men) (Travis, McBride, & Solomon, 2005). These realities place an additional burden on mothers upon reentry to communities after serving time in jail. Many juggle employment and housing challenges while reestablishing family dynamics (Few-Demo & Arditti, 2014; Weiss, Hawkins, & Despinos, 2010). Reducing recidivism (i.e., cycling through the prison system multiple times) for women is crucial

Low-income and previously incarcerated women have limited opportunities for employment. Birth work, specifically work as a doula, provides a viable income with a flexible schedule.

to meaningfully effect cyclical incarceration rates within families.

Problem and Intended Improvement

Incarcerated women have gender-specific needs in addition to traditional re-entry issues (e.g., finding employment) that have not been adequately addressed, including reconnecting with or establishing their roles as mothers, repairing social relationships with family and other sources of support, and healing from trauma-related emotional stressors (Garcia & Ritter, 2012). Providing employment and vocational opportunities to recently released individuals has been well recognized as an important strategy to reduce recidivism. This strategy builds self-esteem, provides legal employment, and can potentially improve the likelihood of successful reintegration (Garcia & Ritter, 2012; Kuruvilla & Gamble, 2012). Some programs have been successful in training previously incarcerated individuals as members of the health care workforce and to work with populations from which they come (Garcia & Ritter, 2012; Health Connect One, 2014; Wang et al., 2010). Other programs have been developed that use birth doulas in the context of incarceration and support for incarcerated pregnant women (Health Connect One, 2014; Hotelling, 2008; Schroeder & Bell, 2005; Shlafer, Hellerstedt, Secor-Turner, Gerrity, & Baker, 2015). However, to date none have described community-based doula work as a potential viable employment option for low-income and previously incarcerated women of color.

It was in this context that the EBCBSP was developed as a nurse-led, primary, public health prevention strategy to determine if a vocational training program grounded in doula principles and peer-to-peer support for previously incarcerated women would contribute to a reduction in recidivism. Doula training, and more broadly birth work, was chosen for four reasons. First, there is an active and vibrant doula community in the San Francisco Bay Area. Second, doula work is flexible in terms of client scheduling and work hours. Third, clients do not screen and discriminate against doulas with a history of incarceration unlike other vocations. Finally, there is infrastructural support for doulas in the Bay Area in the form of several volunteer based services and organizations (Zoila-Perez, 2015) that are focused on improving birth outcomes for women of color.

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Methods

Sample

Funding for this program was restricted to individuals who experienced incarceration; however, given the aim of developing a community-based program to train doulas, it was quickly recognized that program expansion would be necessary to minimize stigma. The future participants would be vulnerable to nonconsensual disclosure of their histories of incarceration, so the program team expanded the eligibility criteria to include low-income women. Given the effects of mass incarceration on women of color, the overrepresentation of women of color who are low-income in the Bay Area, and the documented health related disparities in birth outcomes, the program team decided to purposively target recruitment efforts to women of color. Half of the slots ($n = 8$) were designated for individuals who previously experienced incarceration and half ($n = 8$) were designated for low-income women for a total of 16 participants. All potential participants, 18 years or older, completed applications and interviews with the program staff. These interviews were designed to elicit information regarding ability and willingness to participate in training, stability of housing and child care, and knowledge of doula and birth work. Participants needed to commit to completion of the entire program for one calendar year.

The program team decided that training, food, child care, materials, and other affiliated services would be provided to all 16 participants free of charge, but financial remuneration would only be provided to the eight previously incarcerated women (named the funded cohort), since the project was funded to support eight individuals with a history of incarceration. The construction of the funded cohort was purposive in order to reach individuals at high, moderate, and low risk for recidivism. The program team defined risk categories for recidivism using time since last incarceration to develop a measure; in other words, participants were considered at greater risk for recidivism if they had been incarcerated more recently.

Inclusion/Exclusion Criteria

Given the depth of information to be covered during the training, the program team considered personal birth experience as an inclusion criterion but later disregarded that consideration. None

of the members of the core doula planning team, including the Primary Investigator of the project have children or are parents. It seemed hypocritical to assume that previously incarcerated women with high school educations could not be adequately trained to support women through birth as doulas if we were mindful about how we prepared our curriculum. Additionally, having children is not a prerequisite for participating in birth work in the Bay Area doula community, and our community partners thought that this requirement would not necessarily be received well by the larger community of birth workers. Exclusion criteria included active or recent drug use (currently enrolled in a drug treatment program or discharge from a drug treatment program less than 6 months ago) and conviction of a violent and/or sexual crime against a child. Although no transgender individuals applied, the program discussed this possibility and determined that these individuals would be considered on a case-by-case basis.

Measures

Anonymous data were collected from all 16 participants regarding their satisfaction with and experiences in the training program, including suggestions for improvement. In-depth data collection (e.g., demographic surveys, individual interviews, and focus groups) was only conducted with the funded cohort. The members of the cohort received compensation as if they were working, albeit at a reduced rate. On average, paid doulas in the Bay area can make between $800 and $2000 for two prenatal visits, around the clock continuous birth support, and two postpartum visits per client. Financial remuneration of up to $200 was provided to the doula trainees for each activity they completed, including training and each birth, individual interview, survey, and focus group. Additionally, the program was designed to be nonpunitive meaning stressful life events and other issues associated with a history of incarceration would not disqualify participants.

Participants in the funded cohort completed comprehensive demographic surveys based on the Behavioral Risk Factor Surveillance System (BRFSSQ) questionnaire developed by the Centers for Disease Control and Prevention (2014). Additionally, they were invited to participate in two focus groups and two individual interviews. Interview guides for the qualitative data were designed to elicit the trainee's perspective on becoming a doula, working with other women during birth, and experiences in our program. Focus groups were scheduled for 1.5 hours and individual interviews for 1 hour. Thematic analysis was used to determine themes across the focus groups and individual interviews.

Ethics Considerations

Human subjects approval was obtained to collect data from the funded cohort. Given the nature of the program and the data collection methods, it was determined that a certificate of confidentiality (COC) was needed and was granted by the Health Resources and Services Administration (HRSA). Members of the funded cohort privately provided written consent prior to the training and were given full information about the sampling procedures and cohort construction. Additionally, participants consented to allow the program to directly access their child protective services records from the county public health department. An exemption was obtained to collect anonymous data from the eight nonfunded participants.

Planning the Intervention

The program team took 6 months to create an interprofessional curricular sub-committee of senior doulas, nurses, novice doulas, and other health care professionals that worked together to develop a 48-hour, comprehensive training. The training was conducted during three weekends and included hands on and didactic learning. Content was focused on birth doula functions, postpartum care, and breast feeding support. Compared to traditional training in health care, the length of this training may seem short. However, it is crucial to understand that doulas provide emotional, informational, and spiritual support and comfort measures to birthing women, in other words, nonmedical and nonclinical care. The committee also developed binders of materials and doula bags with birth support materials for the participants. The training included interactive sessions with interprofessional experts in all aspects of doula care and support for birthing women. Most doula programs, including those that lead to certification, are held over a single weekend (i.e., 16 hours) and do not include content on the postpartum period or breastfeeding support (Morton & Clift, 2014).

Our training was designed for women with high school educations and histories of incarceration. Consistent with most doula training (Morton & Clift, 2014), we did not require previous volunteer or work experience in health care. The team also developed a doula mentor program to provide new doula trainees with support for their first five births.

Doula training is a transformative experience for low-income and previously incarcerated women.

Participants were paired with mentor doulas ($N = 13$) after additional funding was obtained to financially compensate mentors for their expertise and time.

Planning the Study of the Program

The funder of this intervention required the use of a results-based accountability (RBA) framework (Results-Based Accountability, n.d.). We included qualitative data collection in our RBA evaluation plan. Based on our previous work with providing doula support to women in San Francisco jails, we hypothesized that many of our doulas would report an increase in positive, personal, decision making regarding their own health and a greater positive life outlook. A written report of our progress was due quarterly to the funder, and an in-person assessment of how the team was accomplishing its goals was also required. Any programmatic delays or modifications needed to be requested in person and approved by the funder.

Results

In order to recruit women of color, we developed culturally appropriate flyers, recruitment materials, a logo, and program name that specifically addressed this demographic. This targeted recruitment resulted in 16 women of color exclusively participating in and completing the training. The ages of the 16 participants ranged from 22 years to 65 years (median 39). The 16 participants had a total of 17 children; five mothers in the funded cohort had 11 children among them, and six were less than the age of 18. Four mothers in the nonfunded cohort had a total of 6 children, all less than the age of 12. Except for one mother with adult children, all of the mothers in our program had their children living with them. Six participants had no children.

More detailed demographic data were collected on the funded cohort (see Table 1). Consistent with reentry demographics, all of the previously incarcerated participants were low-income and had a variety of work experience, including day jobs, temporary work, and public assistance. Those with consistent, part or full time jobs worked in retail and customer service, child care/home care, medical billing, and cosmetology. None of the participants committed violent crimes, and all were arrested for the most common reasons for arrest among women: prostitution, drug use (their own or in proximity to partners and/or other family members), and crimes involving money (shoplifting, bad check writing, default on fees/fines). Three participants were at high risk for recidivism (released in the last 6 months), three were at medium risk (released in the last 2 years), and two were at low risk (released 5 years ago or greater).

Assessment of Intervention

Adequacy. The doula training was focused on women of color and materials were culturally appropriate. Additionally, 80% of trainers and guest speakers were persons of color. Post training satisfaction surveys showed that all 16 participants wanted additional time for the training but focused their comments on the postpartum training, which was only one weekend: "It might need to be a little longer. Sometimes we had to rush through sections and conversations. One more day might have been nice." Another participant responded to the open-ended question *What are the major weaknesses of the training?* "Hmmm that it ended at 5pm! Given the energy of the group we could have gone on longer the first weekend, and/or have additional weekends of training/group building." Peer-to-peer doula sharing circles were established early as bi-monthly meetings at which the new doulas could meet with the nurses and senior doulas to debrief cases; watch informative documentary movies, fictionalized videos, and educational films; and review concepts that were rushed during the training. Anecdotally, the new doulas developed an active social media page to continually support each other and share information.

Progress. All of the participants completed the didactic portion of the training; however, this did not occur as planned. Two participants missed one day each of the training, and make-up sessions were developed for them. The curricular team foresaw the need for a modular curriculum that did not require sequential completion. Group activities that were missed were recreated in the peer-to-peer sharing circles, and new doulas who attended births led these session. As of the conclusion of the program in April 2015, 14 of the 16 doulas have supported 60 families in birth. Three members of the funded cohort were unable to provide birth support during the funding period due to factors related to unstable housing and employment. This type of factor should be considered when designing programs for low-income women and individuals who have experienced incarceration.

Table 1: Demographics of Previously Incarcerated Doulas (Funded Cohort, *n* = 8) Compared to Overall Demographics of Doulas in the United States

	Previously Incarcerated Doulas (Funded Cohort)		U.S. Doulas[a]
	Range	Mean	Teens to Mid-60s
Age	22 yr to 65 yr	39.3 yr	
	Frequency (*N*)	Percent (%)	
Race/Ethnicity			Nationally, most doulas are White
African-American	6	75%	
Other or mixed	2	25%	
Education			
General education degree (GED)	1	12.5%	Most doulas have attended some college or have completed college. Much of the knowledge of birth and reproduction is self-taught
High school with some college	5	62.5%	
Associate degrees	2	25%	
Reproductive Health and Pregnancy	Frequency (*N*)	Percent (%)	
Number of lifetime pregnancies			
None	3	37.5%	Approximately 60% have children
One	1	12.5%	
Four	2	25%	
Five	1	12.5%	
Decline to state	1	12.5%	
Number of births & living children			
None	3	37%	
Once	1	12.5%	
Twice	2	25%	
Three or more	2	25%	
Number of Abortions			
None	4	50%	
One	2	25%	
Two	1	12.5%	
Three	1	12.5%	
Number of miscarriages			
None	6	75%	
One	1	12.5%	
Two	2	12.5%	

Note. [a]Demographics for U.S. doulas from Morton, C. H. & Clift, E. G. (2014). *Birth ambassadors: Doulas and the re-emergence of woman-supported birth in America.* Amarillo, TX: Praeclarus Press. pp. 113–114. Used with permission from Praeclarus Press.

However, during the funding period, all participants had scheduled clients. Due to the inability to support themselves on our stipends, two participants (at moderate risk for recidivism) took on additional part time jobs. Another participant at low risk for recidivism experienced a violent assault in December 2014 and was still recovering from her injuries. Additional factors identified

by participants that affected their ability to accept clients included loss of public financial benefits due to increased income related to improved employment, lack of access to affordable child care for their own children, concerns regarding transportation, and the costs associated with serving clients. As awareness of the project and programmatic referrals have increased, our doulas have been requested across the Bay Area, which has resulted in added transportation costs and commute times not anticipated by the program staff.

Additionally, some of our new doulas have expanded their skills to include placenta encapsulation (the process of dehydrating placentas and grinding it so that it can be eaten) and support of teens; many have become volunteer doulas with existing Bay Area programs. Despite the fact that our program was only funded for 18 months, we continue to have active communication with our doula trainees, and many continue to provide birth support to low-income women without compensation from our program.

Outcomes

Focus group questions were written to elicit responses from participants regarding their perceptions of empowerment, doula skills, employment, and perceived ability to provide doula support.

Empowerment. The participants viewed the training as empowering and felt competent to remain in the workforce:

> So to do it and you feel comfortable, it's like, I never thought—(crying) because I never do nothin' for myself. I always do stuff for everybody else, and I put everybody ahead of me. So when this came along, and it was something that I loved, that I saw that I loved, it's just really emotional, and I be trying not to cry. Because I'm finally happy because I don't be stressin' myself out. Because I be so worried about if I do this, am I gonna not be able to help somebody? Am I not going to be able to do nothing for somebody else or something like this. But to just see that the path that I want to go in, and how the teens that I really want to help because of—I hate how they get judged and I'm not the judge. There's no way I can judge anybody from the life that I've been through. So I'm not that type, so I just really want to help them and be their mouthpiece to be able to do things that they didn't think they can do because they're young. So that's my main thing is I'm happy because I get to finally do something that I want to do.

Many participants commented that participating in the doula training was meaningful to them and contributed to a new and different future in terms of their life and work.

Skills Building. As previously mentioned, many of the doulas have been highly motivated to add new skills to their initial training and have developed specialties within birth work:

> Well, it is like what she—what you—you open it up, you didn't think, you just thought—just by coming to get certified in breastfeeding. I want to know to make sure that when they ask me I have the answer. I don't want to always have to give them—yeah, let me get back to you, or no, I want to know.

The sharing circles and social media pages developed by the participants continue to serve as opportunities to build skills, and informally mentors have been crucial to continuing the education needs of the program participants.

Employment and Educational Opportunities. Participants repeatedly stated that becoming a doula afforded them many opportunities that were not previously available:

> I think it's kind of going to be a gateway for me, to be honest with you. And that's why I'm looking at direct entry midwifery, because I don't want to be a nurse. So I think it's going to be—or maybe it'll be a gateway to public health. So I think this is just an added bonus to be able to serve my community.

Another participant described her experience:

> I have my own business, but somewhere in between have some type of co-op so we're—like I don't have it all together, but that was just an idea. That it was a co-op so that folks could know that they would have not just one person but more than one person coming on, so we both come on with our different knowledge and support of that one family. So I like that idea of teaming up.

But they see themselves as more than just small business owners with flexible work schedules:

> My initial interest and intent to be a part of the training was just in line with the community work that I do, and I was just like, without knowing all the details, I just knew that it was something dealing with birthing work, and I just saw it as an opportunity to equip myself with something that'd just make me that much more of a resource to my community.

Recidivism. Participants have not experienced recidivism, and many were not at high risk to return to jail. However, at any given time, two to three participants were out of communication with our team for as long as three weeks because of stressful life factors such as unstable housing, break-ins, and violence. Our team continued to maintain communication with all participants even if they did not immediately respond to telephone or digital communication.

Impact

Partnering early and establishing clear work agreements allowed for efficient and successful recruitment and training. Additionally, our team established an advisory board and engaged community mentor doulas to assist in the work efforts. Finally, we took advantage of summer training programs, internships, and other special arrangements with health professions students to address gaps in expertise, including Spanish language and cultural perspectives, child care and data collection, management, and analysis.

Sustainability

Our funder created innovative "Learning Cafes" where grantees come together for three-hour quarterly sessions to discuss successes and failures in their programs. These facilitated technical assistance meetings that allowed us to problem solve and develop innovative solutions for the administration of our program. The program team is currently applying for additional funding to further support the participants, and we are working with other community-based and policy organizations to create mechanisms for reimbursement of doula support from public (Medicaid) and private insurance.

Nurse-led community-based doula training should be developed and rigorously evaluated for improvement in birth outcomes for low-income women.

Discussion

Similar to other programs, our work has shown that providing employment and vocational opportunities to recently released individuals is an important strategy for reducing recidivism (Kuruvilla & Gamble, 2012; Wang et al., 2010). Our program is novel in that we focused exclusively on women and women of color in the context of birth work as opposed to computer training or other types of work. Our findings are consistent with those of previous researchers who found that most doulas in the United States are not capable of financially supporting themselves by doing this work, and thus they seek to advance their educations (Lantz, Low, Varkey, & Watson, 2005; Morton & Clift, 2014).

However, our results should be viewed with caution for three important reasons. First, several infrastructural supports and partnerships existed prior to the initiation of our training, including successful, volunteer-based doula programs (Zoila-Perez, 2015) and social service agencies with whom we partnered that were already serving currently and previously incarcerated women. Partnership with BWBJ, an organization rooted in the Black community and with strong links to other communities of color, facilitated recruitment of diverse participants and provided culturally competent trainers/trainers of color who could meet the needs of the participants. Additionally, partnership with BJP allowed us to expand on the work they were already doing with women incarcerated in San Francisco jails. Second, we had an existing doula curriculum, a seasoned nurse trainer led the curricular committee, and several, practicing doulas with more than 25 years of experience guided the team. Finally, our team was able to take advantage of resources available to the county public health department, which funded the program. We had access to public health nurses and other personnel participating in the 10 home visiting programs and other maternal child health services available for low-income women in Alameda County. This in-kind support was crucial for networking, referrals, and provision of content experts. Our program would be extremely difficult to replicate without this support.

Limitations

Our research team never voluntarily revealed which of our participants were previously incarcerated, but we were completely transparent about the fact that some of our trainees were being compensated for their participation and others were not. However, we also acknowledge that we missed a prime opportunity to collect more comprehensive data from the nonfunded cohort, which could have provided useful comparative data. The 16 participants were similar in terms of age, socioeconomic status, geographic location, and race/ethnicity, however, the program team felt it would be inappropriate to ask the non-funded cohort to complete time intensive data collection activities (e.g., focus groups, in-depth interviews) without remuneration for their time. We were unable to collect data from the women and families we supported during their birth experiences because of financial restrictions of the project and the focus on previously incarcerated individuals.

Conclusion

Comprehensive, free, culturally appropriate doula training for low income and previously incarcerated women is a novel job program that should be integrated into postrelease options designed to reduce recidivism. This public health nurse led intervention resulted in 16 new doulas of color who are currently providing emotional, nonmedical, and social support for 50 other low-income women and their families who generally lack this support during the birth experience. Future investigators should collect data from birthing women and their families to determine the direct effect that doula support has on birth experiences and outcomes.

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