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## Barriers and Facilitators: Parolees' Perceptions of Community Health Care

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### Abstract

Paroled individuals have physical and mental health problems and addiction disorders at rates greater than the general population. The aim of this study was to identify the perceived barriers and facilitators parolees encounter in their efforts to access and utilize health care services in the community. Qualitative data were collected via individual interviews with 17 chronically ill, middle-aged male parolees. Study results included financial and administrative barriers to care; structural facilitators to care; and the influence of clinicians' professional demeanor on health care access. Increased access to health care can provide opportunities to address both the health care and reintegration needs of individuals on parole.

### Keywords

parolees; health care access; barriers; facilitators

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Paroled individuals frequently have limited employment skills, have not finished high school, and have physical and mental health problems and addiction disorders. The prevalence and variety of health problems that incarcerated and paroled individuals experience are often greater than in the general population (National Commission on Correctional Health Care [NCCHC], 2002; Watson, Stimpson, & Hostick, 2004). The estimated prevalence of HIV infection in the prison population is 8 to 10 times greater than the prevalence in the total U.S. population (NCCHC, 2002). Hepatitis C infection rates for the prison population are 9 to 10 times higher than the general population (NCCHC, 2002). Lifetime prevalence rates for schizophrenia/psychosis, bipolar disorder, and posttraumatic stress disorder are approximately 1 to 4 times higher for state prison populations than for the general population (Pollack, Khoshnood, & Altice, 1999). Rates of substance use disorders (SUD) for this population are also high: 74% of all state prison releaseses have a substance use disorder and 11% are dually diagnosed with a mental illness and addiction disorder (Beck, 2000).

Although many health problems are addressed while an individual is in prison, once released former prisoners are often uninsured or not eligible for health care coverage (Hammett,

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Roberts, & Kennedy, 2001; Nelson & Trone, 2000; Pollack et al., 1999). Those individuals eligible to participate in public insurance programs often find their benefits discontinued due to incarceration. Reinstatement of benefits can be time-consuming and cause a gap in health care coverage (Nelson, Deess, & Allen, 1999; Nelson & Trone, 2000). As a result of being uninsured and lacking access to primary care services, formerly incarcerated individuals are more likely to have poorly controlled illness, increasing their need for both emergency and tertiary health care services. Furthermore, the high rates of infectious disease among this population place their family members, friends, and communities at risk for infection as well (Freudenberg, 2001, 2002; Nelson et al., 1999; Nelson & Trone, 2000; Springer et al., 2004; Stalans & Seng, 2007).

Several studies have documented the importance of health care access for parolees and its positive impact on recidivism and reintegration (Conklin, Lincoln, & Flanigan, 1998; Hammett et al., 2001; Rich et al., 2001; Sheu et al., 2002; Vigilante et al., 1999). This research suggests that high-risk individuals will utilize and potentially benefit from medical and social services, particularly those provided by a consistent network of familiar clinicians and support staff (Rich et al., 2001; Sheu et al., 2002; Vigilante et al., 1999). Regular medical care may help prevent high-risk behavior leading to rearrest and reincarceration. However, there is still limited understanding of how ex-offenders access community health care and employ clinical services as part of their reintegration. Investigation of parolees' perceptions of and encounters with medical care can provide a broader understanding of the role clinical services play in their lives. Such research also offers an opportunity for health care, as a system and as individual clinicians, to facilitate increased engagement with clinical care and address ex-offenders' reintegration needs more comprehensively. Therefore, the aim of this study was to identify the perceived barriers and facilitators parolees encountered in their efforts to access and utilize health care services in the community.

## Methods

Hermeneutic phenomenology guided the conduct of the study and the analysis of the data. The phenomenological method takes into consideration the context in which participants live, their histories, and their concerns (Chesla, 2005). The hermeneutic or interpretive process provides an understanding of how certain aspects of the individual and his situation open up possibilities and close down others in regard to specific experiences or phenomena, such as being on parole and accessing and using health care services in the community (Benner, 1994; Chesla, 1994).

Phenomenological research does not seek quantitative significance. Rather, the method aims to describe distinct beliefs, patterns, and practices among individuals with a shared or similar experience, such as chronically ill men on parole. Phenomenology does this via in-depth analysis of narrative data (Benner, 1994; Chesla, 2005; van Manen, 1990). For this study, data will be presented via exemplars. Exemplars are examples of narrative data that demonstrate a common experience. A range of exemplars illustrates the similarities and contrasts within a shared pattern or thematic instance (Benner, 1994).

## Sample/Setting

Participants were recruited from a nonprofit, community-based organization that provided residential drug and alcohol treatment to men on parole via a social model framework. Some program residents were there voluntarily and some as a condition of their parole. The program housed up to 32 men for 1 to 6 months and served 80 to 90 individuals each year. Substance abuse treatment (SAT) services were provided primarily in group settings, although the program also provided individual case management services and had a transitional housing component. Although the program received funding from the California Department of

Corrections and Rehabilitation (CDCR), it was not operated by or under the administration of the CDCR.

Data were collected via open-ended, unstructured interviews. Participants were asked to complete two 90-minute interviews. Approval for this study was obtained from the University of California, San Francisco Committee on Human Research (CHR). Because the CDCR did not operate the program, it was not involved in the research approval process. However, to ensure the safety of the participants and to protect against coercion, a CHR committee member representing the correctional population reviewed the application.

Study information was announced at house meetings and on flyers posted throughout the facility. As further assurance against coercion, researchers did not directly approach or recruit program residents. Residents were informed that neither researchers nor program staff would ask residents to participate in the study. Individuals wanting to participate were instructed to let researchers know of their interest in the study. Once a potential participant expressed his interest, the researcher would provide further information about the study purpose, eligibility criteria, and informed consent. If the individual still wanted and was eligible to participate, two individual interviews were scheduled. Informed consent was obtained before the first interview.

Of the 20 program residents who expressed interest in participating in the study, 17 met eligibility criteria. To be included in the study, participants had to (a) be male and 40 to 65 years old, (b) have one or more chronic physical or mental illnesses, (c) have been through the cycle of prison and parole at least twice, and (d) be English-speaking. Participants were interviewed twice approximately 1 to 3 days apart. All interviews took place at the SAT program. The short interval in between interviews was due to the high relapse and rearrest rate among the participants. Fifteen participants were interviewed twice and a total of 32 interviews were completed. Two participants were lost to follow-up after leaving the facility. All interviews were audiorecorded and transcribed verbatim.

The sample comprised 17 men aged 40 to 65 years. The participants' average age was 48, with the youngest being 40 and the oldest 62. They identified their health problems as hepatitis C, HIV/AIDS, diabetes, hypertension, coronary artery disease, depression, anxiety disorder, bipolar disorder, seizure disorder, osteoarthritis, low back pain, glaucoma, and legal blindness. All of the participants stated they had an addiction disorder. The most common substances abused were heroin, crack cocaine, and methamphetamines. All but three of the participants were uninsured. One of the participants had disability benefits for medical reasons and two received disability benefits as a result of mental illness. Eight of the participants identified as African American, five as White, two as Hispanic/Latino, and two as mixed race and ethnicity: Native American and White, and Filipino and White. Participants were incarcerated an average of 15 years (range 2 years to 38 years) and successfully completed parole supervision an average of two times (range 1 to 5 parole supervisions).

## Findings

Study findings revealed the social and structural barriers and facilitators participants encountered in their efforts to access and utilize health care. Barriers included financial and administrative constraints and difficult interactions with health care professionals. Facilitators included medical professionals' demeanor toward participants and a relative ease of access to clinics and ancillary services.

## Barriers to Health Care Access

Although participants did have access to health care in the community, their engagement with health care services was sporadic. Participants' street and prison lives limited their capacity to access care in a regular way and the multiple barriers they encountered when actively seeking health care was discouraging. Several of the participants were very involved with health care as a result of their illnesses and their access to clinical services was less problematic. However, the majority were disaffected by the health care system in part due to social and structural barriers. This analysis revealed three barriers to health care access: financial, administrative, and clinicians' uncaring professional demeanor.

**Financial barriers**—Financial barriers to health care access included being uninsured and being poor. As a result of participants' marginalized circumstances, their options for accessing health care were limited to the safety net system of county hospitals and clinics. Participants doubted the competency of the care provided within this system. For example, Paul (all names are pseudonyms), a 42-year-old African American, suffered from osteoarthritis in both knees. As a result, he was unable to work in the jobs available to him, construction and unskilled labor. At the time of this study, Paul was considering a total knee replacement of his right knee. However, Paul believed that he would not receive adequate or competent treatment at the county hospital.

For one, I'm not financially situated to have the right type of doctor to do it. And I don't have the money to go to the right therapy afterwards ... And if I don't get the right therapy and the right surgeon in order to do it like it's supposed to be done, it could really hinder me down the line. And it's by me not having no insurance, and that is real hard ... because [in] society right now - money talk. Insurances and hospitals, if [you have] insurance, it's all great, they're gonna do everything they can to make sure that leg, that part of your body is took care of right.

Had Paul been able to access a higher-tier system of care, he would have done so, but he was limited in his choices because of his uninsured status and his poverty. Paul feared that mistakes would be made during surgery or postoperatively; such mistakes would further complicate his situation and hinder opportunities to achieve long-term stability in his home community.

**Administrative barriers**—Administrative barriers included bureaucratic and procedural obstacles to receiving care, ineffectual treatment from medical and administrative staff, and excessively long wait times for care. John, a 47-year-old Mexican American, expressed frustration at the administrative failures that impeded his access to further treatment for his back problem. John suffered from osteoarthritis in his lower back as a result of a work-related injury 4 years earlier. For a time, John managed his pain and immobility with heroin. However, as his pain worsened, he began to utilize the county health care system. John received appropriate diagnosis and treatment in addition to building a case for permanent disability income and insurance. In the midst of his treatment, he was reincarcerated for 12 months on a parole violation. Upon release, John reconnected with the health care system and hoped to resume his disability case only to learn his medical records could not be located at the county hospital.

They lost my records in the county hospital so I can't go forward with my SSI to get ... therapy and stuff like that. So now they say I have to go through the whole shebang again, get the X-rays ... then I have to go back into the MRI again ... And I'm not [laughing] really looking forward to doing that, but I know I have to 'cause I can't work. I can't do no hard labor ... I want to try to get this SSI so I can get, get my necessities, my place and stuff like that ... before I got busted ... I was supposed to go to a (physical) therapist ... And they're not saying none of that right now 'cause they lost all my records, so I can't follow up ... I signed a waiver already to Social

Security the other day, and ... maybe they'll look a little deeper, 'cause I believe they just didn't lose my records. I really do.

Without documentation, John was unable to reinstate his care with the county hospital and had to repeat required evaluations. Through the system's carelessness, John lost access to needed medical care and had fallen behind in his effort to achieve financial independence via disability benefits. Furthermore, he was unable to work in the jobs available to him and with which he had experience. Although John's incarceration history interrupted the continuity of his care, he wanted and needed to participate in health care services. However, an administrative mistake made it seemingly impossible for him to move forward with his disability case and his life as an integrated member of the community.

**Uncaring professional demeanor**—Participants' willingness to utilize health care services was also limited by their social interactions with clinicians and other medical staff. Participants characterized clinicians' professional demeanor as lacking in empathy, cursory in their approach to participants' problems, and stigmatizing of participants' addiction disorders and circumstances. For example, Luke expressed a feeling of being judged for having a SUD and receiving inadequate treatment because of it.

[Long pause] ... I've gone in where they've (abscesses) broke out before, and you have to have them lanced ... And their (the hospital staff's) mind goes right to drug addict, which, whatever. It is what it is. And they might split you a little more uncaringly, or squeeze you a little too hard. But that's just life, you know [laughs]. You know you're not getting taken care of. You don't like the way they're thinking about you, but that's what it is ... if you go into the ER, you can see how their pleasantness or something changes when you go in there with like a cellulitis or something like that.

The change in the ER staff was palpable when they realized Luke required treatment for an abscess and cellulitis. The staff assumed Luke was a drug addict, and while this was true, the shift in the ER staff's perception of him stung. Perhaps more injurious to Luke than the tacit judgments of hospital staff was the actual medical treatment of his infection. Luke believed his care was overly aggressive. However, over time, Luke had come to anticipate such reproachful and insensitive treatment as an inherent aspect of receiving medical care as a drug addict.

As the above exemplars suggest, structural and social barriers to care limited participants' desire and ability to access and participate in care. Financial and administrative barriers restricted participants' sense of choice and feelings of confidence that the system would address their problems. When participants did receive care, they could not be certain it would be either compassionate or competent. Participants frequently lost interest in seeking care and their problems remained untreated. As a result of their disaffection from health care services, any potential for the health care system to address problems (e.g., SUDs) specifically related to their reintegration was never developed.

### Facilitators to Health Care Access

There were two primary facilitators to health care access: clinicians' caring professional demeanor and an ease of access to health care services. A caring professional demeanor was characterized by demonstrated concern and respect for participants in combination with the provision of relevant care. Participants experienced an ease of access to health care services in the following ways: (a) clinical services were conveniently located or integrated into other services and programs; (b) ancillary services, such as labs and low-cost medications, were readily available; and (c) there was access to payment sources. The elimination of social and

structural barriers provided participants with increased access to and opportunities for utilization of services.

**Caring professional demeanor**—Louis, a 50-year-old White man with anxiety and depression, expressed the importance of a caring professional demeanor. In this exemplar, Louis described a positive experience he had with a therapist during a period in the free community 3 years earlier.

... she (the therapist) was real concerned about me ... She came right over on the couch and sat with me. She didn't sit way over there, behind a desk ... She came over and sat with me ... She would say, "Look. If you ever need to talk to me, and you see this door open and I'm not in here with anybody, walk in. 'Cause whatever I can help you with I will." ... After a couple meetings with her, she sent me to that other guy (a psychiatrist), she said she wanted a second opinion. She wasn't passing the buck .... She just wanted another opinion .... And for me to get the medication I need, she said she couldn't prescribe it for me, but she could send me to somebody that can. And that's what she did. Now, it was my fault that I didn't follow up with it because I went to prison.

Louis was impressed with the therapist's concern for him and her interest in resolving his problems. The therapist's physical proximity during their visits was evidence that Louis was an equal and respected partner in the relationship. Her care was relevant in that she wanted to resolve Louis' immediate symptoms and ensure he received needed specialty care. Louis would have continued to engage with these services had he not been rearrested. The circumstances of Louis' street and criminal life overtook his ability to remain in the community, but his encounter with the therapist was one of his few experiences with meaningful and efficacious care.

Frank, a 44-year-old White and Native American with bipolar disorder, had been involved with parole psychiatric services for more than 20 years. Frank believed that the parole department's mental health clinicians assisted him in both managing his illness and improving his circumstances while in the community.

He (the psychiatrist) helps me; he helps me move my SSI paperwork; he helps me with ... the side effects of the lithium ... it hits your kidneys really bad. So he writes me out a potty pass .... Because these groups (at the drug treatment program) last sometimes 3 hours, and they (the program staff) really frown if you go to the bathroom. Well they don't understand I got the gotta go, gotta go right now syndromes. So he writes me out stuff like—you know, he helps me ....

The psychiatrist attended to Frank's practical needs and to the medication's side effects. He helped Frank achieve some financial stability and ensured appropriate accommodations were made for him at the SAT program. The psychiatrist's care improved Frank's immediate circumstances and helped him remain in the free community with the hope of discharging from parole as well.

As the exemplars above indicate, clinicians' caring professional demeanor reassured participants that their concerns were legitimate and worthy of care. Participants appreciated having their clinical problems and practical needs addressed expediently. Although a caring professional demeanor could not counteract the demands of participants' street lives and drug addictions, it did provide an opportunity for them to experience concern and competency within the clinical realm, in addition to having both immediate and long-term problems effectively addressed.



**Ease of access to health care services**—When structural barriers were decreased, participants were able to easily access the care they needed. In some instances, participants were able to access clinical services because such services were offered at the shelters and SAT programs where they resided. Increased access to and use of care was also evident in the convenience of ancillary services such as lab work, low-cost medications, and transportation. Louis described how easy access to health care services provided him with both therapeutic consultation and psychiatric care.

... she (the therapist) referred me to another doctor (the psychiatrist) ... and I went and seen him. Now, and he sat me down and talked to me for an hour too ... And he gave me this prescription ... he put down “no cost” on the thing, right? ... And it was \$129 ... And they (the pharmacy staff) go, “Well, that'll be \$129, please?” And I said, “Better read that.” “Oh, that's right.” You know, because they paid for it. Somebody paid for it. I don't know who paid for it. But ... \$129! I took it real serious because it's like they coulda just gave me some generic whatever, sugar pills or something ... But ... for them to be \$129, something had to be wrong with me for him to give me that medication.

Through his contact with the therapist at the shelter, Louis was able to obtain mental health services he had not previously experienced. The attention he received from the psychiatrist validated Louis's sense that he did have a mental health problem, as did the prescription for costly medication. He utilized these services because they were accessible through the homeless shelter where he had previously lived. Had he been living elsewhere, he may not have had access to such care or the personal and financial resources to find such care on his own.

Max, a 48-year-old White and Filipino man, articulated the importance of the physical location of clinical services.

... she (the clinician) told me to get the card (fecal occult blood test) for the samples and ... that's what I'm doing now. I gotta take the sample card back on Monday. But I [can take] the card to a place close to the program (the SAT program where he lived) because I didn't want to go all the way back out to the main clinic again. So it's nice that there's different places where you can go ... because sometimes it's hard to get on the buses and all that ... that clinic helped me out. And I'm going to keep using it.

Max had an initial consultation at a large, primary care clinic several miles from the SAT program where he was residing at the time of the interviews. Although he valued the clinic's services, it required both time and expense to get to. Due to the clinic's smaller satellite locations, Max did not have to travel a great distance to complete required laboratory tests. Although he had to return to the primary clinic for test results and further evaluation, Max appreciated the satellite clinics because they prevented the cost and inconvenience of a long trip to the primary clinic. The clinic's varied locations made it easy for Max to follow-through on the clinician's request and increased his interest in further health care services.

The services Max and Louis used were a result of the programs and shelters where they resided both at the time of the study and in the past. A few organizations described by participants, including the SAT program where the research was conducted, provided health services on-site and also had referral networks of local clinics, which made it easier for some participants to access and utilize services. However, the majority of community housing, shelter, and treatment agencies that participants described did not provide such integrated services. Furthermore, those participants who had the best access to care did so as a result of their illnesses and disabilities, as they were eligible for benefits from Social Security, Medicaid, and the Veterans Administration. For participants without severe and chronic conditions, i.e., those ineligible for insurance or disability programs, access to clinical services was irregular.

Additionally, many participants' health care choices were limited to the county hospital, which they considered to be unwieldy and inefficient.

Although participants articulated barriers to accessing and utilizing clinical care, these findings suggest that health care delivered on a smaller scale and in a more personal manner facilitated their access to and involvement in health care. The primary facilitator of participants' willingness to engage with the health care system was clinicians' caring professional demeanor. Participants were encouraged by the care they received and wanted to continue their engagement with these clinicians, despite other barriers they may have encountered. The second facilitator, ease of access to services, provided access to treatment not otherwise available and increased participants' use of clinical services. Structural and social facilitators could not overcome the instability of participants' drug addictions and criminal lives. Nevertheless, these facilitators offered participants an opportunity for improvement of their health conditions and an understanding of how consistent and meaningful clinical services could assist them with their health problems and reintegration efforts.

## Discussion

Study participants faced multiple barriers in their attempts to access clinical services. As a result of their uninsured status, participants were limited in their medical options for resolving their problems. They felt stigmatized for being poor, having an SUD, and being on parole. Their assignment to the indigent system of care contributed to their concerns that their health problems would never be resolved and could potentially worsen over time. The medical institution's bureaucracy also limited access to and utilization of services. As a result of overwhelming administrative procedures, participants limited their engagement with the system, leaving their physical and mental health problems untreated and the larger issues related to their reintegration, such as addiction disorders, unaddressed.

Research has demonstrated that clinical care delivered in smaller, more personal settings with a familiar cadre of clinicians and support staff has been shown to increase use of clinical services and reduce rates of recidivism in formerly incarcerated individuals (Conklin et al., 1998; Rich et al., 2001; Sheu et al., 2002). Smaller, decentralized clinics in locations where parolees frequent, such as parole departments, job training and educational facilities, counseling centers, or SAT programs, can increase male parolees' utilization of health care services. Additionally, collaboration between health care agencies and correctional institutions can enhance formerly incarcerated individuals' access to clinical services and more effectively address the complexity of their circumstances (Conklin et al., 1998).

Despite their distrust in the health care system, participants responded well to medical services provided in a compassionate and efficient manner. Clinicians with a caring professional demeanor were the most influential facilitators of health care access. Participants continued to access care, even when other barriers were present, because they felt they would be treated in a meaningful and effective way. While such a finding may appear to be grounded in common sense, this study illuminated how such a demeanor can be lost within the clinical setting.

The concept of a caring professional demeanor offers a model for clinicians to work more effectively with this population. Clinicians can incorporate caring and empathic behaviors into their practices by taking a few minutes at the beginning of each encounter to hear what the individual has to say. Clinicians can also emphasize that patients are equal partners in the relationship and their circumstances and situations are respected. There are many formats in which discussions between clinician and patient can be facilitated, such as motivational interviewing and nonviolent communication (Miller & Rollnick, 2002; Rosenberg, 2005).



Clinicians should become adept in at least one approach and employ it regularly with this population.

Results from this study indicate the importance of easy access to health care services in managing health problems. Participants described how easily accessible and affordable care both assuaged their health concerns and increased their interest in participating in clinical services. Although the services participants accessed were often inconsistently available, both as a result of their criminal lives and the availability of the services themselves, they responded positively to the services they received and actively sought further care. Future research can help define what types of clinical services and programs are most effective for this population.

This study's results reflected the experience of chronically ill middle-aged men on parole residing in a single SAT program. The findings may not be generalizable to healthier or younger men or those not enrolled in a structured drug-treatment program. Additionally, the results were drawn from a small and nonrandomly selected participant group. However, the findings indicate that the health care system can be a positive influence in these individuals' lives. To effectively support and care for chronically ill individuals on parole, the health care system, as an institution and as individual clinicians, must begin to decrease the social and structural barriers to care. Facilitators to care, particularly ease of access and a caring professional demeanor, must be emphasized in policy and program planning. Increased access to health care can provide opportunities to address both the health care and reintegration needs of individuals on parole.

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