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Prison Experiences and the Reintegration of Male Parolees

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Abstract

Approximately 60% to 70% of all individuals on parole are reincarcerated within 3 years of release from prison. The purpose of this study was to examine the impact of parolees' correctional experiences on their reintegration efforts. Qualitative data were collected via individual interviews with 17 male parolees. Findings revealed 3 types of correctional system adaptations—acquiescence, inaction, and aggression—and 2 patterns of system dependency—reluctant acceptance and complete reliance. Effective health and reintegration policy for individuals on parole must integrate the problems and issues of long-term involvement in correctional and criminal life into programs and interventions for these individuals.

Keywords

adaptation; dependency; prison; prisoners

Parolees often have long criminal histories and their time in the free community is punctuated by multiple incarcerations. Approximately 60% to 70% of all individuals on parole in the United States are rearrested and reincarcerated within 3 years of release from prison.[1–4] Formerly incarcerated individuals frequently have limited employment experience and have not finished high school. These individuals also have physical and mental health problems at rates greater than the general population.[5,6] Of those released from US prisons in 2006, 93% of incarcerated individuals were men, 37% African American, 20% Hispanic, and the remainder were white or of other ethnicities.[7] Three to 5% of parolees have never been employed and one-third were unemployed 1 month prior to their arrest.[2] Forty-one percent of all state and federal inmates have not completed high school or its equivalent compared with 18% of the general population aged 18 and older.[8] Rates of substance use disorders for this population are also high. Seventy-four percent of all reentering state prisoners have a substance use disorder, and 11% are dually diagnosed with a mental illness and addiction disorder.[9]

Parolees' health problems are often related to risky behaviors, for example, drug use, as well as social determinants such as limited education and poverty.[10,11] Research also suggests that incarceration itself poses a risk to a person's physical and mental well-being.[12,13] Prison threatens health both directly via exposure to violence and infectious disease and indirectly via the deprivations inherent within correctional facilities.[10,12–15] On reentry to the community, many parolees will access clinical services through community-based clinics and hospital emergency departments. Nurses working within these settings will have the opportunity to care for these individuals. Therefore, an understanding of the impact of incarceration on an

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individual's capacity to function in free society is essential for working effectively with this population.

Most ex-prisoners reenter their communities having spent at least 2 years in prison with limited prerelease preparation for life on the outside and less parole assistance with community reintegration once there.[16–18] Only 35% of all state prisoners participate in educational, vocational, or prerelease programs, and only 6% of all prison expenditures are for such programs.[17] Limiting expenditures on prerelease preparation, substance abuse treatment, job training, and skill-building programs in prison decreases the chances of an individual successfully reintegrating into the community upon release.[19]

Nearly a quarter of all reincarcerations are for parole violations, that is, noncompliance with the conditions and requirements of parole supervision, rather than for committing new crimes.[20] Parole violations can include disregarding mandatory curfews, associating with other offenders, having a positive drug test, and not reporting to the parole department. On reentry to the community, individuals are often given a new period of parole supervision, rather than resuming their previous supervision. Because of the frequency with which individuals violate their parole conditions, they can be on parole longer than the period of parole supervision itself. Therefore, parolees frequently find themselves in an extended cycle of release, rearrest, and reincarceration, and their time in the free community is punctuated by multiple imprisonments.[2,18,21,22]

Prisoners are released to their home communities or neighborhoods of origin with little or no money and without necessary identification needed to access substance abuse treatment, employment opportunities, or public assistance.[19,23] Because of the public's stigmatization of persons with a criminal record, individuals on parole experience disenfranchisement from employment opportunities, housing, and family and community support networks.[18,24] Parolees are frequently returned to communities where they are re-exposed to high rates of criminal activity, substance abuse, and other parolees, thereby increasing their risk of reoffending or violating their parole requirements and returning to prison.[16,18,25]

In addition to reentering society with multiple problems and few resources, many parolees have grown accustomed to life in the correctional system. Therefore, a seamless transition from prison to the free world is often not possible. Parolees leave a highly structured, closely monitored, nonprivate environment to enter a socially isolated world that requires self-regulation, self-control, and independent decision-making skills. This can be disorienting for newly released individuals, causing stress, fear, and destructive behavior frequently leading to rearrest and reincarceration.[14,19] Continued entrenchment in the correctional system can make successful reintegration, and therein, opportunities for legal employment, permanent housing, and improved health outcomes, difficult to achieve. Understanding the role that the correctional system plays in paroled individuals' lives is essential to explicating their experiences in the free community and the processes of reintegration success or failure. Therefore, the purpose of this study was to examine the role that participants' correctional experiences played in their ability to achieve long-term stability in their home communities. For this study, the terms long-term stability and successful reintegration both signify that the individual has desisted from criminal activity, maintained abstinence from drugs and alcohol, has a permanent home and regular employment, is positively engaged with family and community life, and has experienced some improvement in his specific medical conditions and overall well-being.

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.[26] 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 regards to specific experiences or phenomena, for example, being on parole or adapting to life in a correctional facility.[27] Hermeneutic phenomenology allows the voice of the participants to be heard and understood by those unfamiliar with the experience or with participants' circumstances.[26] When those outside of the experience, as clinicians, academicians, or policymakers, understand the complexity of participants' lives, an opportunity for change is created. Phenomenological research has the potential to positively influence the policies and programs affecting individuals on parole in their attempts to successfully reintegrate into their home communities.

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, that is, middle-aged men on parole. Phenomenology does this via in-depth analysis of narrative data. 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.

Sample/setting

A prospective interpretive design with repeat individual interviews was conducted. Approval for this study was obtained from the University of California, San Francisco, Institutional Review Board. Participants were recruited from a community-based residential substance abuse treatment facility for parolees via direct recruitment at house meetings and via flyers posted in the facility. Assurances were made that participation did not impact treatment options.

The sample comprised 17 men aged 40 to 65 years. Middle-aged men were the focus of this study because they were more likely to have been under parole supervision more than once and because they have higher rates of illness and disability than that of younger men.[28,29] The participants' average age was 48 with the youngest being 40 and the oldest being 62. They identified their health problems as hepatitis C, HIV (human immunodeficiency virus)/acquired immunodeficiency syndrome, 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 that they had an addiction disorder. The most common substances abused were heroin, crack cocaine, and methamphetamines. All but 3 of the participants were uninsured. One of the participants had disability benefits for medical reasons and 2 received disability benefits as a result of mental illness. Eight of the participants identified as African American, 5 as white, 2 as Hispanic/Latino, and 2 as mixed race and ethnicity: Native American and white and Filipino and white. Participants were incarcerated an average of 15 years (range 2–38 years) and successfully completed parole supervision an average of 2 times (range 1–5 parole supervisions). At the time of the interviews participants had been in the community an average of 5 months (range 2 weeks to 24 months).

Fifteen of the participants completed 2 interviews 90 minutes to 2 hours in length. Two of the participants were lost to follow-up after leaving the facility where the study took place. The 2 interviews covered 3 primary lines of inquiry: (1) specific events and circumstances while in prison or on parole that impacted participants' reintegration efforts; (2) perceived barriers and facilitators participants encountered when accessing healthcare and supportive services in the community; and (3) participants' healthcare beliefs and practices. The latter 2 lines of inquiry are discussed elsewhere. Six to 12 interviews have been recommended for adequate data and analytic saturation.[28,30] For this study, saturation was achieved when no new themes or patterns emerged from the analysis.28 Two formerly incarcerated individuals, 2 social service professionals working with paroled individuals, 2 lay persons, and 2 interpretive scientists reviewed the study findings.

FINDINGS

Participants did not shift seamlessly from prison to parole to reintegration but frequently repeated the same cycle of prison, parole, and reincarceration for long periods of time; the majority of participants had been involved in the correctional system for at least 15 years. These findings elaborated the primary ways in which participants' became accustomed to, and in some instances dependent upon, the correctional system and are represented by 2 major themes, necessary adaptations and dependence. Necessary adaptations were of 2 sorts: (1) acquiescence in the face of demands by powerful others that was linked to subsequent inaction and (2) aggression as a response to and defense against living in an environment saturated with violence. Dependence varied from reluctant acceptance of dependence on the institution to complete, unconflicted reliance. These themes provided a framework for understanding participants' experiences coping with life both in and out of the correctional environment.

To tolerate the conditions of prison life, the majority of participants made psychosocial adjustments or necessary adaptations. These adaptations were essential if participants were to cope with the multiple degradations and deprivations of the correctional system. Although the necessary adaptations made by participants were effective skills within the institution, they often resulted in decreased personal agency and self-esteem as well as hindered participants' capacity to successfully negotiate the demands of the free world. In addition, participants reentered their home communities with limited structural or social resources to assist them in their reintegration efforts or in learning more efficacious ways of coping with life in mainstream society. For many of the participants, prison provided resources, structure, and support they were unable to access in their home communities. While coping poorly with life in the free world was not always or directly related to institutional dependence, several participants relied on the prison system to meet basic needs, for example, housing, food, and employment. The findings represented variations in participants' adaptations to correctional life and the differing degrees of participants' institutional dependency. These results also reflected the deleterious impact of long-term involvement with the correctional system on participants' capacity to successfully reintegrate into their home communities.

Necessary adaptations

Three primary adaptations were identified in this analysis: (1) acquiescence, (2) inaction, and (3) aggression. Acquiescence was related to participants' belief that they had to be complicit with the system's brutality and neglect as a means to protect themselves from further punitive treatment. Such tacit consent often led to inaction or the feeling that there was no point in acting on any moral impulses or personal agency as it would only result in harsh treatment on the part of the correctional staff. Because inaction often immediately followed or resulted from acquiescence these 2 themes are presented together. Aggression was characterized as an adaptation to the violent conditions of prison life. An aggressive or predatory stance toward other inmates provided a form of self-protection and ensured some semblance of status within the institution, that is, the aggressive inmate was not disrespected or taken advantage of.

Acquiescence and inaction—Mark, a 62-year-old Puerto Rican– American, had a long incarceration history beginning in the late 1960s. Mark articulated his regret and distaste both for his own passivity as a result of correctional power and for his necessary collusion with it as he recounted witnessing the death of another inmate. At the time of this incident, Mark was hospitalized in the prison's skilled nursing facility. He was placed there after he fell from his bunk and sustained a detached retina in his right eye. The prison nursing facility was a lockdown unit and inmates were confined to their cells for most of the day. When the doors were closed and locked, a window in the center of the door provided the primary means of communication between inmates and staff.

R: Then when I was in the hospital there I was sitting in the bed, and … there's a little window… and I'm looking through the window, … and the guy across the street (the hallway) from me, he was a older guy too, maybe 60 somewhere, you know, there. So the guy's telling me … from his side, from his window, he's trying to talk to me, and he's telling me that he wants—he's going like this: "Give me some water, water, water, water."And I'm looking at him, and I'm saying, "How can I give you some water,"[Laughs] I'm locked in… . And the guard comes, and they open the guy'sroom. Hewas dead… . So that'swhat happened … he tried to get from the bed to the toilet, and that's when he had his heart attack. So… that was a hell of an experience… I mean I've seen people get killed in prison, but not that way, you know?

I: And why was it such an experience for you?

R: Because they made a big issue out of it … since I was across the guy, they made me sign papers… . Like saying that … it was a accident, that I didn't see any—I told them, I don't hear, I don't see, I don't know, man. "All right, sign here,"you know? And… they had the people (other inmates) to sign papers too… that they (the prison) were not the cause of his dying, you see what I'm saying? When actually maybe they coulda helped him. Had the door been open. See?

This incident disturbed Mark because he was forced to participate in a conspiracy around the death of a person whose life could have been saved had the system been more attentive. Mark saw his own susceptibility and endangered position in this other inmate— a man of similar age and circumstances. For Mark, acquiescence and inaction signified impotency in his ability to act on behalf of a fellow inmate, even in circumstances that led to the man's death.

Robert, a 40-year-old African American with a seizure disorder, also articulated a sense of acquiescence and inaction in response to the prison system's inattention particularly in regards to addressing his healthcare needs.

R: … And I guess the healthcare I was getting in the prison and in the county jail kinda reinforced that, because they wouldn't put too much emphasis on it. They'd give me my Dylantin because I guess it's mandatory you're gonna have a seizure, on my record, but they wouldn't do no follow-ups or… and they kinda downplayed it, and I kinda went along with it. [Laughs]… It made things easier … because I guess in prison or in jail, whenever … they have to stop what they're doing to take you to medical and all that, it makes more work on them, so… they make things harder on you, so to speak … they might take you to medical and leave you sitting in one of the holes … for hours before the doctor sees you. Then the doctor 'll see you, and, … make light of whatever it is that your concern is … you're like I do all this for nothing, you know what I mean? So, you know, like it was no big deal. I just go on and just make my time as easy as possible and get on outta here. And that's been my experience.

Robert's complicity with the system shaped how he managed his health problems. Robert was aware that the prison health system was not seriously addressing his seizure disorder and he accepted this. He believed that to advocate for himself and his health would be pointless and ultimately result in his prison term being made more difficult by the correctional staff. In addition, Robert was not acutely or seriously ill making it easier for the system to dismiss his health problems and easier for him to be complicit in this dismissal.

Aggression—Matthew, a 44-year-old African American, had adapted to the demands of prison life by becoming the aggressor.

R: … And I can say when I first went in, prison made me a very violent person… to where I learned that you don't stop until somebody else has stopped… that's what prison did to me when I first went in. It made me into a predator… . On my E number (his 1st incarceration)

[was] the first time I actually seen somebody get stuck, stabbed. Fucked with me for over a month … I'm standing on the yard and one of the guys come said "Excuse me, you know, I have to get something" and he pulls out a rusty piece of steel and virtually goes, puncturing it into this guy. He sticks it in about 27 times, and it's like I'm new in the system, and everyone else has just adapted to it; it's a common thing, and I'm over there freaking out… . It took me to actually do another violation and to actually have to do it to someone else for me to get used to it. This is just common … You … would prey on someone or they would prey on you.

During his first incarceration, Matthew realized that he had to acclimate quickly to the commonplace violence of prison and the inertia of the other inmates to survive. Adapting to the amorality of prison life did not come naturally to Matthew. He was conflicted by the bind he found himself in; he wanted to live and the most obvious way to do this was to become the predator, while at the same time he knew this was not right. However, over time, Matthew grew accustomed to assuming a predatory stance while incarcerated, and it became the way he managed in his home community as well.

Louis, a 50-year-old white man, also articulated the importance of being a predator rather than prey in prison. He spoke to the liability of developing relationships with other convicts.

R: … They always want something … and I've always learned you don't take nothing from nobody, you know? If you don't got it, you don't need it. If you really want it, you'll go and get it. That's how I learned … I've had things, I've had a lotta things in prisons by doing things I never should have done … that I've hurt a few people … I'm sorry for some of the things I've done.… But to make me feel better, is if I didn't do what I did, I probably wouldn't be here today… . That hurts, that I did it. There're certain things in your life, a few things, that you can't take back. So what I do is I tell myself, what woulda happened if I hadn't done it? … I'd probably be six feet under right now. You know, it's like survival in prison. So when you do a lotta time, you learn to do things that you—you don't normally do… . I gotta tell myself that I did the right thing on that part… I'm not ashamed of what I did or nothing. It hurts, but I feel like I'm alive today because I did it.

To cope with the threatening circumstances of prison life, Louis developed a preemptively aggressive stance. Although he was remorseful over his violent actions toward others, Louis believed his behavior was life sustaining. Despite Louis' claim as the aggressor, it was more likely that Louis had been the victim of violence and exploitation more frequently than he had been the perpetrator of it. Louis was a small man with a physical disability—all things that suggested he would have been a target in prison. As a result of his repeated exposure to institutional violence, Louis was suspicious, hypervigilant, and believed he could trust no one. These feelings exacerbated his social isolation and made meaningful interactions with others, in prison or in mainstream society, difficult to achieve.

The preceding narratives illuminate 2 adaptations to the correctional environment, acquiescence and inaction, and aggression. As a result of multiple incarcerations, participants reentered their communities having adjusted to the violent and coercive nature of prison life. However, adaptations that were critical for survival in the correctional facility were ineffective for life in their home communities. Acquiescence and inaction diminished participants' sense of agency and self-direction required for successful reintegration, and they were often unable to organize themselves to meet the demands of the free world. Aggression or predatory adaptations hampered participants' ability to establish positive relationships with family, friends, and community service providers and further increased their sense of social isolation. As a result of necessary adaptations, participation in prosocial activities such as substance abuse treatment and legal employment could often be maintained only for short periods of time. Failure to develop skills and behaviors more suited to life in mainstream society

frequently led to a return to drug use, criminal activity, and reincarceration. Complicating participants' situations further was that they had become inured to the patterns and mores of the correctional institution; what once was disturbing had become familiar. To a degree, participants managed more effectively within in the confines of prison and their time spent in the free community was often marked by frustration, alienation, and failure.

Dependence

Dependence occurred when participants relied on the correctional system to meet basic needs of daily living, needs that they could not meet independently, for example, food and housing. Two patterns of dependence were revealed in this analysis: (1) reluctant acceptance and (2) complete reliance. With reluctant acceptance, participants did not want to acknowledge their acceptance of and reliance on the correctional institution. Yet, they were unable to succeed or to remain in their home communities for long periods. Complete reliance was the belief that repeated incarceration not only improved participants' health but also saved their lives. Their lives made sense only within the context of the correctional system and these participants were unable to see beyond their experiences of prison and parole.

Reluctant acceptance—Several participants articulated the processes by which they reluctantly accepted their status as inmates and their resultant inability to craft lives for themselves in the free world. Matthew provided a clear instance of this pattern. Although he did not consider himself to be institutionalized, he was disturbed by his prison experiences. He was unable to leave his predator stance and feelings of powerlessness behind as he reentered the community.

R: … When I got out, I have this code of not being disrespected. I'll take that to the streets with me. And the woman who did the time with me when I got out. At the slightest inkling of disrespect, I became an abuser. So you know, and that's all I knew… . And it's like … once you get over that initial intake of prison and what it takes to survive in prison, you can be okay to go back into that setting because you know what it takes… . So it's not like I came out with the most sanest state of mind, and was able to program (meet the requirements) on parole and get off parole. There's always been some negative conducts or actions or some difficulties that draw me right back into prison. And one thing that I've found, and I really evaluated this, is that I'm not institutionalized but I'm okay with going back to prison. Prison brainwashes you and take away serious trains of thought on how to really act out in society.

Matthew's violent behavior, both in prison and at home, was an outcome of living under life-threatening conditions on a daily basis. He demanded in the free world what he did not get in prison—respect and control— albeit unsuccessfully. Matthew could not overcome the practices of prison life in his home community, and to a degree, he was disinterested in doing so. Learning how to survive in prison had been his greatest success and he had few other practices or behaviors to help him meet the requirements of free society.

A third participant, Louis, articulated the discordance between not wanting to belong in prison while knowing there was no place for him in free society.

R: S time is two weeks before you're ready to go home… . They stop you from working. They pull your gate passes … you're just in your cell … you don't go to work no more. They, they freeze your books. You can't go to the store or nothing. That's what S time is. It's for them to get you ready to leave to the streets. Well, once I get into S time, I start getting bad thoughts. All them good thoughts I thought about in prison, what I wanna go do, what I gotta do, this time even, I went to the point of writing them down… I blow all of them away … I start getting scared about leaving… . 'Cause I don't know where to go. So I know I'm gonna be homeless. Nowhere to sleep. Do you know what it feels like, not having nowhere to sleep? Or waking up

somewheres and it's cold or rainy, and you don't know where you're gonna go? You're stuck outside. You have to go into a building, like maybe a bowling alley or something, to get warm. So I'm not really looking forward to going to the streets sometimes. So I get to—you know, I don't care. So what I do is what I do best—is go get some drugs and don't worry about when I go back.

Louis expressed ambivalence about his circumstances. In prison, he was anxious and paranoid about his safety but responded positively to an environment that was somewhat controlled. Prison provided a structure that allowed him to make plans for the future and look forward to that future while ensuring that his basic needs were met. On the streets, he had to provide for himself with limited resources or support. It was within this context that Louis went back to using drugs and waiting to be returned to prison. He did not want to rely upon the system to take care of him but believed he had no other choice. On the streets, Louis was isolated and alone and, although he was reluctant to accept the correctional institution as his primary caretaker, prison provided him with basic necessities that he could not provide for himself.

Complete reliance—Unlike those participants who resisted dependence upon the institution, another group of participants were completely reliant upon it. These participants were aware of the positive role prison had played in their lives and frequently viewed a return to prison as a life-saving event. The correctional system was their primary source of stability and support. These participants believed that they did not have the capacity to improve their circumstances independently, and they were uncertain whether or not they could survive outside the system. Luke and John provided paradigmatic examples of this pattern of dependence. Both men had been involved with the correctional system and engaged in criminal activity for more than 3 decades. Their narratives represented the shared belief among these participants that prison provided a source of stability and organized living unavailable to them in their home communities, particularly after long histories of involvement with the correctional system.

Luke, a 44-year-old white man, had been involved in the prison system since age 12. At the time of this study, Luke had only 52 days left of his parole supervision. On completion of his parole, Luke would no longer have access to the stabilizing influence of the correctional system. He reflected on the ease of prison life and the stress of managing the multiple demands of life in the free world.

R: I've made life-long friends there. You can make life-long friends there. You can learn a lotta things, and there's programs you can take advantage of … prison can be helpful… . And you're gonna live in an environment where you're gonna learn to interact with people… . You're gonna learn to go to work on time… . There's things that you have to do there that you don't have to do on the streets. And it makes you somewhat be more responsible and be a man …

I: Why does all of that fall away when you get out?

R: It's easy. You don't have to pay for your room and board… . You don't have to go out and get a job. It's gonna be provided for you… . When you come out of prison, you have to go see your parole officer. And you may not have wheels. You have to give a place of residence. You might not have family and no job, no—you have to do all kinds of things, and it's so easy that when you fail at one of them, you're gonna fail at a lot of them … when you come outta prison, there's not resources available to you. Your job's not like right around the corner, a quarter block away at the kitchen. Or your laundry's not gonna be brought back to your dorm, and you're just sitting on the bed,so you fold it. And you gotta go out and get meals and have a place to cook them. It's not at the chow hall, where somebody can make it and wipe your table.

So there's lots that's provided for you that, when you come out the gate, it's not provided for you no more. And it's a lotta stress to find those things.

Luke was involved with life in prison in a way that he was not in the free world, where his time was spent predominantly using drugs. In prison, Luke was a responsible worker who kept his room clean and his life organized. He was able to do this because the system did a portion of the basic activities of daily living for him. He did not have to plan for his next meal, organize his day or worry about if he would have the resources available to keep up with the rigors and demands of life in mainstream society; the institution did this for him. Luke lived a socially engaged and satisfying life during his incarcerations that he could not live in his home community.

John, a 47-year-old Mexican American, also found that prison provided a framework for his life that he did not have in the free community. He had less than 2 months left on parole and was concerned about what would happen to him on completion of his parole supervision. John had been involved in criminal activity and the correctional system for over 30 years. While John did not want to return to prison, he questioned his ability to transition successfully from his life as convict and criminal to one as a responsible citizen.

R: …'Cause I sure don't want to go that other route (back to prison)… . Yeah. [Long pause] … I mean I'm discharged in February … and it's kinda scary … leaving in February to me is just like, OK, there's another part of my life. Well, I do what I do. And don't got no regrets … but I do—I'm remorseful and I'm sorry for the things I've done in society… I'm not twisted in the brain, you know what I mean? … But what I'm saying is now here I am again… being put out the door, with nothing, you know what I mean? For a 47-year-old man… . And because I'm off parole, the State's not paying for my bed no more, so adios, you gotta go…

With his impending discharge, John would lose the structure that had defined his life for so long. The completion of his parole term signified a loss of resources and support he would not otherwise have. He had become dependent upon the system to define and chart the course of his life. Discharge from parole represented a rejection from his primary way of life and from his community. In addition, John believed that the correctional system, most specifically parole, had saved his life.

R: … I'll go back to the system to regenerate my health… . And to go, and get healthy and come back out and whip myself again, so that's how parole saved my life, and a lotta times, whether you know it or not, there'll be those intervals of some shit happening here on the streets where people are getting smoked (killed). And then at that time you're out, out there, and you could have been that number six one. But, you know, you get arrested. [Laughs]… . So I'm outta harm's way now. I'm outta harm's way, and I'm back over there (in prison), and I'm getting healthy, and eating good and, getting my rest and exercising and getting ready to come out for another run. That's, that's what I did for years, that's what I did for years. That's how parole did save me. [Laughs] …There's pro's and con's to parole, and a lotta times it saved me, 'cause if I would have been out doing the same thing for years, I wouldn't have been talking to you right now.

Prison provided a respite from the violence and harsh conditions of street life. A period of incarceration restored John's physical health and prepared him for a return to the community, where he could resume his drug use and criminal activity. In being discharged from parole, John would no longer have his safety net and would be unprotected from the long-term damage and destructive nature of his addiction disorder and criminal life.

As Luke and John's narratives indicate, this group of participants developed a certain ease with which they entered and exited prison. They had adjusted to and grown dependent upon the

rhythms of the correctional system despite its demands and degradations. Prison life often provided the only stable force in these participants' lives, as they were overwhelmed by the rigors of free society and entrenched within their criminal lives and drug addictions. A period of incarceration served 3 primary functions as a place to achieve stability and success not available to them in the free world, a familiar community to which they belonged, and a retreat from drug use and street life. Participants were well prepared for institutional life but severely limited in their capacity remain in free society for extended periods of time.

DISCUSSION

Participants responded to the demands of the correctional institution in 2 primary ways: (1) acquiescence and inaction and (2) aggression. These patterns of coping were necessary adaptations developed in response to the violent and controlling nature of the prison facility. While necessary and useful for prison life, these adaptations were a liability in the free community and often negatively impacted participants' reintegration efforts. For example, the pattern of acquiescence and inaction participants' developed in prison was often associated with difficulty in accessing the self-motivation required for free world life. In many instances, participants were not concerned about what happened to them upon release from prison and immediately reengaged in their addictions to manage the alienation and stress of life in the free world. Those participants who adapted to prison life via predatory violence struggled to control their anger and at the smallest provocation reacted with ferocity. These reactions were disproportionate to the situation at hand, and participants found themselves isolated from family and friends or quickly rearrested. Both types of adaptations limited these participants' capacity function effectively in free society. Their established patterns of response to prison, when enacted in society at-large challenged them in maintaining employment, receiving direction from others, or participating with those around them in a positive way. As a result of their difficulty in coping with life in mainstream society, participants found themselves increasingly reliant on the correctional system to meet their basic needs. Participants responded to this dependency with both reluctance and appreciation. The demands and deprivations of prison were unwanted, but the institutional structure provided security, comfort, and companionship not accessible to them in their home communities.

While the concept of necessary adaptations and the resultant negative emotional and psychological outcomes have been documented elsewhere in the literature,[14,31] this study provides further evidence that the skills and behaviors required for correctional life are ill suited to life in mainstream society. Goffman[31] articulated the process of institutionalization as totalizing, that is, the institution's routines foster in the inmate reliance upon the institution to tend to basic needs and to provide a sense of personal identity. As a result of being transformed and shaped by the institution, the inmate loses the ability to function in free society. Goffman's description of the process of institutionalization did not reflect the experience of those individuals who were able to overcome their incarceration histories and live successfully in their home communities. However, Goffman's study of institutionalization captured the multiple practical and psychosocial challenges individuals faced as they reentered society after a prison term. The findings from this study demonstrated that individuals presently reentering society after incarceration still face similar difficulties.

Haney[14] also described the difficulties that individuals encounter upon release from prison. Haney articulated several psychological attitudes and behaviors, for example, social isolation and withdrawal, exploitative behaviors, diminished sense of self-worth, and institutional dependence, individuals developed in response to exposure to the correctional system. Haney noted that the development of these seemingly antisocial behaviors were, in essence, normal responses to the pathologic conditions of prison life. However, these responses often became deeply internalized, continued upon release from prison, and negatively affected individual

reintegration efforts. This study's results supported Haney's description and emphasized how pervasive such antisocial patterns of coping are among newly released individuals. Participants' necessary adaptations and institutional dependency were often significant barriers to their reintegration efforts. However, such adaptations were also the least likely to be addressed by the healthcare or social service systems. Formerly incarcerated individuals' opportunities for success or to overcome the processes of institutionalization were also restricted by the limited availability of prerelease preparation and postrelease structural and social support.

Implications for nursing practice, policy, and research

The healthcare system, and nurses in particular, can provide a venue for the development of positive relationships with the potential to sustain newly released individuals in their home communities for an extended period of time.[32,33] However, effective clinical practice with men on parole should incorporate assessment of and accommodation to the multiple and complex needs of this population. By demonstrating interest in their problems and serious clinical attention to parolees' complaints, nurses can encourage male parolees' engagement with the healthcare system. Conversations about the role of illicit drugs on medical conditions can provide a basis for more in-depth discussions about patients' addiction disorders and interest in changing their circumstances. Non-judgmental exploration of parolees' readiness to change and discussion about the negative and positive roles that addiction and criminality play in their lives may enhance parolees' disclosure and clinical engagement. Nurses should ask patients directly about the support or assistance they would like from healthcare services and the nurses themselves. In turn, nurses must be willing to accept when patients do not want to change or see no purpose in it. There are many formats in which such questions can be asked and discussions can be facilitated, for example, motivational interviewing and nonviolent communication, and nurses should become adept at least in one approach and employ it regularly with this population.[34,35] Such communication can provide the foundation for a trusting and long-term relationship between patient and provider, a rare thing in many parolees' lives.

Research has indicated that regular contact with the healthcare system can support individuals in their efforts to achieve stability in their home communities and reduce recidivism.[32,36,37] For example, Conklin et al[37] described an integrated program that provided clinical services for individuals incarcerated during their imprisonment and upon release. The program was a collaborative effort between the public health and correctional systems. This program found a decrease in recidivism rates for its HIV-seropositive patients. While the authors were unable to determine the significance of this decrease in recidivism and similar decreases were not found in those without HIV infection, these findings suggested the importance of continuous clinical services during and after incarceration. Perhaps more importantly, this model demonstrated that collaboration between correctional institutions and healthcare agencies is possible. Nurses working within correctional and public health settings are in an ideal position to form partnerships to address the multiple needs of this population. Such collaborations can provide a viable means of caring for individuals enmeshed in the correctional system while increasing opportunities for successful reintegration. Programs that link correctional health services with community-based care can enhance formerly incarcerated individuals' access to clinical and supportive services as well. Increased access provides opportunities not only to address individuals' health problems but to more effectively address the complexity of their social circumstances as well.

However, collaborative partnerships between the correctional institution and the healthcare system are not without difficulty particularly in states that are geographically large, with high rates of incarceration, and numerous prisons. System integration is further complicated by the

different funding streams that underwrite the efforts and directives of prison and healthcare systems. The political climate and public attitude toward the criminal population also influences how seamlessly institutional change can occur. However, current research indicates that financial restraints and differing institutional objectives can be overcome to create an economically viable, efficient, and humane system of care.[33,37] Nurses, as both clinicians and patient advocates, are ideal professionals to develop linkages between correctional and community healthcare. In addition, nursing research that emphasizes not only effective policies and programs but addresses the root causes of incarceration, for example, lack of education and income inequity, has the greatest potential to increase the rates at which men on parole successfully achieve long-term stability in their home communities.

CONCLUSION

While this study's results reflect the experience of chronically ill, middle-aged men on parole and may not be generalizable to healthier or younger men, it does represent the tremendous changes formerly incarcerated individuals must make to be successful in their reintegration efforts. In essence, individuals on parole are expected to radically change their lives with meager resources and support from either the parole or healthcare systems. Opportunities for success are limited even for the healthiest and most intact parolee and further restricted for those with extensive incarceration histories and chronic conditions. To effectively address the complex problems of individuals on parole, the healthcare system and within that, nursing professionals, must begin to integrate the influence of long-term involvement in correctional and criminal life into its evaluation and treatment of these individuals.

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REFERENCES

1. Durose, MR.; Mumola, CJ. Profile of Nonviolent Offenders Exiting State Prisons. Washington, DC: US Department of Justice, Bureau of Justice Statistics; 2004.
2. Petersilia, J. Parole and prisoner reentry in the United States. In: Tonry, M.; Petersilia, J., editors. Prisons. Chicago, IL: University of Chicago Press; 1999.
3. Langan, PA.; Levin, DJ. Recidivism of Prisoners Released in 1994. Washington, DC: US Department of Justice, Bureau of Justice Statistics; 2002.
4. Solomon, A. Does Parole Supervision Work?. Washington, DC: Urban Institute; 2006.
5. Watson R, Stimpson A, Hostick T. Prison health care: a review of the literature. Int J Nurs Stud 2004;41:119–128. [PubMed: 14725776]
6. NCCHC. The Health Status of Soon-to-be-Released Prisoners. Chicago, IL: NCCHC; 2002.
7. Sabol, WJ.; Couture, H.; Harrison, PM. Prisoners in 2006. Washington, DC: US Department of Justice, Bureau of Justice Statistics; 2007.
8. Harlow, CW. Education and Correctional Populations. Washington, DC: US Department of Justice, Bureau of Justice Statistics; 2003. p. 1-12.
9. Beck, A. state and Federal Prisoners Returning to the Community: Findings From the Bureau of Justice Statistics; First Reentry Courts Initiative Cluster Meeting; Washington, DC: Bureau of Justice Statistics; 2000.
10. Galea S, Vlahov D. Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. Public Health Rep 2002;117 suppl 1:S135–S145. [PubMed: 12435837]
11. Woolf SH, Johnson RE, Phillips RL, Phillipsen M. Giving everyone the health of the educated: an examination of whether social change would save more lives than medical advances. Am J Public Health 2007;97(4):679–683. [PubMed: 17329654]

12. de Viggiani N. Unhealthy prisons: exploring structural determinants of prison health. Sociol Health Illn 2007;29(1):115–135. [PubMed: 17286709]
13. Massoglia M. Incarceration as exposure: the prison, infectious disease, and other stress-related illnesses. J Health Soc Sci Behav 2008;49:56–71.
14. Haney, C. The psychological impact of incarceration: implications for postprison adjustment. In: J, Travis; M, Waul, editors. Prisoners Once Removed. Washington, DC: Urban Institute; 2003. p. 33-66.
15. Haney C. Mental health issues in long-term solitary confinement and "supermax" confinement. Crime Deliquency 2003;49:125–156.
16. Lynch JP, Sabol WJ. Prison reentry in perspective. Crime Policy Rep 2001;3:1–26.
17. Stephan, JJ. State Prison Expenditures, 2001. Washington, DC: Bureau of Justice Statistics; 2004.
18. Travis, J.; Solomon, A.; Waul, M. From Prison to Home: The Dimensions and Consequences of Prisoner Reentry. Washington, DC: Urban Institute; 2001.
19. Nelson, M.; Deess, P.; Allen, C. The First Month Out: Post-Incarceration Experiences in New York City. New York: Vera Institute of Justice; 1999. p. 1-31.
20. Seiter RP, Kadela S. Prisoner reentry: what works, what does not and what is promising. Crime Delinquency 2003;49:360–388.
21. Greene, J.; Schiraldi, V. Cutting Correctly: New Prison Policies for Times of Fiscal Crisis. Washington, DC: Urban Institute; 2002.
22. Hughes, T.; Wilson, DJ. Reentry Trends in the United States. Washington, DC: US Department of Justice, Bureau of Justice Statistics; 2002.
23. Nelson, M.; Trone, J. Why Planning for Release Matters. New York: Vera Institute of Justice; 2000. http://www.vera.org.
24. Hammett TM, Roberts C, Kennedy S. Health-related issues in prisoner reentry. Crime Delinquency 2001;47:390–409.
25. Cadora, E.; Swartz, C.; Gordon, M. Criminal justice and health and human services. In: Travis, J.; Waul, M., editors. Prisoners Once Removed. Washington, DC: Urban Institute; 2003. p. 285-311.
26. Chesla, C. Parents' caring practices with schizophrenic offspring. In: Benner, P., editor. Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness. Thousand Oaks, CA: Sage; 1994.
27. Chesla, CA. Family Processes in Chinese Americans With Diabetes. San Francisco, CA: UCSF; 2005. p. 1-39.
28. Guest G, Bunce A, Johnson L. How many interviews are enough? An experiment with data saturation and variability. Field Methods 2006;18:59–82.
29. Conklin TJ, Lincoln T, Tuthill RW. Self-reported health and prior health behaviors of newly admitted correctional inmates. Am J Public Health 2000;90:1939–1941. [PubMed: 11111273]
30. Morse, J. Designing funded qualitative research. In: Denzin, N.; Lincoln, Y., editors. Handbook for Qualitative Research. Thousand Oaks, CA: Sage; 1994.
31. Goffman, E. Asylums Essays on the Social Situation of Mental Patients and Other Inmates. New York: Anchor Books; 1961.
32. Sheu M, Hogan J, Allsworth J, et al. Continuity of medical care and risk of incarceration in HIV-positive and high-risk HIV-negative women. J Womens Health 2002;11:743–750.
33. Vigilante K, Flynn M, Affleck P, et al. Reduction in recidivism of incarcerated women through primary care, peer counseling, and discharge planning. J Womens Health 1999;8:409–415. [PubMed: 10326995]
34. Rosenberg, MB. Nonviolent Communication: A Language of Life. 2nd ed. Encinitas, CA: Puddle Dancer Press; 2005.
35. Miller, WR.; Rollnick, S. Motivational Interviewing: Preparing People for Change. New York: The Guil-ford Press; 2002.
36. Rich J, Holmes L, Salas C, Macalino G. Successful linkage of medical care and community services for HIV-positive offenders being released from prison. J Urban Health 2001;78:279–289. [PubMed: 11419581]
37. Conklin TJ, Lincoln T, Flanigan TP. A public health model to connect correctional health care with communities. Am J Public Health 1998;88:1249–1251. [PubMed: 9702163]