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The Impact of Health Care Access on the Community Reintegration of Male Parolees

by
Elizabeth Marlow

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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in the
GRADUATE DIVISION

of the
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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Elizabeth Marlow

...there is a close relationship between flowers and convicts.
Jean Genet, 1949

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THE IMPACT OF HEALTH CARE ACCESS ON THE COMMUNITY

REINTEGRATION OF MALE PAROLEES

Elizabeth Marlow

ABSTRACT

Of the 784,400 individuals released from prison in 2005, most were likely to have not finished high school, have limited employment skills, represent ethnically diverse and marginalized communities, and have multiple health problems. These individuals often have long criminal histories and their time in the free world is punctuated by frequent reincarcerations. The purpose of this study was to understand how health care access affects the community reintegration of male parolees. The specific aims were to: examine the health beliefs and practices regarding general health care and specific medical conditions from the parolee's perspective; identify the perceived barriers and facilitators parolees encountered in accessing community health care services; describe the impact of health care access on reintegration from the parolee's perspective; and identify specific events in the parolee's life that may have affected his reintegration. Hermeneutic phenomenology guided the study conduct and data analysis. Data were collected via repeat individual interviews with chronically ill male parolees 40 to 65 years of age. Thirty-two in-depth interviews with 17 participants were completed. Study results included: structural barriers to health care; personal and group responses to interacting with health care while on parole and how these interactions facilitated or diminished reintegration efforts; social barriers and facilitators to health care participation, e.g. the influence of a clinician's caring professional demeanor on participation in clinical care; the role that addiction disorders play in the need to access and utilize health care; and the influence of institutional and criminal adaptations, e.g. interpersonal distrust, social isolation and institutional dependence, on reintegration efforts. These findings suggest a need for new ways of conceptualizing reintegration that includes health more centrally in the processes of success or failure. The health care system has the potential be a positive influence in these individuals' lives. In order 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 integrate the problems and issues of long-term involvement in street and prison life into its evaluation and treatment of these individuals.

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CHAPTER 1: REENTRY AND REINTEGRATION AFTER PRISON

Introduction

What is Reintegration? Reintegration can be thought of as the ultimate goal for the prisoner reentering his community after a prison or jail sentence. Reintegration begins with reentry, i.e. leaving the correctional institution and returning to the free community. All prisoners excepting those that die in prison experience the immediate transition of reentry regardless of their method of release or form of community supervision. Reintegration is also a transition, although not as immediate as reentry, which involves an individual's successful reconnection with the institutions of free society such as the labor force, families, communities, schools and religious organizations (Solomon et al, 2005; Visher & Travis, 2003). It is through the process of successfully reintegrating that the benefits to the individual, his family and community, and the larger society can be seen; these include economic stability due to regular participation in the work force, prosocial involvement with family and community due to decreased criminal activity, and increased public safety.

While the majority of incarcerated individuals experience reentry, very few achieve a successful reintegration and for those that do it is not without confronting multiple and long-term difficulties (Lynch & Sabol, 2001; Nelson et al., 1999; Travis et al., 2001). The questions then become what are the key components to successful reintegration and how can society's institutions assist the formerly imprisoned person to transition from the correctional institution to the free world with a modicum of ease and minimum of distress (Visher & Travis, 2003). The answers to these questions have been sought after for several centuries by reformers, law enforcers and researchers alike yet

despite many efforts and attempts at reform, enforcement and understanding these questions still remain (Foucault, 1977; Petersilia, 2003; Travis, Solomon, & Waul, 2001). There is a wide and varied body of literature that addresses the fundamental questions of punishment and retribution, reentry and reintegration (Foucault; Goffman, 1961; Haney, 2003a, 2003b; Seiter & Kadela, 2003; Travis et al, 2001; Travis & Waul, 2003b; Visher & Travis). However, how the questions are asked and are answered depends upon the questioner's orientation towards the individual who must undergo the imprisonment and subsequent release. Is this individual a vicious criminal or misunderstood outcast? Is this individual an inmate, a parolee, a patient, a research participant, a Bureau of Justice statistic, a penitent person or an individual without remorse? The context in which this individual is viewed will impact society's understandings and approaches to the individual himself and to his reentry and reintegration whether it is from the perspective of policy, research or health care.

The purpose of this chapter is to provide a review of relevant research on the processes of reintegration and the multiple obstacles an individual encounters in his efforts to be successful. This chapter will conclude with an overview of how my dissertation research will begin to address this gap as well as outline the project's theoretical frameworks and its research methodology to be discussed in the following two papers. In order to lay the groundwork for this review, the first section will describe the parole system in the United States, i.e. how individuals are released from prison. This section will include a brief history of parole and the present state of parole in the United States. The Second section will discuss studies of who is on parole in the United States followed by what is known about the barriers an individual faces upon reentry to free

society. The fourth section will review the major health problems of prisoners and parolees and the implications of such problems for both the health of the individual and the community. Section five will discuss gaps in current research, most specifically the missing perceptions, experiences and voices of formerly incarcerated individuals in this body of research. This paper will conclude with an overview of how my dissertation research will begin to address this gap as well as outline the project's theoretical frameworks and research methodology to be discussed in the following two papers. The literature reviewed for this paper has been drawn from the fields of health care, sociology and criminology as well as the work being done by the Urban Institute, the Vera Institute of Justice and the Bureau of Justice Statistics.

A Brief History of Parole

Parole is a period of community supervision after completion of a prison term. Until the 1970's, there were four main components of parole: indeterminate sentencing, a system for granting release, post-release supervision, and specific criteria for parole revocation (Petersilia, 2003; Travis et al., 2001). The decision to release a prisoner from prison to the community was made by a state's parole board. The parole board determined what type of supervision the ex-offender would be under in addition to demonstrating some interest in what the individual's plans were upon release from prison.

The idea of parole originates in the French word "*parole*", meaning promise or word as in "to give one's word". The parole system itself was initially developed and implemented under the auspices of Captain Alexander Maconochie (1787-1860) while in charge of Norfolk Island English Penal Colony off the coast of Australia. Captain

Maconochie's plan for punishment to reformation was comprised of five phases: imprisonment, chain gang labor, limited freedom, parole ticket and conditional pardon, and finally, full restoration of liberty. He believed that prisoners should be prepared for full freedom through a gradual process of conditional release (Petersilia, 2003). Captain Maconochie did not believe in physical punishment or brutality as a management system or change agent, but rather in education and training. In Australia Captain Maconochie transformed, within four short years, a brutal convict settlement into a stable and productive environment and the inmates released from his institution were so successful they were known as "Maconochie's Gentlemen". However, his attempts to achieve a similar system of parole in England were not as successful; he was dismissed for being too lenient.

Zebulon Brockway (1827-1920) implemented the first parole system in the United States as the superintendent of the Elmira Reformatory, a facility in New York. It was comprised of a two-pronged approach for both managing the prisoner population and preparing them for release: indeterminate sentencing followed by a period of parole supervision (Petersilia, 2003). Over the course of their incarceration, each male inmate (16 – 30 years) began his term in the second grade; six months of good behavior would result in promotion to the first grade with an opportunity for release should the good behavior continue; bad or poor behavior would result in the inmate being demoted to the third grade where he could work his way back to the second and first grades. Upon release, the individual would have six months of required supervision in the free community. He would be required to report monthly to a volunteer guardian who would make a written report to the institution; this volunteer guardian would ultimately become

today's parole officer. Brockway's model quickly spread throughout the United States and in 1907, New York was the first state to formally adopt a parole system complete with the following components: indeterminate sentencing, a system for granting release, postrelease supervision, and specific criteria for parole revocation. Less than 40 years later, all 50 states had a formal parole system. From the beginnings of parole to the 1970s, the philosophical tenor of both incarceration and parole was that criminals could be reformed and that treatment should be individualized. It was during the 1970s, however, that attitudes and policies regarding the imprisonment and release of individuals began to change (Martinson, 1974; Travis et al. 2001).

The Present State of the U.S. Parole System

The concept of parole outlined above was drastically altered during the 1970s. In her book, "When Prisoners Come Home Parole and Prisoner Reentry", Petersilila (2003) outlines three primary reasons that indeterminate sentencing and parole release came under attack in the 1970s. Indeterminate sentencing refers to prison sentences and release decisions that are determined via the discretion of the judicial system, parole boards and other correctional officials as well as by the individual's behavior while incarcerated (Tonry, 1999). First, it was alleged that there was limited scientific evidence that parole release and supervision reduced recidivism. This belief was grounded in a 1974 review of 231 experimental studies that suggested that neither in prison rehabilitation programs nor parole supervision had an impact on reduced rates of recidivism (Martinson, 1974). While the report itself did call into question the efficacy of rehabilitative strategies to reduce recidivism it more strongly criticized the research methodologies themselves both in their execution and in the questions they posed. However, one of Martinson's

concluding statements, “that if we can’t do more for (and to) offenders, at least we can safely do less” (p. 48), proved to be the most influential in the delimitation of rehabilitative efforts both in prison and the community, rather than pushing the research community to evaluate its interventions and methodologies. Second, there were prisoners who argued that indeterminate sentencing kept them in “suspended animation” and was unjust and inhumane (Petersilia, p. 63; Tonry) Third, parole boards had a significant amount of autonomy and were not subject to outside scrutiny; concerns were raised that the parole boards’ release decisions were arbitrary and racially biased. The idea that there was limited scientific evidence to support incarceration and parole as a rehabilitative process coupled with the belief that discretionary parole release was an ineffective and biased system led to a tremendous shift in how the United States was to incarcerate and release its citizens. The sociologist, James Q. Wilson’s statement perhaps best captures this perspective:

Instead we could view the correctional system as having a very different function—to isolate and to punish. That statement may strike many readers as cruel, even barbaric. It is not. It is merely recognition that society must be able to protect itself from dangerous offenders. It is also a frank admission that society really does not know how to do much else (Wilson, 1985 as cited in Petersilia, 2003, p. 64)

In addition to this, there was a public understanding that parole boards gave criminals a “free pass” and that prison sentences overall were too lenient (Lynch & Sabol, 1997; Tonry, 1999). In response to this, the criminal justice and correctional systems placed punishment above rehabilitation as its primary purpose (Travis et al., 2001). Prior to the 1970s, prison education and training was part of incarceration, and parole functioned as a link to the successful reintegration of ex-offenders into the

community. However, with the public's belief that prisoners were getting both a free education and free room and board at the tax payers expense, legislators altered, and have continued to alter, the discretionary parole process, sentencing guidelines and ways ex-prisoners are released back into the community.

In 1977, 72 percent of all prisoners were released via parole board decision versus 24 percent in 1999 (Travis, 2003). By 2002, 16 states had abolished their parole boards in favor of determinate and truth-in sentencing (Petersilia, 2003; Seiter & Kadela, 2003; Travis et al., 2001). These sentencing guidelines require that the prisoner spend a specific amount of time in prison before release regardless of his behavior or participation in prison programs (Petersilia). Once the prisoner has "maxed-out" his sentence, he is released from prison with either no parole or mandatory parole supervision. The problem posed by this process is that violent felons who have "maxed-out" lengthy sentences are released to the community with no supervision while those who were convicted of non-violent or drug related crimes have the most stringent mandatory parole requirements (Austin, Irwin, & Hardyman, 2002; Petersilia, 2003; Solomon, 2006; Travis et al., 2001).

Annually over 784,400 individuals are released from state and federal prisons nationwide (Glaze & Bonczar, 2006). Approximately 80 percent are released to community supervision either through discretionary release, where a parole board uses its discretion to determine if an individual is ready for reentry, or mandatory release, where no determination of readiness is made but the individual has completed his sentence (Solomon, 2006). The majority of parolees spend an average of 26 months under discretionary or mandatory supervision, with mandatory parolees comprising the bulk of formerly incarcerated individuals (Solomon). Regardless of the changes in sentencing

and release practices, the rates of recidivism, defined as rearrest, reconviction and reincarceration, have remained the same – within three years of release, 69 percent of nonviolent ex-prisoners are arrested for a new crime and of these, 20 percent are arrested for a crime of violence (Durose & Mumola, 2004). According to the Bureau of Justice Statistics (BJS), over 200,000 parolees return to prison each year (Solomon). The current parole system, and the many federal and state laws passed to enforce it, have contributed little in the way of increased public safety or decreased criminal activity begging the question, does parole supervision work (Durose & Mumola; Solomon)?

In her analysis using BJS data on 38,624 prisoners released in 15 states in 1994, Amy Solomon (2006) attempted to answer this question. The results were discouraging although in keeping with current recidivism estimates (Langan & Levin, 2002); this study's multivariate regression analysis found that 61 percent of both mandatory parolees and unconditional releasees will be rearrested at least once within two years, in comparison to 57 percent of those on discretionary parole, i.e. parole has not significantly influenced rates of recidivism or public safety. This study does add further evidence that prisoners released via discretionary decisions may do better than those released via other mechanisms although these individuals may have been the lower-risk prisoners to begin with (Solomon, 2006). There is research to suggest that the lower risk individuals, i.e. those with less criminal involvement, fewer drug problems and more connections with family, housing and employment, may receive more intervention and supervision from the correctional system but actually may need less of it (Anglin, Longshore, & Turner, 1999; Simpson, Joe, & Broome, 2002). Solomon proposes this as well but does not specifically compare the services and supervision received under discretionary or

mandatory parole supervision versus what services or support an individual released unconditionally may have access to. Furthermore, due to the aggregate nature of the BJS data this study was unable to address state-level variations in parole supervision, it did however, offer an overview of the present parole process.

The current parole system has changed the role of the parole agent from one who assisted with community reintegration to one who polices for future criminal activity. Parole agents' caseloads are large averaging 70 parolees per agent or approximately two 15-minute meetings per month (Pollack, Khoshnood, & Altice, 1999; Solomon, 2006). Their offices are frequently located outside of the communities where the parolees reside making it difficult for the agent to make connections and develop relationships within those communities (Solomon). Parole agents receive little if any education on substance use disorders, mental illness and case management services (K. Grant, personal communication, June 22, 2006; Solomon, 2006). Furthermore, given parole's current emphasis on surveillance there is little room or support for substance abuse treatment even though there is no dearth of evidence demonstrating the importance of such treatment for this population in and out of prison (Anglin et al., 1999; Gossop et al., 2005; Kelly et al., 2004; Martin et al., 1999; Moos et al., 1999; Simpson et al., 2002; Wexler et al., 1999).

Parole officers, unlike judges and prosecutors, are not immune from prosecution and are susceptible to negligent supervision lawsuits from victims and offenders (Petersilia, 2003). Therefore, a parole agent is more likely to revoke an individual's parole, even on a technicality, e.g. violating curfew, having a positive drug test, or associating with known felons. This has increased the number of persons who are

returned to prison for technical violations. In 1998, 23 percent of all new admissions to state prisons nationwide were for parole violations, and of these, 76 percent were for technical violations (Seiter & Kadela, 2003). This is expensive. For example, California, which has 18 percent of the nation's parole population, spends \$800 million to \$1 billion a year reincarcerating technical parole violators (Greene & Schiraldi, 2002; Hughes & Wilson, 2002; Petersilia, 2003; Travis et al., 2001).

In 2004, the U.S. prison system housed over 1.4 million people, an increase of 50 percent since 1980 (Golembeski & Fullilove, 2005; Harrison & Beck, 2005; Travis & Waul, 2003b). Of an annual budget of \$40 billion, approximately \$6.4 billion is spent on parole services or \$2,000 to \$3,000 per parolee per year (Lynch & Sabol, 2001; Greene & Schiraldi, 2002). This is in contrast to the amount spent to house prisoners - \$22,000 to \$70,000 per year depending on the age of the prisoner (Petersilia, 2003). It has become clear that the U.S. prison and parole system is expensive and ineffective. What is more dire than the financial cost, is the human expense. The impact of these new policies is most evident in the inner cities, some the nation's most marginalized and vulnerable communities (Cadora, Swartz, & Gordon, 2003; Lynch & Sabol, 2001; Lynch & Sabol, 1997).

Who is on Parole?

Race. In 2005, 784,400 individuals were released to communities nationwide, approximately 2100 per day (Glaze & Bonczar, 2006). Those released were likely to have not finished high school and have limited employment skills. In 1999, 90.1 percent of releasees were male, 47 percent were African-American, 16 percent were Hispanic and the remainder were white or other ethnicities (Hughes & Wilson, 2002). Presently, there

are more African-American men, aged 20 to 29, in prison, on parole or probation than the total number in college (Bonczar & Beck, 1997). Bonczar & Beck calculated that the lifetime chances for an African-American going to prison is 28.5 percent compared with 16 percent for Hispanics and 4.4 percent for whites. The high rates of African-Americans entering prison and parole is striking because they represent only 12 percent to 13 percent of the total U.S. population.

The war on drugs has had a disproportionate effect on African-American males and it has been speculated that this imbalance is associated with more stringent sentencing policies for drug-related offenses and increased police presence in certain communities (Chambliss, 1994; Lynch & Sabol, 1997; Petersilia, 2003). In their analysis of data from the Survey of Inmates of State Correctional Facilities (SISCF) and the National Corrections Reporting Program (NCRP), Lynch and Sabol found that between 1986 and 1991 two-thirds of the increase in incarceration rates for African-American men was associated with non-violent crimes and of these, 50 percent was due to incarceration for drug-related offenses. Chambliss spent over 100 hours riding with the Washington, D.C. Police Rapid Deployment Units (RDU). His ethnographic study revealed that RDU officers stopped cars driven by or carrying young black men on an average of one every twenty minutes (Chambliss). However, only ten percent of these vehicular stops detected any illegal activity (Chambliss). Although this study was limited by its exposure to and observation of one specialized unit of one urban police force, it is a powerful representation of the interaction between members of minority communities and law enforcement. Chambliss proposes that the intensive surveillance of African-American

neighborhoods has created a definition of crime as a problem specific to young men of color.

Young African-American and Latino men are defined as a criminal group, arrested for minor offenses over and over again, and given criminal records which justify long prison sentences. The culture of the black community and the black family is then blamed for high rates of ... crime (Chambliss, 1994, p. 183).

Employment and Education. Although many parolees have had limited or no work experience, a Government Accounting Office (GAO) report of 1997 Bureau of Justice Statistics (BJS) data found that 66 percent of state and federal inmates were employed one month prior to their arrest (Stana, 2000). However, the GAO report did not describe whether this work was full or part-time, was legally documented via W-2 forms and payroll receipts or was under the table with salaries being paid in cash. Therefore, despite this seemingly high rate of employment within this population, stable, full-time work may be difficult for many former prisoners to obtain. For example, a study that followed 491 adolescent males (16-19 years) and 476 adult women (≥ 18 years) while incarcerated in a New York City jail and for 15 to 18 months post-release found that 87 percent of the young men and 40 percent of the women identified unemployment as a major problem. Furthermore, a year and a half after release from jail only one-third of the study participants had legal employment and 14 percent of the young men and 19 percent of the women reported income from illegal activities. Although this descriptive study represented only 69 percent of its original sample ($n = 1410$) and did not explore what type of work was being done by the two-thirds that had found it, it does provide evidence of the minimal work opportunities and experience for those released from the correctional system be it prison or jail (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005). This study also represents a reality shared by many formerly incarcerated

individuals; they survive financially through a combination of legal and illegal work practices.

In combination with limited stable employment opportunities, those entering parole frequently return to “core counties” or counties with a large metropolitan area (Lynch & Sabol, 2001). Within these core counties, parolees are concentrated in a few central cities and neighborhoods, frequently low-income communities of color (Cadora et al., 2003; Lynch & Sabol, 2001). The neighborhoods themselves have limited employment opportunities and, although being situated in a county with a large urban center, are frequently far removed from the core county’s center of job opportunities and economic growth (Cadora et al.; Lynch & Sabol). Like the growth of the prison population, the concentration of those individuals returning to core counties has increased as well. Lynch and Sabol’s analysis found that the increasing rates of incarceration for non-violent and drug related crimes came from a relatively few number of communities, i.e. core counties. For example, between 1985 and 1992 more than 37 percent of all state prison admissions in California came from Los Angeles County although it comprised less than 12 percent of the state’s total population (Lynch & Sabol).

In addition to limited legal work experience and residing in communities with minimal legal opportunities for economic self-sufficiency and a heavy police presence, incarcerated and formerly incarcerated individuals have much lower levels of education than the general population. Harlow (2003) estimates that 41 percent of all state and federal inmates have not completed high school or its equivalent compared with 18 percent of the general population aged 18 and older. Petersilia (2003) states that 40

percent of all state inmates are functionally illiterate and 19 percent are completely illiterate compared with 21 percent and 4 percent, respectively, of the general population.

A study of language-learning disorders compared two groups of boys (mean age 17 years) - those with language disorders who had been in a juvenile institution (n = 17) and those with similar disorders who had not (n = 19) (Linares-Orama, 2005). A multidisciplinary research team utilized standardized tests, questionnaires and clinical observations to determine the differences between the two groups. This study found that in addition to language-learning disorders, the delinquent boys frequently had substance abuse disorders, limited family support and significant family problems, and undiagnosed attention deficit hyperactivity disorder compared with those boys who had never encountered the juvenile justice system but came from supportive families with opportunities for treatment and positive participation in their communities (Linares-Orama, 2005). This study suggests the complex educational, social, and familial contexts in which individuals may or may not become entangled in the legal and correctional systems. It also indicates the importance of appropriate and timely educational interventions in the primary prevention of adolescent criminal behavior, particularly for those at high-risk for such behavior as well as in the secondary prevention of recidivist activity that may continue into adulthood (Linares-Orama, 2005). However, this study was limited by its small sample size as well as by how it was reported, i.e. the author did not state if the differences between the two groups were significant or whether the language disorders themselves were a significant risk associated with greater involvement in the legal and correctional systems.

It is well documented that the population of incarcerated and formerly incarcerated men are the some of the most disadvantaged in our society (Cadora et al., 2003; Lynch & Sabol, 2001; Lynch & Sabol, 1997; Travis & Waul, 2003b). However, what is also documented but not as commonly discussed is that even the face of multiple hardships, these men are also individuals with ties to their communities. Lynch and Sabol (1997) clearly documented this in their previously mentioned analysis. The authors described the increase in the incarceration of “socially integrated offenders”. Social integration is defined by the ties that individuals have to their communities and legitimate institutions such as families, education and employment (Lynch & Sabol, 1997). Between 1986 and 1992, the rate of incarceration for socially integrated African-American men with incomes above the poverty level increased from 21 to 37 per 1000; eight times the rate for a similar group of white men (Lynch & Sabol, 1997). The authors propose that it may be unwise and unnecessary to incarcerate non-violent offenders with ties to their families, schools and communities as these individuals may be the least likely to reoffend. Furthermore, imprisoning individuals who are generating income and are involved with their families may weaken the social fabric of their communities leading to increases in unplanned pregnancies, single parent households, substance use and juvenile crime as well as the health and social risks that come from living in such communities (Chambliss, 1994; Golembeski & Fullilove, 2005; Lynch & Sabol, 1997; Travis & Waul, 2003a).

Barriers to Successful Community Reentry and Reintegration

Release and Reentry. In their study of 3073 newly released prisoners with Axis 1 diagnoses, Pogorzelski et al. (2005) explored the interaction between individual

characteristics and policy restrictions related to criminal convictions. The authors found that these newly released, mentally ill individuals faced multiple restrictions and limited access in regards to employment, public assistance and housing; critical resources if the formerly incarcerated individual is to avoid recidivism and begin the process of reintegration (Pogorzelski, Wolff, Pan, & Blitz, 2005). Moreover, due to the public's stigmatization of persons with a criminal record (and mental illness), individuals on parole experience disenfranchisement from these basic institutional structures (Freudenberg, 2001; Irwin, 1970; Travis et al., 2001).

Many ex-prisoners reenter their communities having spent longer times in prison - an average of 28 months in 1998, an increase from 22 months in 1990 - with limited pre-release preparation for life on the outside and less parole assistance with community reintegration once there (Lynch & Sabol, 2001; Stephen, 2004; Travis et al., 2001). They are frequently released alone and at night (Hammett et al., 2001; Nelson et al., 1999). Nighttime releases make it difficult for a family member, a social worker or a parole agent to meet the newly released individual. Nighttime releases also limit immediate access to community-based services such as health care and housing. Prisoners are released to the community (usually the county of sentencing) with little or no money and without necessary identification needed to access substance abuse treatment, employment opportunities or public assistance (Nelson et al.; Nelson & Trone, 2000). In addition to these barriers, parolees are frequently returned to communities where they are re-exposed high rates of criminal activity, substance abuse and other ex-offenders, thereby increasing their risk of re-offending and returning to prison (Blitz et al., 2005; Cadora et al., 2003; Lynch & Sabol, 1997; Travis et al.).

In addition to leaving prison with few resources or plans to address the formerly incarcerated person's problems and needs, many individuals *enter* prison with significant problems. While some of these problems may be addressed while the individual is incarcerated, there is little or no preparation for the prisoner's ultimate return to his community. Lynch and Sabol (2001) reported that in 1997, only 27 percent of soon to be released inmates participated in vocational programs, 35 percent participated in educational programs and 13 percent participated in pre-release programs. At that time, only 6 percent of prison expenditures were spent on education and training programs for prisoners (Stephen, 2004). Golembeski and Fullilove (2005) state four reasons for the decline in in-prison and post-prison treatment programs over the past decade: 1) public antipathy to these programs, 2) the belief that these programs do not work, 3) the popularity of punitive measures associated with the public's fear of crime, and 4) restrictions and misallocations of prison budgets. Limiting expenditures on pre-release 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 (Nelson et al., 1999; Pogorzelski et al., 2005).

Institutionalization. Persons entering prison are strictly and swiftly institutionalized to new rules and processes of the prison. Yet at release – sometimes after many years – there is no comparable orientation to the outside rules and processes of the community. Parolees leave a highly structured, closely monitored, non-private environment to enter a socially isolated environment that requires self-regulation, self-control and independent decision making skills. This can be shocking and disorienting for the newly released individual causing stress, fear and dysfunctional or destructive

behavior frequently leading to rearrest and reincarceration (Haney, 2003; Nelson, Deess, & Allen, 1999). In his description of an incident with a parolee on his first day out, Irwin (1970) illustrates the difficulties many newly released prisoners face as they reenter conventional society.

During several hours spent with a parolee on his first day outside, I witnessed the difficulty the simple act of purchasing a coke at a hot dog stand can present the unprepared “stranger”. He went to the window and a young waitress brusquely asked him for his order. He was not able to reply immediately and when he did, his voice was not sure, his pronunciation not clear. The waitress, who appeared unsettled, didn’t understand the order, even though I did with ease. The second time she understood it and went to fill his order. When she returned, handed it to him and quoted the price, he was still unsettled. He did not have the money ready. After a brief hesitation, during which the waitress waited quietly but nervously, he started searching his pockets for money. He was especially slow at getting the money out of his pocket and could not rapidly pick either the right change or a larger sum to cover it which most people would do in this situation. He seemed to have to carefully consider these somewhat strange objects, cogitate on their relative value, weigh this against the price quoted, and then find some combination of them which would be equal to or more than that price. He admitted afterwards that he had been very unnerved by this experience and had been having similar difficult experiences since his release (Irwin, 1970, pp. 116-117).

This man’s trouble at ordering a coke stems from the shock of being in the free world again but it also is representative of what happens to a person within a correctional institution. Due to the regimented and controlled nature of the prison environment, many individuals lose their ability to take care of themselves upon release; the personal agency and taken-for-granted knowledge they once possessed in the free community has been lost to the institutional self and the processes that create such a self, i.e. institutionalization. Institutionalization can be defined as the mechanisms by which inmates assume the culture of the institution (Goffman, 1961). For prisoners, this process is often referred to as prisonization; it is a coping mechanism for dealing the indignities, deprivations and restrictions of prison life (Haney, 2003b). Correctional institutions

beset prisoners with such a network of rules and regulations and immerse them in both highly delimited external controls and visible monitoring systems that their own internal controls may deteriorate over the course of their sentences, particularly for those individuals serving long terms or spending long periods of time in solitary confinement (Goffman; Haney, 2003a; 2003b). Furthermore, many prisoners grow accustomed to their loss of independence and become reliant upon the institutional structures they once may have railed against (Goffman; Haney, 2003b). Perhaps even more dire are the profoundly institutionalized persons who experience severe distress and disorientation upon the restoration of their freedom and autonomy; this can lead to harmful or destructive behavior and an ultimate return to the institution (Haney, 2003a).

Families. Ex-prisoners frequently have weakened family ties and it may be difficult for them to immediately reconnect with family members particularly after a lengthy prison term (Magaletta & Herbst, 2001). More than 1.5 million minor children in the United States have parents who are in prison and approximately 40 to 69 percent of incarcerated men are fathers of two or more children (Hairston, 1998; Mumola, 2000). Therefore, family is important in understanding the reintegration of former prisoners as post-release success appears to be influenced by strong ties between prisoners and their families (Irwin, 1970; Magaletta & Herbst, 2001; Nelson et al., 1999). A prisoner or parolee's family is often the only source of hope and connection in the face of the overwhelming correctional system (Magaletta & Herbst; Nelson et al.).

These ties can be difficult to maintain however. Highly regulated communication between families and prisons is prohibitive to maintaining the bonds between the parent and child (Hairston, 1998). Two correctional policies that affect the ability of parents to

maintain contact with their children while in prison are in-prison visits and telephone and mail communication (Braman, 2004; Braman & Wood, 2003; Cincotta, & Solomon, 2003; Hairston, 1998; Travis,). In-prison visits can be difficult for the families due to long travel distances to prison (100 to 500 miles), long waits to see the prisoner and inhospitable visiting environments for parents and children. Telephone calls can only be placed via collect calls and are expensive for an already financially burdened family; calls from prison cost \$1 to \$3 per minute (Braman, 2004; Travis et al., 2003). Mail comes with a stamp identifying that it is from a correctional institution. These restrictions make it difficult for the parent and child to maintain a close and trusting relationship during the incarceration and then harder to reestablish the relationship upon release. Despite the positive influence a family can have in the life of the incarcerated or formerly incarcerated parent, the experience of the family as it adjusts to the release may become chaotic, particularly if the returning family member presents a new financial burden (Braman; Magaletta & Herbst, 2001;).

The loss of a parent to prison often means the loss of income; among incarcerated fathers, 60 percent had full-time jobs prior to their incarceration (Mumola, 2000). Fifty-three percent of fathers had personal savings of \$1000 or less in the month prior to their arrest (Mumola). This can be considerable for families who may already have limited resources. It also means the mother must become the sole provider for her children. This can lead to personal change in the mother as she becomes more self-sufficient and independent. Her expectations of the role that the former prisoner will assume in the family upon his return can change and cause conflict within the relationship and with the father's reunification with his children (Magaletta & Herbst, 2001; Nurse, 2004). A

seamless transition into family life upon release is not easy and paroled fathers are often not equipped to face the changes in the family structure (Magaletta & Herbst). This can lead to a sense of isolation and alienation from the parolee's family and his community, making the difficult transition from prison to the free world even more challenging and overwhelming (Nurse, 2004).

Much of the data and research described in the previous two sections demonstrates the many needs of formerly incarcerated men. While the risks of incarceration and reentry to both the individual and to his family and community are relatively well understood, the most effective means of addressing these risks is less clear. It is perhaps ironic that 32 years after Martinson (1974) published his "What Works?" review current researchers are still asking the same question. Most certainly today there is a deeper understanding that personal demographics such as socioeconomic status, educational level and race can be risk factors for entanglement with the legal and correctional systems. It is also understood that incarcerating non-violent, drug offenders is not an efficacious means of reform or of improving public safety and that treatment, education and employment can play role in decreasing criminal activity. However, what current research and policy still seems to be struggling with is what are the best practices for decreasing the rates of criminal activity and recidivism in U.S. society as well as how to effectively assist and support someone as he transforms his life from one of persistent involvement in the legal and correctional systems to one of active participation in the institutions and practices of conventional life. The latter idea is an overarching focus of this dissertation research, i.e. does health care, one possible aspect of the former prisoner's lived experience, positively impact the reintegration to his community.

The Health Care Needs of Parolees

Infectious Diseases. The prevalence and variety of health problems that prisoners experience are often greater than in the general population (NCCHC, 2002; Watson, Stimpson, & Hostick, 2004). The mortality rate for both male and female former prisoners is four to five times higher than the general population (Pollack *et al.*, 1999). In its report on the health status of individuals soon to be released from prison and jail, the National Commission on Correctional Health Care (NCCHC) found that 17 percent of the estimated 229,000 persons living with AIDS in 1996 were formerly incarcerated individuals. The prevalence of Hepatitis C for this population was also high (Beck, 2002; NCCHC, 2002). Of 4.5 million people infected with Hepatitis C nationally, 28 percent to 32 percent were prison and jail releasees. In addition to HIV and Hepatitis C, the NCCHC report estimated that approximately 12 percent to 15 percent of formerly incarcerated individuals were infected with Hepatitis B. Finally, the report found that two percent of persons released from prison or jail had tuberculosis disease (TB). This seemingly small percentage of releasees represents 35 percent of the total U.S. population with TB.

Chronic Illnesses. The NCCHC report (2002) also addressed the three chronic illnesses most common in correctional populations: asthma, diabetes and hypertension. Prisoners experience greater asthma prevalence (8.5 percent) than the general population (7.8 percent). Due to the age of the prison population – 50 percent of the U.S. male prison population is between the ages of 25 and 39 years (Harrison & Beck, 2005) - their

prevalence rates for diabetes and hypertension are lower (4.8 percent and 18.3 percent) than the general population (7.0 percent and 24.5 percent). However, a survey of 119 men aged 50 years and older incarcerated in Iowa found that 45.4 percent of the participants had arthritis and 39.7 percent had hypertension (Colsher, Wallace, Loeffelhotz, & Sales, 1992). Although the overall prison population may not be greatly affected by chronic illness, there are currently 249,900 U.S. prisoners over the age of 45 who have the potential to experience chronic problems such as hypertension and heart disease both in prison and upon release (Harrison & Beck). Furthermore, because of lack of access to primary care services, prison and jail releasees are more likely to have poorly controlled illness increasing their need for both emergency and tertiary health care services.

Mental Illness. Approximately 14 to 16 percent of reentering prisoners had a major mental health disorder (Beck, 2002; Peters, LeVasseur, & Chandler, 2004). The NCCHC report (2002) found that lifetime prevalence rates for schizophrenia/psychosis, bipolar disorder and post-traumatic stress disorder were approximately one to four times higher for state prison populations than for the general population. Moreover, these individuals' mental health picture is often complicated by more than one disorder. Blitz et al. (2005) found in a population of "special needs" inmates (n = 974), i.e. those with behavioral health disorders, that 68 percent of these individuals had a least one additional Axis 1 diagnosis, personality disorder or addiction problem. Although this study was descriptive rather than one that explored what interventions may be effective with this population, it did document that 25 percent of these special needs inmates released to the community returned to core counties (Blitz, Wolff, Pan, & Pogorzelski, 2005). Therefore, this study offers further evidence that some of society's most marginalized

individuals with the most severe problems are released to areas with the fewest financial and institutional resources.

Upon release, mentally ill ex-offenders are given a limited supply of psychiatric medication and then expected to access mental services through their parole agents or the community (Solomon, Waul, Van Ness, & Travis, 2005). A national survey of parole administrators, suggested less than a quarter of the respondents stated they had special programs for mentally ill parolees (Lurigio *et al.*, 2001). California programs exemplify this limited resource. It releases approximately 18,000 mentally ill parolees each year and has only four regional mental health centers encompassing four large geographic regions (CDC, 2005; Petersilia, 2003). For example, Region II covers 18 counties from the Oregon boarder to the Los Angeles County line (CDC, 2005). Psychiatrists and therapists are assigned to individual counties, however, the staffing is often not enough to meet the demand. In Alameda County (in Region II), there is one psychiatrist and one therapist for approximately 3200 parolees (R. Lewis, personal communication, March 11, 2005).

Addiction Disorders. Frequently coupled with mental illness is substance abuse. Seventy-four percent of all reentering state prisoners had a drug or alcohol dependency and 11 percent were dually diagnosed with mental illness and addiction disorder (Beck, 2000). Of these individuals, only 18 percent actually received any in-prison treatment and then it was usually limited to non-intensive self-help and peer support groups (Beck). Lack of drug treatment either in prison or on parole has implications for recidivism and the failure of community reintegration – 84 percent of ex-offenders were involved with drugs or alcohol at the time of the offense for which they were convicted (Hughes &

Wilson, 2002). Presently in the United States, there are over one million arrests for drug offenses annually and over 500,000 individuals at any given moment are in prisons or jails for such offenses (Fischer, 2003); the correctional institution has become the de facto treatment center for those with addiction disorders regardless of how ill-prepared it may be to address such disorders. Like mental health services while on parole, treatment slots are limited. For example, a search of the California Department of Corrections and Rehabilitation Community Resources Directory listed only 35 substance abuse treatment facilities and of these, only 17 residential programs (www.cdcr.ca.gov, August 6, 2006). Although this is an underestimation of all of the treatment programs in the state it does exemplify the limited access that the 86,000 parolees with substance use disorders have to proper treatment and recovery programs (Beck, 2000).

Despite the limited financial, institutional and professional resources, certain correctional institutions are attempting to address the complicated picture of mental illness and addiction disorders in their prison populations. In 2004, a survey of the 50 state correctional systems and federal prisons found a total of 27 Co-Occurring Disorders Treatment programs (CDT) in 18 state and federal prison systems with another ten state systems planning to develop such programs (Peters et al., 2004). CDT programs, although relatively new, offer prisoners a structured and intensive set of treatment activities similar to the treatment approaches used in community settings. The majority of the CDT programs surveyed had adopted a therapeutic community model with an emphasis on the integrated treatment of addiction disorders and mental illness. All of the programs offered approximately 25 hours of treatment services per week; these included group and individual therapy, relapse prevention training and psychiatric consultation

(Peters et al., 2004). In addition to this, these programs had implemented or were planning to implement services to help inmates transition from prison to the community upon release. This survey also documented that the majority of CDT programs were collecting post-release outcomes data on criminal recidivism, community employment, housing and use of community emergency services on each of its participants. Several of these programs had found that those who participated in the CDT program had reduced rates of recidivism when compared with those inmates who received traditional mental health services while incarcerated (Peters et al.). This survey did not examine how programs measured post-release outcomes or how long participants were followed after release from prison. Nevertheless, the CDT program model may be an effective practice for assisting individuals with complex problems to successfully reintegrate into their communities upon release. However, these programs are few in number and serve only a small and specific portion of the prison population; for the rest, they must serve their sentences with little or no support from the institution or the surrounding community.

This is distressing as there is some evidence that treatment can be efficacious in reducing substance use disorders and resultant criminal behaviors in individuals involved in the correctional system (Anglin et al., 1999; Gossop, Trakada, Stewart, & Witton, 2005; Kelly, Finney, & Moos, 2004; Martin, Butzin, Saum, & Inciardi, 1999; Moos, Moos, & Andrassy, 1999; Simpson, Joe, & Broome, 2002). For example, Kelly, Finney and Moos (2004) found that individuals mandated to substance abuse treatment (SAT) in the community experienced both reductions in substance abuse and increases in employment stability at 1 and 5-year follow-up. The purpose of this prospective cohort study was to examine the possible differences amongst three groups participating in one

of 15 Veterans Affairs SAT programs: individuals on probation or parole with a court mandate to attend SAT (n=141); individuals on probation or parole without a court mandate for SAT (n=235); and individuals with no involvement in the legal or correctional system (n= 1719). The authors postulated that court-mandated participants might fare better in SAT than those not legally required to participate in treatment. Participants were male veterans diagnosed with an addiction disorder, 42-years of age on average and predominately African-American (49%). Participants completed surveys regarding their substance use patterns, coping skills and arrest history at baseline, immediately upon discharge from the program, and at one and five years after program completion. Logistic regression models were utilized to compare post-treatment outcomes amongst the three groups at one and five years post-treatment. Results revealed significant increases in abstinence in all three groups at one and five-year follow-up ($p<0.05$) with court-mandated participants more likely to be abstinent. While there were no significant differences between the court-mandated group and the two non-court mandated groups for rates of rearrest or long-term employment, all groups demonstrated increased rates of employment and decreased rates of rearrest at five years post-treatment – outcomes associated with longer-term stability in the free community. Unfortunately, the authors were unable to determine the significance of the positive findings because there was no non-intervention or similarly matched comparison group. As a result of this limitation, the influence of the treatment program on participants' overall improvement was not well explicated. However, these results indicate that individuals, particularly middle-aged men involved in the correctional system, can benefit from substance abuse

treatment both in regards to decreased recidivism and increased maintenance of regular employment.

Gossop et al. (2005) found similar improvements in recidivism in relation to substance abuse treatment (SAT). This study was also a prospective cohort study that followed 1075 heroin-addicted participants admitted to 54 SAT residential and community programs throughout England. Treatment facilities were purposively selected based on their location and capacity to enroll a sufficient number of participants. Participants were predominately male (74%), white (91%) and their average age was 29 years. Data on convictions for all participants were collected from the Offenders Index (OI) at baseline of initiation of SAT and one, two and five-year follow-up post-treatment. Three types of criminal offenses were examined: acquisitive, (i.e. theft, robbery or burglary), drug sales and violence. Seventy-four percent of the entire study sample (n=799) had one or more lifetime convictions and one-third of these had been convicted of one or more crimes in the prior year. The remaining 26 percent of participants had never been convicted of a crime (n=276). McNemar tests and repeated measures ANOVAs were used to assess changes in rates of criminal conviction from treatment initiation through the follow-up period. Significant decreases ($p < 0.001$) in convictions for all types of offenses were seen at all follow-up points in comparison to treatment initiation. This study suggests a positive relationship between SAT and decreased criminal activity in drug-addicted participants. However, due to this study's limitation as a cohort study with no control group, the influence of treatment on recidivism is not clear.

This study did not examine which treatment program or program components may have been most efficacious in decreasing drug dependency and therein, decreasing criminal activity associated with addiction disorders. Other factors in the participants' lives such as family circumstances, education, and length of drug addiction may have influenced their desistance from crime more significantly than SAT. This study did not examine participants' level of involvement with community parole and probation supervision. Participants undergoing more intensive community supervision may have experienced improved outcomes in regards to drug use and crime as a result of consistent engagement with the parole and probation system. Additionally, participants in this study were actively seeking treatment and may have already been engaged in the process of change. Therefore, these results may not be applicable to individuals more deeply involved with drug use and criminality. Despite these limitations, this study replicated a trend seen in other similar research, i.e. as access to appropriate treatment and support is made available rates of substance use disorders and criminal activity decrease (Kelly et al., 2004; Simpson et al., 2002).

Simpson et al. (2002) completed a study of cocaine-dependent adults in the United States. Study participants (n=708) were recruited from 45 SAT programs in 8 cities and followed for five years post-treatment completion. At the five-year follow-up, they completed structured interviews and provided hair and urine samples. Participants were predominantly male (64%), African-American (56%) and their average age at treatment admission was 33 years. Four-six percent of participants were involved in the legal system, predominantly on probation. Repeated measures ANOVAs were used to assess changes over time in cocaine use and criminal involvement ($p < 0.05$). Results

revealed significant decreases ($p < 0.05$) from intake to follow-up in both weekly cocaine use (69% to 25%) and any illegal activity (40% to 25%). Arrests amongst participants also decreased from 34 percent at intake to 18 percent at follow-up. Participants with more stable social and family circumstances did better overall at five-year follow-up. However, those participants with more severe addiction disorders, mental illness and personal problems also received benefit from treatment particularly when enrolled in longer-term residential care. This study's positive findings may have been influenced by participants' voluntary entry into drug treatment. Furthermore, this study was hampered by the lack of a control group and a limited examination of the programs themselves. While participants enrolled in more extended SAT programs seemed to do better, the efficacy of specific program components was not examined.

Moos et al. (1999) did consider the relevance of program orientation in their evaluation of 88 community residential SAT programs. The authors examined the impact of different treatment approaches on length of stay in treatment and one-year symptom and functioning outcomes. Researchers also investigated whether treatment orientation, individual length of stay and level of participation in care were independently related to participants' one-year outcomes. This study was a prospective study that followed 2,376 participants who entered residential facilities across the nation during a twelve-month period. These facilities had contracted with the Department of Veterans Affairs to provide SAT to veterans. Participants were predominantly male (99%) and were, on average, 42 years of age. Fifty-two percent were White and 37 percent African-American.

The authors collected data on participants' length of stay, program completion and level of involvement in program activities. Their dependent variables included abstinence, no substance use problems, distress, psychiatric symptoms, arrest rate, and employment. Treatment programs were categorized into four types based on the major emphasis of the program: therapeutic community, psychosocial rehabilitation, 12-step and undifferentiated. Paired t tests ($p < 0.05$) revealed that participants in all four types of programs had significantly increased abstinence and decreased substance use related problems ($p < 0.05$), with those participants in more directive programs faring better. Positive outcomes were comparable amongst the three groups participating in well-defined treatment programs. However, logistic regression analysis found that programs with specific treatment approaches, as opposed to undifferentiated programs, predicted improved one-year outcomes for all variables with the exception of employment ($p < 0.001$). Longer episodes of care and program completion were associated with better one-year outcomes for abstinence, substance use related problems and regular employment ($p < 0.001$). These factors, i.e. well-defined and extended care, were also associated with participants' increased involvement in program activities and therein, better outcomes at discharge and one-year follow-up.

Although participants in all four program types experienced improvement in their addiction disorder and social circumstances, these findings suggest that structured and longer-term care can provide the greatest benefit in treating addiction disorders and the associated negative consequences. However, this study was limited by a lack of randomization to treatment facilities and participant self-selection. Additionally, the authors relied on managers' reports of their program's treatment orientation rather than

on independent observation. The sample was predominantly composed of middle-aged, men in the VA system of care and may not generalize to men who are not veterans or who are more entrenched in street and criminal life.

While the above research is limited by lack of randomization, control groups and self-selected participant populations, it does provide evidence about the positive relationship between substance abuse treatment (SAT) and improvements in drug addiction and recidivism. These studies are relevant to this dissertation research because they represent outcomes for middle-aged men with legal and correctional system involvement. Additionally, these studies suggest an association between appropriate care for addiction disorders and the maintenance of regular full or part-time employment (Kelly et al., 2004; Moos et al., 1999). Employment is critical to successful community reintegration as it can provide opportunities for income equity, stable housing, and consistent health care. Regular employment is also a requirement of parole supervision. While the focus of these studies was the impact of SAT on addiction and recidivism rather than SAT's influence on salient stabilizing factors such as employment, they do indicate that treatment for addiction disorders can increase individuals' chances for successful reintegration.

Implications for Community Health. While health problems may be addressed while an individual is in prison, once released former prisoners are often not eligible for publicly funded health care services (Freudenberg, 2001, 2002; Nelson & Trone, 2000; Solomone et al., 2005). Many individuals who were eligible for services prior to incarceration became ineligible as a result of incarceration and subsequent parole (Freudenberg; Nelson & Trone). Furthermore, problems diagnosed in prison often receive

little attention upon release to the free community. With little or no access to care, the poor health status of a large number of these former prisoners places them at increased risk for exacerbation of illness and for transmission of infectious disease to those around them. Pollack et al., (1999) cite several problems in the provision of health care to former prisoners. Many former prisoners, upon release will experience poverty, violence and/or inadequate nutrition. They quickly return to patterns of drug or alcohol abuse upon reentry. Parole agents are not clinicians or social workers, nor are they necessarily linked to community health care and treatment services. Their caseloads are large, making it difficult for agents to provide adequate supervision and support to parolees (Pollack et al., 1999; Solomon, 2006). There is little or no pre-release coordination between the prison, the parole agency, health care services and housing agencies, making it difficult for former prisoners to receive proper treatment for addiction disorders and medical and mental health conditions. While health care in prison is constitutionally mandated, little effort is made to connect inmates with community health services or medical payment sources prior to their release (Freudenberg, 2001; Hammet et al., 2001).

Hammett et al.'s review (2001) of health related issues in prisoner reentry found that 92 percent of state and federal prisons provided some discharge planning in the form of referrals to community agencies and programs. However, very few institutions actually made appointments with service providers for those soon-to-be-released inmates (Hammett et al.). The federal government allows states to provide Medicaid to parolees but program enrollment often takes up to six weeks, too long for those in need of treatment for mental illness, HIV/AIDS, substance abuse and/or chronic medical conditions (Freudenberg, 2002; Nelson & Trone, 2000). Although individuals on parole

may eventually receive Medicaid, a four to six week gap in health coverage can result in an exacerbation of disease resulting in hospitalization. Uncontrolled disease can make finding a job and/or housing, resources critical to successful community reintegration, more difficult. In the case of mental illness or substance abuse, individuals who are unable to access treatment can be reincarcerated for violent or disorderly behavior or drug-related charges before their health benefits become active. Therefore, timely linkages to community health services can improve health outcomes and potentially increase the rates at which formerly incarcerated persons successfully reintegrate into their communities (Freudenberg; Hammett et al.).

It is evident that the individual reentering his community brings with him significant health problems and limited to access to services. While there is a profound understanding of the gravity of these problems there is less understanding on the part of research and policy of how to connect these individuals to needed services. As discussed above much of the research on the health care problems of formerly incarcerated individuals is descriptive in nature rather than evaluative of currently available programs or experimental/quasi-experimental in exploring what interventions and programs may be the most effective. Therefore, research should begin to focus further on exploring and understanding what may or may not work in regards to linking newly released individuals to health care services (including drug/alcohol and mental health treatment) and whether such linkages could play a role in increasing formerly incarcerated individuals' opportunities for successful reintegration.

Gaps in Research

Many researchers in both the criminological and health care literature identify the need for pre-release reinstatement of Medicaid benefits and discharge planning, and post-release case management as a means to help former prisoners reintegrate into their communities (Hammett *et al.*, 2001; Nelson *et al.*, 1999; Nelson & Trone, 2000; Pollack *et al.*, 1999). This literature describes the difficulties in connecting parolees with critical services and the role that lack of access to those services may play in limiting or preventing community reintegration. However, these studies and reviews do not lend insight into the parolee's perspective on what may be most beneficial for his own reintegration.

The inclusion of the population of interest is a critical component to designing effective programs, but in much of the literature the voice of the newly released prisoner is missing (Green & Kreuter, 1999). Additionally there have been limited studies on what individual characteristics, strengths and skills of the parolee are most useful in helping him to reintegrate and to advocate for his health care needs while in the community. There have been studies attempting to predict what characteristics of the parolee and his environment are most strongly correlated to recidivism, but there is scant research on what predictors are most strongly linked to successful community reintegration particularly from the view of the parolee (Gendreau, Little, & Goggin, 1996; Visher & Travis, 2003).

Gendreau et al. (1996), in their meta-analysis of 131 studies of recidivism predictors, found that criminogenic needs, i.e. antisocial attitudes supportive of antisocial behavior and lifestyle, was one of the strongest predictors for recidivism. Although this predictor is most often used to quantify an individual's risk for criminal behavior upon

return to the free community or for behavioral problems within the institution, it is also has the potential to capture aspects of the individual's lived experience from a qualitative research perspective. The idea of criminogenic needs, while a gauge of recidivism, is also holistic in that it is centered on the concerns of the person within the setting of his social world. However, within the context of Gendreau et al.'s meta-analysis, criminogenic need is an actuarial measure rather than an aspect of the formerly incarcerated person's lived experience. From a qualitative research stance, another way to employ this concept is to ask the individual what he thinks about his criminal or antisocial behavior and how it may have influenced his understanding and experience of his world. Research that explores the meaning of criminal activity in the parolee's life from his vantage point provides another vehicle for understanding both what may lead to recidivism and what may create opportunities for successful reintegration.

For example, Cooke's (2004) qualitative study, "Joblessness and Homelessness as Precursors of Health Problems in Formerly Incarcerated African-American Men", is one of the few studies that explores the reintegration experience from the vantage point of the former prisoner. Cooke found that for African-American men leaving prison (n=17), employment and housing were critical for successful reintegration and avoiding health problems. Incarceration and a criminal history limited the pool of employment opportunities for these participants as well as hindered their ability to be hired for potential jobs. Stable housing was difficult for these men to obtain due to limited shelter bed space and/or affordable living spaces as well as disenfranchisement from family members and partners (Cooke). Lack of employment and housing were found to limit these participants' access to health care services. Cooke's research, however, did not

address personal health care practices, specific health conditions or experiences with health care systems and how such practices, conditions and experiences may influence an individual's community reintegration.

The literature has documented coordinated health care models that demonstrate the importance of health care access for parolees and its impact on recidivism and reintegration (Conklin, Lincoln, & Flanigan, 1998; Hammett, Roberts, & Kennedy, 2001; Rich et al., 2001; Sheu et al., 2002). For example, Sheu et al. found in a prospective cohort study of 871 HIV-positive women and 439 high-risk HIV-negative women that those participants who had a continuous relationship with a single health care provider for more than 2 years were 50 percent less likely to be incarcerated than those who did not during the two-year study period. Although there was no causal relationship between continuity of medical care and decreased incarceration rates, this work suggests that consistent medical care may be an indication of a person's involvement in a larger social and supportive network which may assist the individual in preventing high-risk behavior (Sheu et al.). Future studies may benefit from considering the quality of the relationship between the patient and the clinician or clinical network and what role that relationship may play in decreasing rates of incarceration in high-risk communities.

Project Bridge, a federally funded demonstration project that provided intensive case management services to HIV-positive ex-offenders (n=98), found that although 18 (19 percent) of the study participants were reincarcerated two or more times, 58 (59 percent) of the original study group completed the 18-month program (Rich et al., 2001). This high rate of program completion was attributed to project's ability to continue to offer supportive medical and social services during reincarceration. Furthermore, for

those participants who expressed a need for and received referrals to services outside of HIV care, e.g. mental health treatment, drug treatment, and shelter, close to half of the participants kept their scheduled appointment for these services. While this study does not suggest that continuity of care leads to decreased rates of incarceration, it does support the idea that high-risk individuals will access, utilize and potentially benefit from medical and social services, particularly those provided by a regular network of providers. However, this study is limited by its lack of a comparison group as well as a lack of outcomes data on the benefits of Project Bridge such as decreased substance use or increased medication compliance.

While these studies have demonstrated that integrated health care services can impact rates of recidivism and utilization of services, there is still limited understanding of how ex-offenders view and experience health care access as being a part of their reintegration. Furthermore, these studies focused on offender populations with specific diagnoses such as HIV/AIDS; for parolees without such conditions knowledge is limited. Where research appears to be lacking is on former prisoners' own perceptions and understandings of health care. There is limited information on how parolees take care of their health both generally and in relation to specific medical conditions.

There have been studies on the health perceptions of prisoners but these studies were descriptive and documented only that prisoners perceived their health as good, fair or poor; that they were willing to utilize medical services; and, that they engaged in high-risk behaviors and had multiple health problems (Conklin, Lincoln, & Tuthill, 2000; Lindquist & Lindquist, 1999). These studies did not reveal any information about the inmates' health care beliefs or practices that may have been useful to their reintegration

into the community. Future research should be directed towards understanding how health care access affects the ability to reintegrate as well as the relationship of health care access to employment and housing – two critical elements of successful reintegration. For example, individuals with chronic obstructive pulmonary disease (COPD) are frequently released from prison without the proper medications. Limited community health care access results in individuals going without necessary treatment and support for long periods of time (Hammett et al., 2001). This results poor health status making it difficult for individuals to meet the demands of their parole, i.e. finding a job and stable housing (M.K., former patient, personal communication, Summer 2004). Research that addresses these relationships and includes the voice and experience of the formerly incarcerated individual could help shape more effective policies and programs potentially leading to greater success in community reintegration.

Conclusion

The proposed dissertation project, “The Impact of Health Care Access on the Community Reintegration of Male Parolees” directly addressed what is missing in the literature: an understanding of parolees’ health beliefs and practices and how their experiences with or without health care may have impacted their ability to successfully reintegrate into their communities. The purpose of this study was to understand how health care access affects the community reintegration of male parolees. The specific aims were to: 1) examine the health beliefs and practices regarding general health care and specific medical conditions from the perspective of the parolee; 2) identify the perceived barriers and facilitators parolees encounter in their efforts to access health care services in their communities; 3) describe the perceived impact of health care access on

community reintegration from the parolee's perspective; and 4) identify specific events while in prison or on parole that may have affected the community reintegration of the parolee, in addition to health care access.

The proposed study used hermeneutic phenomenological methodologies to gain access to and an understanding of the parolees' lived experiences with health, illness and health care. What made interpretive phenomenology salient to this project was that the open-ended and unstructured interview process allowed for the exploration of both the practical concerns and the lived experience of the phenomena by the participant (Benner, 1994). Central within this was the researcher's goal "to hear and understand the voice of the participants" (Benner, p. 100). For a liminally positioned group such as parolees, being heard and being understood particularly through the process of research was critical both from ethical and public policy standpoints. Interpretive phenomenological understandings, i.e. the "results" of this study, gave those on the outside of the experience – whether outside as clinicians, academicians, policy makers or private citizens – access to the parolees' experiences in as an immediate way as possible while still respecting that the participants' lived experiences could never be completely accessed or understood (Benner).

The goal of interpretive commentary is neither a total systems account nor a single-factor theory. Interpretive commentaries or theories are not considered more "real" or "true" than the text itself [i.e. the interview transcript]. The interpreter seeks to give greater access and understanding of the text in its own terms, allowing the reader to notice meanings and qualitative distinctions within the text...The guiding ethos is to be true to the text. Throughout the interpretive project the researcher asks, "What do I now know or see that I did not expect or understand before I began reading the text?" (Benner, 1994, p. 101).

This phenomenological project further benefited from its three guiding theoretical frameworks: Visher and Travis's Transitions from Prison to Community, Michel

Foucault's Discipline and The Panopticon and Erving Goffman's Total Institution (Foucault, 1977; Goffman, 1961; Visher & Travis, 2003). Visher and Travis's (2003) Transitions from Prison to Community provided a foundation from which to begin to examine the processes that influence how an individual may or may not reenter the community after a period of incarceration. Foucault's Discipline and The Panopticon were pertinent to this dissertation research because they situated the project in the salient power relations and the technologies used to implement those relations in both prison and free society. Goffman's conceptualization of the Total Institution was germane to the project at hand because it was a representation of what can happen to the individual self when confined to an institution specifically committed to the operation of power technologies and the enforcement of those technologies on the individual. Through the use of phenomenological methodologies coupled with the three conceptual frameworks this dissertation project created a representation of the experiences men on parole have had with and without health care as well as of the circumstances in these men's lives that they deem significant. It was hoped that this project would illuminate some of the barriers and facilitators to health care that may impact an individual's community reintegration as well as put forth a project that was both humanizing to the participants and meaningful in regards to how health care services are provided to incarcerated individuals as they exit the correctional institution to reenter free society.

CHAPTER 2: THREE FRAMEWORKS FOR UNDERSTANDING REINTEGRATION

Introduction

Prison places extraordinary psychological and physical demands on the individual (Kupers, 2001). In order to adjust to prison life and endure frequently long periods of imprisonment, the individual must develop habits of thinking and acting that are considered highly dysfunctional in free society (Hofer, 1998). These adaptations such as interpersonal distrust, social isolation and institutional dependence are necessary for prison life however atypical they might be in civil society (Haney, 2003b). They are also components of institutionalization, a transformation that can occur while incarcerated. Institutionalization is a process through which the individual is transformed by the environment of the institution (Goffman, 1961; Peat & Winfree Jr., 1992); within the correctional institution this is often called “prisonization”, a term for the coping mechanisms required to deal with negative psychological effects of imprisonment (Goffman; Haney; Hofer). Through this process of institutionalization or prisonization the individual becomes accustomed to the multiple deprivations, limitations and humiliations that prison life imposes (Edwards, 1970; Haney). It is important to note that in some respects these adaptations and adjustments one must make while in prison are actually normal reactions to the abnormal conditions of institutional life (Haney; Hofer). These adaptations become problematic when they are so deeply internalized they persist upon reentry to the free world; it is the dependence upon institutional patterns of behavior that can negatively affect an individual’s opportunities for reintegration to the free world (Haney). Although it is difficult, an individual can readjust and readapt institutional

patterns of behavior to ones more suited for civil society. However, very few individuals exit prison unscathed and most are completely changed by it (Goffman; Haney; Irwin, 1970). Therefore, the purpose of this chapter is to present three conceptual frameworks for understanding the process and impact of institutional structures on the individual and how he is able to overcome the affects of imprisonment to successfully reintegrate to the free community. These three conceptual frameworks informed the proposed dissertation research, “The Impact of Health Care Access on the Community Reintegration of Male Parolees”.

The first and introductory framework, Transitions from Prison to Community, as developed by Visher and Travis (2003) provided the grounding concept as it is both concrete and holistic regarding the processes that influence how an individual reenters the free community after a period of incarceration. The work of Michel Foucault (1977) and his presentation of modern technologies of power, most specifically Discipline and The Panopticon as put forth in “Discipline and Punish: The Birth of the Prison” provided the second theoretical foundation for this project. Foucault’s Discipline and The Panopticon were relevant to this project because they situated the research project in the salient power relations and the technologies used to implement those relations both in prison and free society. The final framework was based on the work of Erving Goffman (1961) and his descriptions and definitions of the total institution. Goffman’s conceptualization of the total institution was relevant to the project at hand because it was a representation of what can happen to the individual when located in a place specifically committed to the operation of power technologies and the enforcement of those technologies on the individual. The primary sources for this paper were Foucault’s, “Discipline and Punish”,

Goffman's, "Asylums Essays on the Social Situation of Mental Patients and Other Inmates", and Visher and Travis's article, "Transitions from Prison to Community".

This paper begins with an outline of Visher and Travis's (2003) model and the opportunity it created to explore issues of reintegration from the perspectives of Foucault (1977) and Goffman (1961). The paper then discusses Foucault's Discipline and The Panopticon. The third section of this paper presents Goffman's work on the total institution. Specifically, the mortification of the self and secondary adjustments as processes of institutionalization are reviewed. The next section discusses the complementary and contrasting aspects of Goffman's and Foucault's concepts and a critique of each framework follows. This paper concludes with a discussion of how the three ideas create both a deeper background understanding as well as further questions for this research project.

Transitions from Prison to Community

Visher and Travis (2003) challenged current research on reentry and reintegration after a prison term as being too narrowly focused and too defined by recidivism outcomes, i.e. rearrest, reconviction and reincarceration (Solomon, 2006). The authors suggest that an individual's ability to desist from criminal activity and successfully reintegrate, i.e., adopt the norms and values of the free, non-criminal community, is a complex mix of factors that includes personal and situational dimensions. Each of these dimensions may influence whether or not a newly released person may be successful in his reintegration, in his desistance from crime. Therefore, the challenge for researchers is to better understand the pathways of reintegration (Visher and Travis). Visher and Travis raise the questions of how research should go about conceptualizing reintegration as well

as determining what social supports, either private or governmental, are associated with successful reintegration. It is also appropriate to question how the unarticulated influences such as institutional power over the individual may affect reintegration and a person's ability to reconnect with conventional society. These questions are not being asked by research that focuses solely on recidivism outcomes (Hofer, 1998; Visher & Travis; Zamble & Porporino, 1990).

The framework put forth by Visher and Travis (2003) is a dynamic one that proposes four dimensions of the transition from prison to community: a) individual characteristics, b) family relationships, c) community contexts and d) state policies. These dimensions are not isolated constructs. Rather they interact with one another and reflect the mutable qualities of the individual as he moves from incarceration to freedom. Within this framework (see Figure 1), the social nature of incarceration and release are captured, e.g. how an individual's family relationships may help or hinder his reentry (Hairston, 1998; Nurse, 2004). In addition to acknowledging the social processes of imprisonment and reentry, the life experiences of the individual relevant to the reentry transition are also conceptualized. The authors outline the life experiences of the individual in four stages: a) life prior to prison, b) life in prison, c) the moment of release and immediately after prison release, and d) life during the months and years following prison release. While some research on criminal desistance and recidivism incorporates aspects of the transitional framework presented by Visher and Travis much of the research does not address the impact of imprisonment and its aftermath on a person's ability to desist from criminal behavior let alone successfully reintegrate back into his community (Austin et al., 2002; Edwards, 1970; Visher & Travis; Zamble & Porporino,

1990). In addition, there is limited information on the role that health care may play during this transition (Freudenberg, 2000, 2001, 2002; Hammett et al., 2001).

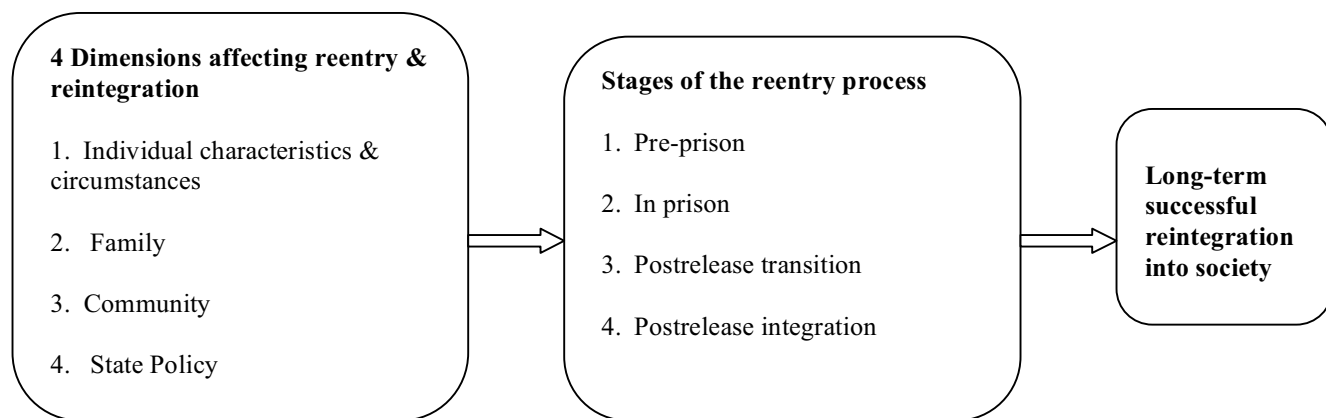


Figure 1. Visher and Travis' (2003) conceptualization of individual transitions from prison to community.

In order to better capture the dynamics of incarceration on the individual and what may or may not be useful in the reentry and reintegration process, Visher and Travis (2003) suggest studying desistance from crime and thereby successful reintegration as a longitudinal process rather than as a discrete outcome, i.e. rates of recidivism. The process of transitioning from prison, a total institution to the chaotic free community is also not well understood in the research although it is an experience common to and traumatic for most newly released individuals (Irwin, 1970; Nelson et al., 1999; Visher & Travis). The authors' primary call is for researchers to more broadly explore the processes of incarceration and reentry and why some newly released individuals may be ready to accept the demands of the free community and move towards a conventional lifestyle whereas others may not or may never be ready.

The conceptualization put forth by Visher and Travis (2003) is holistic in its attempts to incorporate every facet of a person's life experiences over time inside and out of prison that may impact his ability to desist from crime and become an integrated and

involved member of his community. Although the authors advocate for a life-course history approach to studying reintegration, their framework does not dictate specific research methodologies or outcomes; rather it encourages different vantage points for understanding the prison and the reintegration experience. Therefore, this framework provided a useful foundation for my dissertation research, as it allowed me to explore the work of Foucault (1977) and Goffman (1961) while being situated in the idea of how an individual may “transition from prison to community”.

Foucault (1977) and Goffman (1961) presented parallel ideas about inmates and the institutions that confine them but the strength of employing these two frameworks together comes from their contrasting perspectives on institutional power. Foucault’s central premise is that of control of the self derives from panoptic discipline. It is through this power technology that the self is manufactured as a body and therein controlled whereas Goffman presents the self as always in conflict with and resistant to the self produced via institutional power. The self will always try to define its individuality in contrast to the confines of the coercive power of panoptic discipline. For Goffman, it is via the interactions with this coercive power that the individualized self is constituted. Through these two differing but complementary theses, the impact of the correctional institution pre and post-release can be understood in its complexity as a lifelong process that can leave deep psychological marks on the incarcerated and formerly incarcerated self (Haney, 2003a, 2003b). It is these marks upon the self that present difficulties, challenges and obstacles to the individual as he attempts to exit one part of society, the correctional institution to enter another, the free community (Goffman; Haney, 2003b; Irwin, 1970; Nelson et al., 1999; Visher & Travis, 2003). This paper will explore

Foucault's (1977) ideas about power relations and Goffman's concepts of the mortification of self and secondary adjustments as frameworks for understanding the effect of the correctional institution on an individual's ability to successfully reintegrate into the free community. A conceptual figure of these concepts together with that of Visher and Travis is presented in Figure 2.

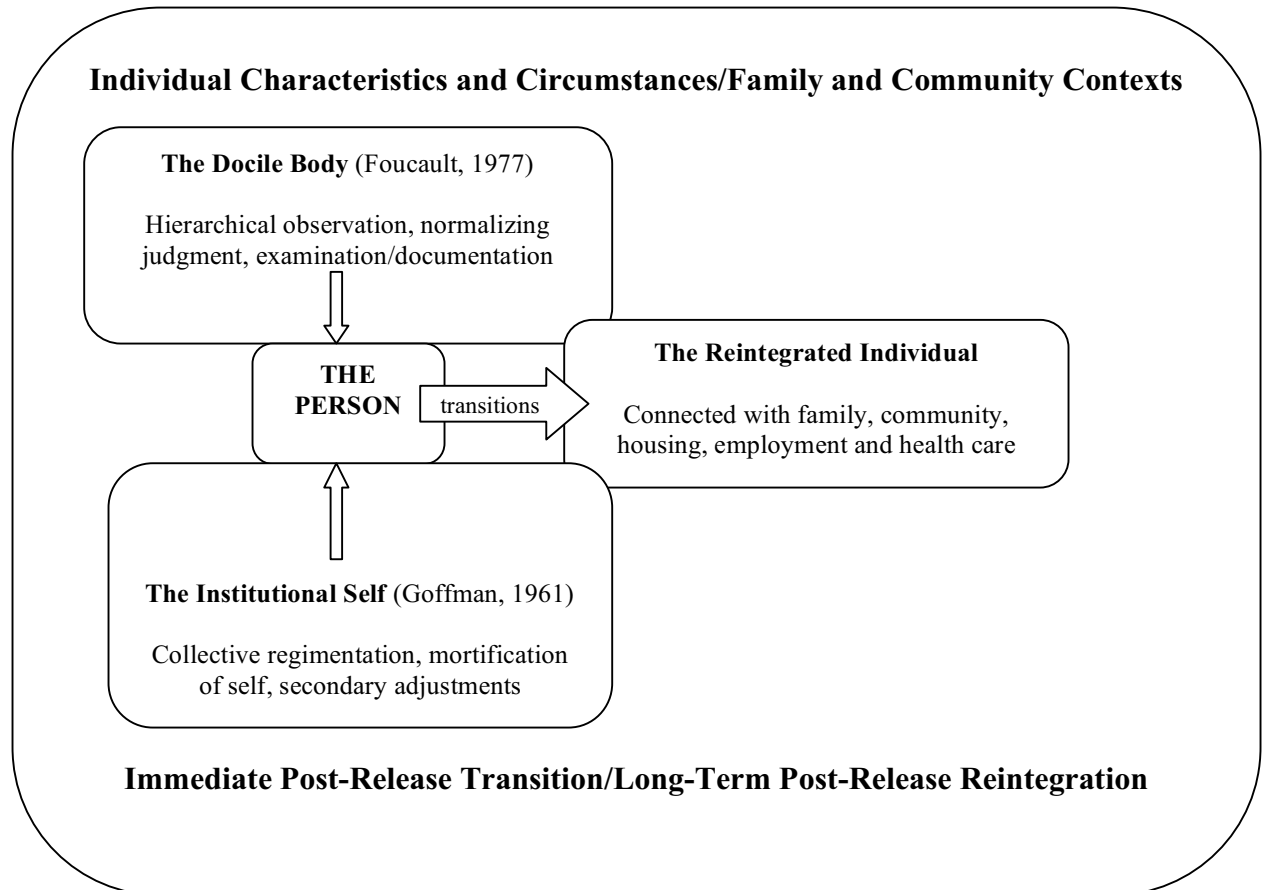


Figure 2. A conceptualization of the project, “The Impact of Health Care Access on the Community Reintegration of Male Parolees”. The relevant ideas of Foucault and Goffman are located within specific aspects of the Visher and Travis framework.

The Foucaultian Framework

Shifting Power, Changing Punishments. In the opening chapters of “Discipline and Punish”, Foucault (1977) outlines the historical shift that occurred in penalty during

the 18th Century both in its philosophy and its administration. During this period European society moved away from the power to punish as being the sole right of the king toward a system of punishment that was organized around codified rules and regulations. With sovereign power, all illegalities committed were committed against the king and it was the king alone that had the right to seek retribution and punishment. However, such punishment was sporadic and therefore, made it difficult for the king to control his subjects' illegal activities (Foucault; Vailier, 2001). As the accumulation of capital and material wealth grew, a more unified and rigorous way of punishing illegalities was required. In addition to this, a more efficient means of enforcing newly codified laws was also necessary.

A penal system must be conceived as a mechanism intended to administer illegalities differentially, not to eliminate them all...[to] Define new tactics in order to reach a target that is now more subtle but also more widely spread in the social body. Find new techniques for adjusting punishment to it and adapting for its effects...In short, constitute a new economy and a new technology of the power to punish: these are no doubt the essential *raison d'être* of penal reform in the eighteenth century (Foucault, 1977, p. 89).

It is important to note that this shift in penalty occurred during the 18th century revolution of Western scientific thought. Revolutionary proponents were not interested in earlier conceptions of the world as meaningful order via God's creation but were focused on knowing the world through objective reasoning, i.e., reasoning that does not appeal to experiences of the senses or anthropocentric properties. Anthropocentric properties are those aspects of an object that can be experienced by the person through sense, feeling or emotion and this rejection of these human qualities was a key thesis of the scientific revolution (Benner & Wrubel, 1989; Taylor, 1985). Senses, feelings and emotions were

considered secondary because they did not lend themselves to objective, context-free explanations of the natural world. This Enlightenment notion or representation conception (Taylor, 1985) of all objects as having absolute and context-free properties that could be broken down into distinct units in order to explain why a thing (or a person) works the way it does was important in knowing and explaining the natural world as something other than a Divine creation. In regards to understanding the person, however, within the representation conception, the self was explained as a subject with the world existing outside of it as an object. Therefore, the person was defined as two distinct entities linked together by representations of the object framed in the consciousness of the mind. It was within this intellectual environment, that modern penalty was conceived of and implemented.

Therefore, both criminality and penalty changed drastically during this time. However, illegality still remained important because it allowed both for punishment should an illegality be committed, and more importantly, for the idea of punishment in individuals' minds. It is the representation of the crime and its subsequent punishment that was thought to be a deterrent from criminal behavior (Foucault, 1977). These "values of opposing pairs" (Foucault, p. 104) or the obstacle signs to crime as representations in the mind of the individual were the first allusion to the new penal technologies of Discipline and The Panopticon both of which were to grow from the 18th Century notion of the ability of the individual to hold object representations in his consciousness (Foucault; Taylor, 1985).

Discipline. It was from this new understanding of the individual as a dualistic entity that the representation of the individual as a subjected and docile body that could

be controlled through a subtle coercion of attitudes, gestures and speeds of movement evolved. This was a moment when the efficient movement of the body, more than the specific individuality or soul of the person, was vital to the production of knowledge and power. The methods utilized to shape the body guaranteed its subjection to the forces that were to control it as well as ensure the body would always be both docile and useful. These methods were ultimately to become Discipline, the general formula for domination in the 18th Century (Foucault).

The purpose of Discipline is to produce subjected, trained and docile bodies. Discipline removes or disassociates the body's personal power and identity transforming them into a skill or a capacity. The skill or the capacity then becomes the thing that the body (and society) wants to increase; the body is subject to its aptitudes and is focused on improving their efficiency. It is the body's subjection to its capacities that attenuates its power to revolt against the disciplines that both define and confine it. The body has accepted the domination of Discipline via its aptitudes and there is no reason for dissent nor does the body have the energy to do so as it is engaged in the perfection of its aptitudes (Foucault 1977). How is Discipline able to achieve such a subtle and pervasive hold on the body? The primary aim of Discipline is to manufacture or fabricate individuals and it does this through three mechanisms or instruments: hierarchical observation, normalizing judgment and the examination.

Hierarchical observation is the "eyes that see without being seen" and it operates on the premise that individuals can be controlled by merely being watched (Foucault, 1977, p. 171; Cutting, 2005). Hierarchical observation is part of the coercive mechanism of Discipline in that it observes activity and if it is being done properly or improperly;

through this observation, change in the body, i.e. greater docility or greater utility is achieved. The observation is hierarchical because generally the body that is being observed is lower in rank than that of the body doing the observation. The first body needs to be observed because it has not reached maximum aptitude or efficiency and will continue to be under observation until it does so (Foucault, 1977).

Normalizing judgment is the second instrument of Discipline. It functions in several ways but all of the operations of this instrument serve to exclude that body which is not conforming, not normal, not docile. One of the central components of normalizing judgment is micro-penalty (Foucault, 1977). Micro-penalty is a system of punishment for small infractions of behavior such as being late for school and having to stay after class. These micro punishments can be deprivations or humiliations but their primary purpose is to make patent that those who do not conform to the specified standards are eligible for punishment. Punishment frequently consists of intensified and repetitive forms of known training such as writing a certain sentence 300 times (Foucault). However, with micro-penalty one can also be rewarded for doing well. This reward is usually publicly administered so that those who are not conforming will be influenced by the success and conformity of another. This system of punishment and gratification also permits the classification of individuals based on the number of rewards or the number of punishments and with this each individual can be ranked and privileges or punishments can be administered accordingly (Cutting, 2005; Foucault).

For Foucault (1977), the purpose of the punishment within the disciplinary machine was not solely to punish. Rather the purpose of punishment within Discipline served to normalize (Welch, 1997). It did this via five separate operations: comparisons

of the individual and his behavior with specified rules set forth to be followed, differentiations between individuals, quantifications and rankings of the individual's nature, prior measures of other individuals that set standards for conformity, and definitions of the outer limit of what is considered normal, i.e. definitions of abnormal (Foucault).

The perpetual penalty that traverses all points and supervises every instant in the disciplinary institutions compares, differentiates, hierarchizes, homogenizes, excludes. In short, it *normalizes* (Foucault, 1977, p. 183)

Normalization is one of the “great instruments of power” because it introduces and imposes homogeneity as well as defines the individual through its capacity to measure gaps and levels of difference (Cutting, 2005; Foucault). Through normalization certain individuals will meet the specified standards while others will fall outside those prescribed standards necessitating normalizing procedures to be exercised over them.

Normalizing judgment and hierarchical observation reach their optimum function as disciplinary mechanisms in the process of the examination. Through the examination Discipline's normalizing gaze is perfected and with that comes the power of surveillance, the power of judgment and the power to punish (Foucault, 1977). The individual is both subjected to and objectified by the examination. The examination allows for the collection and documentation of entire domains of knowledge and power. This knowledge is then used to define categories of normality and abnormality and classify where individual bodies may fit within these categories. Therefore, the examination is able to include normality and exclude abnormality.

The examination surrounded by all its documentary techniques makes each individual a ‘case’. The case is the individual as he may be described, judged, measured, compared with others, in his very individuality; and it is

also the individual who has to be trained or corrected, classified, normalized, excluded, etc. (Foucault, 1977, p. 191).

The examination is the ritualization of Discipline's ultimate goal: to ensure that the subject is seen (Cutting, 2005; Foucault, 1977). When the subject, the individual, the body can be made visible then disciplinary power can be assured of its hold over it (Foucault; Welch, 1997). It is through continual surveillance, observation and documentation that the disciplinary mechanism, i.e. normalization, is most completely exercised and distributed throughout society and to the individuals that exist within it whether they are in the free community or the prison (Foucault). Discipline's drive to achieve transparency through a ubiquitous, surveying and normalizing power technology is no more exquisitely expressed than in the metaphor of The Panopticon.

The Panopticon. In 1787, Jeremy Bentham conceived of The Panopticon as an architectural structure that could efficiently house and monitor large groups of individuals who were to be kept "under inspection" with a minimal amount of staff and expense (Foucault, 1977). The design of The Panopticon is that of a circular building with a tower at its center. From the tower a person can see into the cells of the circular building as each cell is backlit but the individual in that cell cannot see into the tower. The cells themselves are side by side with one another and therefore, the individuals in the cells cannot see or communicate with one another. The individual in the cell is always seen but never sees; "he is the object of information, never a subject in communication" (Foucault, p. 200). The primary purpose of The Panopticon was to evoke and maintain in the inmate a sense of self-conscious visibility that ensures that power functions automatically (Foucault). The principle of this power is that it is at once visible and

unverifiable. It is visible in that the inmate can always see the shape of the tower from his cell; he is always aware that he may be being spied upon. Panoptic power is unverifiable in that the inmate does not know when he is being watched or by whom. What makes The Panopticon so effective is that the power is implied not from a specific person but from the representation of the architectural structure itself. The individual becomes trapped in the power of The Panopticon by its arrangement and distribution of bodies, spaces, lights and gazes and by its representation in the inmate's consciousness. The panoptic machinery then is able to assure power by the anxiety and psychological distress that comes from being under constant surveillance but never knowing when one is specifically being surveyed (Foucault; Haney, 2003a). The Panopticon is highly cost effective in that force, locks, chains, bars are not needed as the representational threat of hierarchical observation is sufficient to transform the inmate into his own disciplinarian and monitor of self-control; there is no need for confrontation as the individual is the object of his own surveillance (Foucault).

He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously play both roles; he becomes the principle of his subjection (Foucault, 1977, p. 203).

Therefore, The Panopticon becomes a model for societal functioning, not just for the management of correctional or other institutions. The Panopticon is a means of organizing and distributing bodies in space in a hierarchical fashion. Along this hierarchy are the centers and conduits of power and it is this diffusion of power that allows it to be implemented in a wide variety of societal locations such as hospitals, schools, and prisons. It is an effective means of applying the bureaucratic processes of power so that at

once they are both visible and invisible (Foucault, 1977). The application of panoptic principles is so insidious that its power is frequently not felt by those who are under it. What was once a structure designed to be an enclosed institution to house, monitor and correct those individuals excluded from society based on classifications of abnormality became the primary mechanism for organizing and disciplining some of modern society's predominant functions – “factory production, the transmission of knowledge, the diffusion of aptitudes and skills, the war-machine” (Cutting, 2005; Foucault, p. 211). How are these now generalized disciplinary technologies relevant and applicable to the situation of the incarcerated and formerly incarcerated individual and to the project at hand?

As mentioned previously the primary purpose of Discipline is not to punish but to normalize (Foucault, 1977). It is through the mechanisms of discipline that normalized and docile bodies are produced; the prison and the industries built around it are no exception. For Foucault the prison and its supporting disciplinary professions (e.g., law enforcement and the courts, psychiatry, medicine, social work, criminology) are committed to the production of “the delinquent” (Foucault, p. 301). The delinquent is critical to the correctional network if the network is to survive as a structure that supports the many disciplinary mechanisms in service to it (Foucault, p. 306). However, the purpose of this paper is not to critique the self-perpetuating nature of the Prison Industrial Complex (Davis, 2003; Richards & Jones, 1997). Rather it is to consider Foucault's proposal that panoptic discipline influences individuals both in and out of prison. The self-disciplinary techniques developed in response to the power technologies of the correctional institution are often different from those required for a more conventionally

disciplined life. It is not that the individual cannot refabricate him self through another version of discipline but it will be challenging; prison's goal, as disciplinary institution, is to manufacture a specific type of body that will work in self-disciplined service for it. Therefore, it is important for the researcher, the clinician or the policy maker to be cognizant of the meaning of disciplinary power and the impact it has on the individual's transition from prison to the free community, i.e. a seamless transition into conventional society is not easy or even possible (Haney, 2003a; Visher & Travis, 2003). The Foucaultian framework presents a metaphor to understand how the institution affects the individual during and after the institutional term. However, it is Goffman (1961) who more specifically depicts how the disciplinary machinery is acted upon the institutionalized individual and how the individual will never be completely disciplined or normalized even in an environment whose singular purpose is to do just that; it is essential to the self to respond in opposition to any technology of power that is operated upon it.

Goffman's Total Institution

The Characteristics of the Total Institution. Goffman's (1961) primary concern in, "Asylums Essays on the Social Situation of Mental Patients and Other Inmates" is the development of an understanding of the structure of the self; particularly those selves confined to psychiatric hospitals, prisons and other "total institutions", i.e. those social arrangements that "may be defined as a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (Goffman, 1961, p. xiii). For Goffman (1961) there are five types of total institutions: institutions

that care for the harmless and incompetent such as the aged, the indigent and the orphaned, institutions for those thought to be a risk to the community such as psychiatric hospitals and TB sanatoria, institutions that confine individuals who are thought to be a danger to the community without regard to the confined individuals' welfare such as jails, prisons and concentration camps, institutions that are formed to serve some higher or industrial purpose such as boarding schools, work camps, and army barracks, and finally institutions that are designed for retreat from the outside world as well as provide religious training such as abbeys, monasteries, and convents (Goffman, 1961). It is clear from Goffman's typology that total institutions are varied and serve a multitude of purposes. However, all of these total institutions possess similarities in structure and implementation. It is these "common characteristics" that Goffman (1961) is interested in. For the purposes of this paper and research project my discussion of the total institution focuses on those institutions whose function is to house individuals thought to be a danger to the community without concern for these individuals' welfare, i.e. the correctional institution.

The first characteristic that separates the total institution from the social arrangements that occur in the free community is collective regimentation. In the free community, the activities of daily living, e.g. sleeping, working, playing, take place in different spheres of the community whereas in the total institution all of these activities are done within the same circumscribed location and not freely chosen by the individuals themselves but are organized and ordered by the administration and staff of that institution (Goffman, 1961). The collective regimentation of people facilitates surveillance of large groups of individuals thereby assuring that all inmates are obedient

to the rules of the institution with a minimal amount of staff and a minimal amount of interaction between the staff and the inmates. Social interactions between staff and inmates are severely limited and the staff frequently view the inmates as dishonest, secretive and angry while the inmates view the staff as mean, condescending and tyrannical (Conover, 2000; Goffman). However, some communication is necessary between the two and much of this involves the lower level staff delimiting the dialogue between the inmates and the higher level staff, e.g. in the prison setting where the prisoner must complete a request form to see the physician but it is the correctional officer who decides when to give the inmate a form (Pilot Study Participants, personal communications, October - December 2005).

The regimented nature of the total institution also affects the inmate's ability to schedule his days specifically in regards to work. In the free world, work is defined as an activity done in exchange for financial payment and the worker is not under the authority of his employer outside of working hours. However, in the total institution, - whether work is a "therapeutic chore" as in a recovery program (Betty Ford Center staff, personal communication, April 21, 2006) or enforced hard labor as in a logging camp (Goffman, 1961) - there is no choice of not working or of what the work will be. In addition to this, the work done is frequently low-skilled and not applicable to potential employment in the free community (Welch, 1997). There is also no financial reward for working; work may be incentivized through some small gratification or privilege or in the avoidance of a punishment or restriction. Either way this practice of compulsory labor is demoralizing to the inmate's self as it is the loss of an adult role valued in civil society as well as will make it difficult to adopt a regular work habit upon reentry (Goffman; Haney, 2003a).

In addition to work, the total institution is incompatible with another institution of civil society – the family. Due to the restrictive nature and often geographically isolated location of the correctional institution it is difficult if not impossible for the inmate to maintain a regular family or domestic life (Hairston, 1998, 2002). Letters between inmates and family members are monitored, telephone calls are expensive (\$1-\$3 per minute), and visits take place in a common area where physical contact is frequently not permitted (Braman, 2004; Hairston, 1998, 2002). Furthermore, the inmate may choose to limit the contact between himself and his family as in-prison visits are a painful reminder of what he has left behind (Magaletta & Herbst, 2001). This removal from the family weakens the individual's relationships with his partner, children and other family members and may make it harder for the inmate to resume his role in the family upon release (Nurse, 2004). It is with these characteristics of the correctional institution - collective regimentation, institutional work and isolation from family - that the institutionalized self begins to take shape and the self that was previously defined by its roles and identities within the free community begins to fade (Goffman, 1961).

The Mortification of the Self.

The inmate, then, finds certain roles are lost to him by virtue of the barrier that separates him from the outside world (Goffman, 1961, p. 16).

The individual comes to the institution with a pre-understood world and taken for granted background practices from within that world; it is this world and the roles and identities of the individual within it that the total institution attempts to break down and redefine (Dreyfus, 1991; Goffman, 1961). Upon entrance into the institution, the individual's self identity is systematically mortified or curtailed (Goffman). This occurs via both a literal and figurative stripping of the inmate's free world self and a redressing

in the self of the institution. It begins with the removal of the individual's personal property and replacement with the institution's standard issue uniform, often of poor quality and previously worn by other unknown inmates. In addition to property dispossession, the dispossession of the self is initiated as one's own name is exchanged for a number. The individual, now officially an "inmate", is then assigned the essential property for cleaning and grooming: toothbrush, soap, comb. Like the uniform, these items are usually substandard making the management of the self's personal image difficult (Goffman). The inmate's free world self no longer holds prestige as it has become mortified, humiliated, debased in the face of the self defined for him by the total institution (Goffman).

Additional processes of personal defacement include having to abide by "the forced deference patterns of total institutions" such as referring to staff as, "sir" or having to beg for a toothbrush or a request permission to go to the clinic (Goffman, 1961; K. Grant, personal communication, Fall 2005). Although the inmate must always address the staff in a deferential fashion, the staff is not required to reciprocate and the inmate may have to withstand taunting and degrading comments on the part of the staff and other inmates.

The low position of the inmates relative to their station on the outside, established initially through the stripping processes, creates a milieu of personal failure in which one's fall from grace is continually pressed home (Goffman, 1961, p. 67).

The inmate is not worthy of even a simple greeting or instruction; instead, the staff may communicate with the inmate through physical contact such as looking an inmate's feet to see if he is wearing socks instead of asking him or pushing the inmate along the hall rather than providing a verbal direction to do so (Goffman). This type of degrading

behavior is humiliating and frequently unnatural to the previously self-determined adult (Conover, 2000; Goffman).

Arbitrary physical contact on the part of the staff is a type of contaminative exposure, another form of mortification by the total institution. In the free community, the individual can maintain boundaries between him self and things he finds distasteful or alien; he has control over what he touches and what touches him. However, in the total institution the protective boundaries the individual has established for his self are violated and he is exposed to what he had previously considered repulsive. One subtle example of contaminating exposure is the initial intake or assessment upon admission. Personal information must be revealed and then documented in a file that is available for the staff to peruse at any moment; what the individual once held as private has now become public property under the authority of the institution (Goffman, 1961). Another and more overt form of contaminative exposure is that that is directly physical such as having to live in the same room as the toilet which frequently does not flush and becomes clogged or having to share a cell with an individual who in the free world would be offensive to the self (Conover, 2000; Goffman; Hofer, 1998). Habitual defilements of the physical self also occur via searches of the inmate's property and body; the strip search is a regular event in the life of the prison inmate as is having his cell searched whenever the correctional staff deems it necessary which can be quite arbitrary (Conover; Goffman). Every level of an inmate's individualized self is open for contamination and mortification by the total institution. Furthermore, the individual cannot distance him self from these processes of mortification. In civil society, an individual is also exposed to mortifying processes such as being asked to do a job he does not want to do. In this instance,

however, the individual can protect him self from this mortification by face-saving expressions such as not showing deference or verbalizing complaints about having to do the job. These face-saving expressions are not allowed in the total institution and in fact the inmate can be further penalized for speaking out against or disrespecting the staff or the rules of the institution (Goffman).

A final example of the mortification of the self as described by Goffman (1961) is the delimiting of an individual's "personal economy of action" (p. 38). For example, an individual in civil society can choose when he wants to eat dinner. He may normally eat dinner at 7:00pm. However, should something occur, perhaps a need to work late, he has the personal agency to postpone his regular dinner hour. There is no one enforcing what time he should finish work and start dinner. This is not the case in the total institution where the inmate's life is compartmentalized into tiny segments managed by the staff and the administration. The inmate has no control over mealtimes, shower times or bed times; his personal economy becomes the economy of the institution (Foucault, 1977; Goffman; Haney, 2003b). The restriction of one's own personal economy of action is possibly the most deleterious effect of the total institution on the self; as upon release, the inmate finds that he has lost the skill of independently organizing his daily life and completing the activities required of a life outside the institution (Goffman; Haney).

These factors create obstacles and difficulties for those persons being released from total institutions such as prison. Through the processes of collective regimentation, social isolation, and the mortification of the self many inmates have difficulty with or are no longer capable of redefining an identity for himself upon release to the free community (Haney, 2003b; Goffman, 1961). Yet, this is what the free community

demands of the formerly institutionalized person: the instant fabrication of an appropriate identity and sufficient self-discipline and self-determination to meet the demands of the community to which he now returns. However, frequently the recently incarcerated person identifies with and is reliant upon the institution. The skills he developed as means of surviving and maintaining the institutional self are no longer relevant for the free world; he must become dispossessed of his institutional self. This is difficult if not impossible because the total institution relies on mechanisms that debase the self on such a fundamental level that the individual may no longer have the internal resources to construct a new self, a normalized self, appropriate for community consumption (Edwards, 1970; Goffman; Haney).

Reorganizing the Self: Secondary Adjustments. All of the processes outlined above create intense psychological stress for the inmate and there are limited resources available to him within the institution to assuage that stress (Goffman, 1961). However, the institute does provide a mechanism for “personal reorganization” through the privilege system, a form of micro-penalty (Foucault, 1977; Goffman, p. 48). Within this system of privileges there are the “house rules” (p. 48) that lay out the regulations for inmate conduct. When the inmate satisfactorily meets these regulations he is rewarded with a small privilege or gratification such as using the telephone to call a family member. Should the inmate not follow the rules a punishment such as the withdrawal of phone privileges will be meted out. The privilege system of the total institution is simple but effective in obtaining cooperation from those individuals who have reason to be uncooperative as well as providing an opportunity for the inmate to recapture some sense of his former self. Activities that in the free community the individual took for granted,

e.g. using the phone to call a family member, now become special treats and minute aspects of an institutionally reassembled self (Goffman).

In addition to using the privilege system as means to regain some of the freedoms accorded to the self in free world, inmates also employ secondary adjustments.

Secondary adjustments are those practices that allow inmates to access prohibited satisfactions without directly challenging or confronting the institutional staff. These practices are frequently referred to as “the angles”, “gimmicks” and “getting over” (Goffman, 1961). Secondary adjustments are also a means of reorganizing and protecting the self from the discipline of the total institution; they are proof that the inmate “is still his own man, with some control over his environment” (Goffman, p. 55). The accomplishment of secondary adjustments, such as taking food from the kitchen after it has closed, necessitates social interaction and stratification based on inmates’ levels of access to contraband, e.g. food from the kitchen. Therefore, secondary adjustments, in addition to being opportunities for self-reorganization, are also social processes that provide opportunities for fraternization with other inmates. It is through the process of fraternization that the inmate may come to see his fellow inmates as human beings and they share the mutual pain and discomfort of being trapped in the deprivation of the total institution together (Goffman). Furthermore and perhaps more importantly, the fraternization resulting from the social nature of secondary adjustments is critical in protecting the inmate from the destructive psychological effects of being rejected by and alienated from the larger society and the subsequent internalization of that rejection and alienation; through cohesive interactions with other inmates, the inmate can reject those who have rejected him rather than having to reject himself (Edwards, 1970; Goffman).

What is ironic in the process of institutionalization is that as much as the inmate fights the institution's definition and confinement of him, the feelings alienation, injustice, and anger that he railed against the institution become attenuated as he nears his release date. He becomes anxious about the skills required for life in free society, as these may have been lost during his institutionalization (Goffman, 1961; Haney, 2003b; Irwin, 1970). The expectation that he must revert back his pre-institutionalized self after a period of confinement from civil society is both stressful and unrealistic as the individual will never be able to completely return to his former identities (Haney; Irwin, 1970). Through the mortifying processes of institutionalization, the self has been redefined and manufactured as an institutional self, i.e. a "delinquent" in the case of the newly released prisoner (Foucault, 1977). The identity of the delinquent is one that is stigmatized and stigmatizing for the formerly incarcerated person. The newly released person as a delinquent inhabits a low status position within the social hierarchy of the free world making the practicalities of daily living such as finding a job and a place to live difficult to achieve (Irwin; Nelson et al., 1999). In addition to this, the inmate may be leaving the institution after finally becoming assimilated to the institution and achieving a position of respect within that social structure. The transition from the institution to the community may actually be a step down for him (Goffman; Irwin). Furthermore, the inmate is still under surveillance by the institution via some form of community supervision; any mistakes while on the outside may result in a rapid return to the correctional institution (Goffman). Although the inmate may now be living in civil society he is still within the grasp of the institution; it is this grasp that will continue to influence the formerly incarcerated person's definition of his self outside its walls for a long period of time

afterwards. He may not return to the institution but the institution will remain within him as it has left an indelible mark upon his self (Goffman; Haney).

Foucault's Power, Goffman's Self

The Docile Body. The Self-Defining Self. Foucault (1977) and Goffman (1961) each put forth means of understanding how institutional power impacts the individual who is under that power. For Foucault the disciplinary mechanisms of hierarchical observation, normalizing judgment and the examination are what create a docile body that will work in self-disciplined service to the power structures that surround him whether in prison or the free community. Goffman describes institutional power as being expressed through the processes of mortification of self and the privilege system. From both of these vantage points, the self of free society is no longer appropriate and must be reformed, corrected, normalized within the institution. The institutional processes described by Goffman are examples of the disciplinary technologies outlined by Foucault. For example, the mortifying processes or the stripping of the self that begins upon entry into the institution is a form of both hierarchical observation and normalizing judgment. It is here that the individual becomes an "inmate" and loses all rights to his former identity and life because he is not deemed to be appropriate to exist in society at-large due to an abnormality, in this instance, criminal behavior. He enters the institution to be observed, to be watched by others who are considered more capable to make the determination of normalcy. The inmate is scrutinized by institutional staff and his actions are recorded; he becomes "a case" (Foucault, p. 191). Through these processes of mortification the inmate is made visible as his former (abnormal, non-docile) self has been stripped from him. The visible or seen subject is a primary target of the Disciplines

as it is via transparency that the operations of power, such as the mortification of self, take hold of the subject and initiate the processes of correction and normalization.

The privilege system as described by Goffman (1961) is another means through which the power technologies of the institution are expressed. The privilege system within the total institution is mechanism of control over uncooperative inmates or undisciplined bodies. It operates by awarding privileges to those who are following institutional rules, i.e. submitting to normalizing procedures or relinquishing their free world identities, and removing or not granting privileges to those who are not as compliant (Goffman). The privilege system reflects the principles of micro-penalty suggested by Foucault (1977). However, these conceptions of gratification and punishment differ somewhat in their primary purposes. For Foucault, the micro-penalty is a component of normalizing judgment always driving the individual, the body towards conformity, towards homogeneity. The micro-penalty also provides a system to measure and rank individuals against one another and against prescribed standards ensuring control over those who do conform and providing a means to address and correct those who do not (Foucault). Disciplinary technologies are consistently directed towards control over the body via observation and normalization both within the institution as well as within society at-large.

Goffman's (1961) presentation of the privilege system differs from that of Foucault (1977). While the privilege system is a means to control unruly or non-compliant inmates, Goffman proposes that the arrangement of privileges and punishments within the total institution is particular to it; the privilege system is not a means of social control pervasive throughout all society. Rather it is an important feature

of the shared culture among inmates not readily understood or appreciated by those outside the experience. Most important in this system is the opportunity to rebuild the self after it has been curtailed and degraded by the institution (Goffman). While the most obvious purpose of conforming to institutional rules is to gain privileges, receiving punishments also have functions within the world of the institution. For example, “messing up” (p. 53) or “getting busted” (p. 54) are means for inmates to express their resentment towards the institution or methods to prolong their stay without having to admit that they are not ready or do not want to leave the institution (Goffman). Therefore, the privilege system as described by Goffman is less about the fabrication of docile, easily controlled bodies and more about the opportunities to define and construct one’s self within the confines of the institution.

The question as it relates to this project becomes, how do these two frameworks influence and deepen the inquiry into how individuals transition from prison to the free community? What are the transformations of the self that take place within the correctional institution and how will they impact a former prisoner’s ability to reintegrate? The strength of these two perspectives lies in their differing views on institutional power. For Foucault (1977), the critical work was not to document the historical evolution of the prison. It was instead to “render visible” (Rabinow & Rose, 2003, p. viii) the thinking and rationale behind why individuals are incarcerated at all and how this reasoning led to a pervasive means of social control that continues to the present day. Foucault illuminated the “reigning conceptual grids” (Rabinow & Rose, 2003, p. viii) that defined what is truth and what are the relations between truth, power, knowledge and the subject, i.e. the body. Through his elucidation of the dominant

structures of thought and power, Foucault created a space in which these ideas, this thinking could be questioned and challenged; no longer was the rationale of punishment by incarceration as method of crime control a taken-for-granted understanding. This is of relevance to the research project at hand because while much of the current research purports that incarceration and the correctional system itself are not necessarily effective means of crime control (Solomon, 2006; Travis *et al.*, 2001), such research does not explore why society persists in incarcerating individuals on such a massive scale. Foucault offers an opportunity and an outline of how to think more critically and creatively about the power and knowledge relations that inform and act upon individuals situated within the correctional institution, the society at-large, and the research process itself (Rabinow & Rose, 2003, p. ix).

Goffman (1961), however, is more concrete. He draws a clear picture of how the institution functions in its exercise of power and control over the individual inmate as well as how the individual responds to that exercise. The inmate is not a docile body working in self-disciplined service towards the goals of the institution. Rather he is a person capable of thought, feeling, action both articulated and unarticulated (Taylor, 1985). The individual comes to the institution with pre-existing identities, specific cultural understandings, and shared social relations that the institution attempts to break down (Benner, 1994; Dreyfus, 1991; Goffman). For Goffman, the inmate is an active, albeit unwilling, participant in the operations of power and he will continually strive to define himself and understand his world regardless of the disciplinary technologies acted upon him. It is the active, responsive individual, the living subject (Jung, 1996) always in search of a self-defined identity that is not accounted for in Foucault's panoptic

discipline. Goffman's presentation of how the self structures itself not as a merely defense mechanism but as an essential component of its self balances Foucault's discussion of the totalizing power of panoptic discipline. More importantly, Goffman's work provides a framework for the researcher to explore how the formerly incarcerated person lives in the world while in the institution and in the free community as well as to consider the individual and shared processes through which prisoners transition from the institution to civil society (Visher & Travis, 2003). While Foucault, on the other hand, continually challenges the researcher to question and investigate the power and knowledge relations that may influence why and how such questions are or are not asked.

Thinking Critically

The Foucaultian Subject. Foucault was not oriented towards the subject as a human agent with the power and ability to respond and react to the world in which he is situated. Rather, the subject as presented in "Discipline and Punish" was "the disciplinary product of a panopticed gaze" (Vailers, 2001, p. 426; Rabinow & Rose, 2003). Foucault has been criticized for this view of the personal agency (Jung, 1996; Smith, 2003; Valier, 2001). Although in his later work Foucault did rethink his relationship to and analysis of the subject (Rabinow & Rose), it is relevant to consider the commentary on Foucault's understanding of the subject in relation to the phenomenological conception of what it means to be a person actively engaged in a social, cultural and historical world.

In her article, "Phenomenology and Body Politics", Jung (1996) contends that the body is "the living subject" (p. 17); the body is not an object amidst other objects but places the person socially and actively in the world. It is through the body's intercorporeality, or the body's engagement with other bodies that the person becomes

attuned to his world and the common practices and shared understandings within it. For Jung, Foucault never came to terms with the body as the living subject, as a being that responds to and interacts with his world, as an individual agent. Instead he was focused on the body as defined by and located in the power relations of panoptic discipline (Jung). Foucault's theoretical concepts of Discipline and The Panopticon did not account for the person's own agency and how such agency may influence the degree to which an individual is transformed by disciplinary procedures. Vailer (2001), while not specifically discussing the body, draws attention to the absence of the unconscious life of the person in Foucault's analysis of the prison and its mechanisms of power. Foucault does not account for the unarticulated responses and actions of the individual to Discipline. Indeed, he argued that disciplinary power took hold of the body so absolutely that it was not necessary to explore the individual's emotional and intellectual reactions to such power (Vailer). However, Foucault's power technologies are never completely totalizing or transformative of the person, as that person still possesses the ability to act as his own agent and respond individually to the situations and circumstances that his world presents to him. Goffman (1961) suggests this idea with his secondary adjustments; the self, both conscious and unconscious, will continue to assert its self and make sense of its world even in the face of the restrictions and deprivations of the correctional institution.

Vailer's (2001) critique further notes that Foucault's thesis does not account for those individuals who are able to move out of or "transcend" (p. 429) the correctional system. This point is well taken as there are individuals who are able to change their lives to such an extent that they do not return to prison yet there is no place for these

individuals within the schema of “Discipline and Punish”. Foucault would argue that although these persons may have exited one of the most extreme models of disciplinary power, they still exist in and are informed by such power as it is distributed throughout society (Foucault, 1977). This may be true but what both Jung (1996) and Vailier put forth is that Foucault, in his analysis, reduces the complex qualities of human nature and agency to a mere body subject to disciplinary techniques. His work also does not consider the peculiarly human quality of relating socially to the world and to others; it is these aspects of being a person that prevents the totalizing power of Discipline from being quite so totalizing (Goffman, 1961; Jung; Vailier).

Goffman (1961) in his discussion of secondary adjustments provides an illustration of how the human being, the person will try to make sense of his world and his self in the context of extreme deprivations and excessive power practices. Through the example of secondary adjustments it becomes clear that the inmate is not solely a passive body awaiting the operation of power. Secondary adjustments are shared practices within the institution that assist the individual in making sense of the world into which he was thrown (Benner, 1994; Dreyfus, 1991). They allow for some individual control over the inmate’s own world as well as emphasize the social nature of the total institution as it frequently requires several inmates working together to achieve a successful outcome. It is the social processes inherent in any setting where human beings live in proximity to one another that Foucault does not consider either in his treatment of the person as a docile and subjected body or in his analysis of the prison as a location for the exercise of power.

The Not-So-Total Institution. While Goffman's explication of the secondary adjustment accounts for some of the ways human beings make the institutional world intelligible to themselves, his presentation of the total institution overall is perhaps no longer relevant for current U.S. correctional institution. In his article, "The Modern Prison as Total Institution? Public Perception Versus Objective Reality", Farrington (1992) refers to the prison as a "not-so-total" institution (p. 7) or one that does not conform to Goffman's (1961) model of a facility isolated and removed from the workings and activities of the free community.

Their encompassing or total character is symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant, such as locked doors, high walls, barbed wire, cliffs, water, forests, or moors. These establishments I am calling *total institutions*... (Goffman, 1961, p. 4).

Farrington draws attention to the modern prison as actually being socially situated in both its host community and in society at-large. Between the prison and civil society there is a stable and ongoing system of varied transactions, exchanges, and relationships signifying a boundary between the two that is permeable and provides an imperfect degree of separation (Farrington, 1992). The author questions if it would in fact be possible to implement the total institution as per Goffman's conceptualization in current American society as well as the desirability of such an institution within that society.

In addition to questioning the image of the prison as possessing a distinct and separate existence from the rest of society, Farrington (1992) draws attention to certain social aspects of the correctional institution that deviate from Goffman's (1961) framework. Most germane to this project are the lives and worlds of the inmates that they bring with them to prison. No matter how rigorous or destructive the processes of

the mortification of self, the former worlds and experiences of prisoners still exist within them and will inform their perceptions and understandings of their incarceration (Dreyfus, 1991; Farrington). This is particularly true for the majority of individuals serving shorter sentences. They bring with them their identities, roles and statuses from “the street” and are often able to maintain them throughout their limited prison stay as well as carry their in-prison experiences to their home communities upon release. This blends the attitudes and aptitudes required for prison with those required for life “on the streets”; prison culture comes to shape and inform street culture. Furthermore, many individuals, particularly those from marginalized communities, are already socialized to the institution prior to entry as prison is an expected or normalized experience within the inner city lifeworld. Therefore, the idea of prisoners being separated from society “for an appreciable period of time” (Goffman, p. x) within the confines of the total institution is a representation of incarceration that persists within the public’s consciousness rather than a realistic understanding of what actually occurs during and after a period of imprisonment. This commitment to the notion of prison as a total institution disconnected and distinct from the free community is a misconception that enables society at-large to deny the complex interrelationships and interconnections between the correctional institution and the social, legal and political spheres of the free world (Farrington); to perceive an impermeable wall between the prison and the public sphere is to ignore the social contexts and processes in which incarceration (and crime) take place. However, society requires this “mythology” (p.18) in order to maintain its sense of freedom and autonomy vital to the American ideal of one’s right to individuality and independence that originated with 18th century thought and continues to the present day (Farrington).

Goffman's total institution with regards to the modern prison has become a trope that provides psychological comfort and security to the public rather than a specific and effective means of removing, confining and incapacitating criminally minded individuals from society (Farrington).

The Missing Questions. As discussed previously in this paper, Visher and Travis (2003) propose a different way of considering what happens to the individual upon release from prison. Their call to researchers is to explore the transitions a person must make reentering and reintegrating to the free community rather than measuring success or failure via limited outcomes such as recidivism rates. They raise important questions about the conceptualization of reintegration and the necessary social supports for it to be successful. Furthermore, Visher and Travis suggest that the individual experience of the formerly incarcerated person be explored from a variety of social contexts and life stages. This framework is one of the few that incorporates as many possible aspects, contexts and situations of the former prisoner's experience that may impact his ability to reintegrate successfully as well as critiques the current research for being too narrowly focused on single outcome measures of reintegration success or failure.

Nevertheless, this model is oriented towards the idea of what can be learned about reintegration from the research process rather than what can be learned from the individual participants themselves within the context of research; the project not the participant is still the central focus in this model. This is perhaps a trite criticism, however, it is a relevant one. Although most researchers, particularly those working with liminally positioned persons, are sensitive and sensitized to the power relations inherent in the research process, the investigator and the investigative process function by *taking*

information from the participant. Therefore, the process of reflection or reflexivity upon the social, cultural and historical contexts of both the investigator and the participant is a critical component of the research process. Questions such as “what does it mean to the participant to take a part in a research project?”, “how does the research process itself influence what the participants will or will not share with the researcher?” and “how does gender, ethnicity and social class influence the data gathered?” are important questions to ask yet reflexivity or reflective processes are not advanced by the Visher and Travis framework. It is particularly relevant to their model because the authors propose using a qualitative life-course methodology that emphasizes the importance of participants’ salient life events as well as the descriptions and understandings of their connections to social relations (Visher & Travis, 2003).

Finally, Visher and Travis’ (2003) transitional framework considers only reintegration albeit holistically, after a prison term. It does not incorporate questions as to why the individual was incarcerated in the first place and more importantly perhaps, why, as a society, we incarcerate people at all. It is true that their framework suggests multiple dimensions from which to understand what happens to an individual before, during and after prison but it does not take issue with the punitive and disciplinary structures themselves. It is clear that the authors want to better understand the successful transitions and pathways to reintegration in order to better assist people. Nevertheless, their framework could be further strengthened by incorporating inquiry that examines the larger societal dynamics in which crime, arrest and incarceration take place.

Conclusion

Fitting It All Together. Although the preceding sections draw attention to some of the potential weaknesses of each of these theoretical frameworks, they nonetheless provide important ways of thinking about my area of questioning for the dissertation research. Visher and Travis (2003) validate the significance of exploring reintegration as a transition one must make from the prison to the free community rather than merely measuring discrete, single outcomes as well as locate the research project within the social dimensions and longitudinal dynamics of the individual. For example, the project at hand, “The Impact of Health Care Access on the Community Reintegration of Male Parolees”, was located within dimensions of individual characteristics and family and community contexts during the life stages of immediate and long-term post-release transitions. Through the interview process I gained access to the lifeworlds of recently released men on parole as well as their perspectives on and experiences with health care in prison and in the free community.

For Visher and Travis (2003) the central aim of their framework is to encourage comprehensive research projects that create deeper understandings of the process of reintegration and the impact that prison has had on an individual’s self and life. They comment that much of current research does not focus on prison as a social process that shapes and defines the individual; their call is to more meaningfully explore how prison does this and how this may or may not affect a person’s ability to successfully reintegrate into his community. However, the authors do not mandate a specific type of inquiry or philosophical approach and this is where Goffman (1961) and Foucault (1977) can further elaborate upon the framework put forth by Visher and Travis.

Within the framework of Visher and Travis (2003), Goffman provides a distinct picture of how the processes of the total institution affect the individual. Survival within the institution requires constructing and maintaining a self-identity that will meet the approval of the institution while allowing, however secretly, for some form of individualized expression. This is difficult and takes a significant toll upon the institutionalized person as can be witnessed, e.g. in “messaging up” or “getting busted” as expressions of not wanting or not being ready to leave the institution (Goffman, 1961). Should someone not be prepared to leave the correctional institution, his reentry and transition to the free community could be affected; he may take action resulting in his return to prison. For the researcher, the questions would center on what societal supports would have been helpful for this person, how his family and community may have played a role in his reintegration, and what happened that he did not want to leave prison in the first place. Goffman’s explication of the process of institutionalization provides a link to consider the impact of incarceration on the individual within the schema of Visher and Travis.

Foucault’s thought (1977), although less clearly related to the ideas of Visher and Travis (2003), offers another position from which to examine the impact of prison on the person. As discussed in the previous sections, for Foucault the primary relations within the prison and society at-large are the power relations over the subject rather than the social relations in which the individual was included. “Discipline and Punish” (1977) illuminated the evolution of the thought behind panoptic discipline of which the prison was its original testing ground. More importantly, Foucault’s work in “Discipline and Punish” challenges the researcher, to think beyond the surface understandings she may

have about the project at hand. His vantage point encourages the researcher to be suspicious of her motivations for doing research as well as question how she may be situated within the process as well as within the power relations and their operations (Frank, 1998; Rabinow & Rose, 2003). Moreover, Foucault offers an activist stance and ensures reflexivity not present in the Visher and Travis construction. This is critical, one of the roles of research should be not just to observe, document and understand the phenomena under study but to challenge the dominant structures in which the phenomena, i.e. incarceration, parole and health care, takes place.

These three theoretical conceptions woven together provided a background for my dissertation research that one, encouraged the exploration of the individual transitions made during the process of reintegration; two, provided a picture of some of the processes of institutionalization; and three, ensured the project will not narrowly explore the phenomena but constantly questioned the relations of power and the veracity of those relations within the prison experience as well as within the research project. Moreover, the frameworks presented in this paper both separately and intertwined together raised further questions such as: how should reintegration be conceptualized? What are the power relations of the free community at work in the participants' lives? How are these relations different from those of prison? What are the power relations within health care and what is their impact on the male parolee? Can Foucault's docile body as the subject and object of disciplinary power be reconciled with Goffman's construction of the institutional self and the phenomenological conception of what it means to be a person (to be discussed further in, "Arriving at Phenomenology")? How, if possible, could this research play a role in such reconciliation? While these questions were not the specific

focus of this dissertation research, they informed, it as they are examples of how my own thoughts and understandings have been expanded through the exploration of the three frameworks presented in this chapter.

CHAPTER 3: ARRIVING AT PHENOMENOLOGY

Introduction

Currently, 1.4 million people are incarcerated in federal and state prisons in the United States, an increase from approximately 160,000 in the 1970s (Harrison & Beck, 2005; Travis, Solomon, & Waul, 2001). Of these, 784,4000 individuals are released to parole nationwide, approximately 2100 per day (Glaze & Bonczar, 2006). The majority of these individuals represent ethnically diverse and marginalized communities. Those released were likely to have not finished high school, have limited employment skills, and have physical and mental health and substance abuse problems (Petersilia, 2003). These individuals also have multiple health care needs. However, there is limited understanding about the impact of health care access on an individual's ability to successfully reintegrate into his community.

The literature has documented coordinated health care models that demonstrate the importance of health care access for parolees and its impact on reducing rates of recidivism (Conklin, Lincoln, & Flanigan, 1998; Rich et al., 2001; Sheu et al., 2002). However, these studies do not lend insight into the parolee's perspective on what may or may not be most beneficial for his community reintegration. The inclusion of the population of interest is a critical component to designing effective programs, but in much of the literature the voice of the formerly incarcerated person is missing (Green & Kreuter, 1999).

There is limited information on how parolees take care of their health both generally and in relation to specific medical conditions. While several studies have demonstrated that integrated health care services can impact rates of recidivism, we do not have an

understanding of how ex-offenders experience health care access as being a part of their reintegration. There have been studies on the health perceptions of prisoners but these studies were descriptive and documented only that prisoners perceived their health as good, fair or poor; that they were willing to utilize medical services; and, that they engaged in high-risk behaviors and had multiple health problems. These studies did not reveal any information about the inmates' health care beliefs or practices that may have been useful to their reintegration into the community (Conklin et al., 1998; Lindquist & Lindquist, 1999). In 2004, Cooke found that for African-American men leaving prison, employment and housing were critical for successful reintegration and avoiding health problems. Cooke's research did not address personal health care practices, specific health conditions or experiences with health care systems although it is one of the few studies that explores the reintegration experience from the perspective of the former prisoner. It is both the dearth of research on health care's impact on integration as well as the descriptive nature of most research surrounding the criminal population that provided a platform for understanding male parolees' experience of health and health care from a qualitative perspective, more specifically a phenomenological one.

What makes interpretive phenomenology so relevant to this project is that the researcher and the participant co-created a dialogue that allowed for the exploration of both the practical concerns and the lived experience of the phenomena by the participant (Benner, 1994a). Inherent in this dialogic process between the researcher and the participant and the resultant text is a critical reflection on, and awareness of, how the specific methodology, the researcher's pre-understandings of the phenomena, and the social and historical contexts in which the project takes place

influenced the interpretation and the representation of the phenomena at hand (Benner). Central within this is the researcher or interpreter's goal "to hear and understand the voice of the participants" (Benner, p. 100). For a marginalized group such as the parolees, being heard and being understood particularly through the process of research is crucial from both ethical and public policy standpoints. As will be discussed later in this paper, the lived experience of being a man on parole is often narrowly represented in the public sphere, i.e. mainstream media and politics, and these representations may lead to public understandings of the former prisoner that are not beneficial either for the parolee or for the public. For example, over the past decade there has been a decrease in spending on in-prison programs despite research that documents their utility both in and out of prison (Anglin, Longshore, & Turner, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Wexler, Melnick, Lowe, & Peters, 1999). However, due to beliefs within the public space that these programs do not work and that these individuals should be punished not provided with services or treatment while incarcerated funding is now limited for in-prison programming (Golembeski & Fullilove, 2005). Therefore, hermeneutic or interpretive phenomenological understandings can give those on the outside of the experience - whether outside as clinicians, academicians, policy makers or private citizens - access to the parolees' experiences in as real a way as possible while acknowledging that their lifeworlds can never be completely accessed or understood. The openness of the interpretive process is powerful in that it allows the researcher and the reader to enter the participants' worlds on multiple levels that are sensitizing to the other and allows for the co-creation of understanding. Because critical reflection or reflexivity is such a vital part of the process, the interpreter has the opportunity to examine and then open up her own

biases, her world and her pre-understandings that influence the project while always keeping in mind the hermeneutic assumption that we will never grasp the meaning of the world in its totality; we can only see and understand the world in the finite and defined aspects it presents to us (Benner, 1994).

To continue this discussion of the appropriateness of interpretive phenomenology to study the question of the impact of health care access on the community reintegration of male parolees this paper is organized into three sections. The first section, *The Method*, will discuss the specifics of the method including its origins and its assumptions. The work of Martin Heidegger as interpreted by Hubert Dreyfus, Patricia Benner and Victoria Leonard will guide this section. In the second section of the paper, *The Concept of a Person*, two differing perspectives will be discussed – the representational and the phenomenological - on what it means to be a person and how that influences how we study, understand and represent human behaviors particularly in relation to the incarcerated and formerly incarcerated person. In this section I will also introduce, The Monster Discourse, as a means to discuss how understandings and interpretations of the criminal are shaped within the public arena by the media the body politic. Taylor's (1985) work on the concept of a person will provide the framework for this discussion. The concluding section, *Creating a (Post-Modern) Research Text*, will discuss post-modern influences on the phenomenological research project including issues around researcher reflexivity, narratives and validity. The work of Julianne Cheek (2000) Patricia Benner (1994) and Max van Manen (1997) will be cited as well as my own self-reflexive dialogue regarding the project. Throughout the following three sections, I will use examples from my first hermeneutic phenomenological research project, "*Dedicated*

to Ruben Hands: Analysis in Progress” to further explicate why this methodology was appropriate for the question, what is the impact of health care access on the community reintegration of male parolees? This project was a pilot study completed for the course S/N285 Advanced Qualitative Research Methods during Fall 2005/Winter 2006 quarters. The pilot study functioned as a learning exercise, in the best sense of the idea, and the course gave me a platform from which to begin to access and understand the concepts of hermeneutic phenomenology as method and philosophy.

The Method

The Representation Conception

In order to understand how interpretive phenomenology came to be it is helpful to review the school of thought to which it was in opposition. Therefore, this section will begin with a brief review of two aspects of modern scientific thought, i.e. objective reasoning and the mind as being distinct from the body, or what Charles Taylor (1985) referred to as the representation conception. In the 17th century there was a revolution in the world of Western scientific thought. During that time the understanding of the world as the embodiment of God’s ideas and as an expression of the Divine was turned upside down (Benner & Wrubel, 1989; Taylor, 1985).

This revolution involved a polemical rejection of the vision of the world as [Divine] meaningful order, and its replacement by a conception of the world as [an] objective process (Taylor, 1985, p. 224).

The 17th Century scientific revolution was not interested in understanding the world as meaningful order via God’s creation. Instead this revolutionary thinking was focused on knowing the world through objective reasoning, i.e., reasoning that does not appeal to experiences of the senses or anthropocentric properties. The rejection of these

anthropocentric properties was a key thesis of the 17th Century scientific revolution (Taylor, 1985).

Anthropocentric properties are those aspects of an object that can be experienced by the subject through the senses, e.g., feeling heat from the sun or hearing the chirping of the birds outside. These properties are secondary because they are subjectively experienced within a specific context such as during a picnic on a warm, sunny day in a Golden Gate Park by the feeler or the hearer and do not lend themselves to objective, context-free explanations of how we are able to feel the sun as hot or take in the birds' sounds as chirping. The 17th Century notion or the representation conception (Taylor, 1985) of all objects as having absolute and context-free properties that can be broken down into distinct units in order to explain why a thing works the way it does was important in knowing and explaining the natural world as something other than a Divine creation and gave birth to crucial knowledge that we use in our world today, e.g., why the sun radiates heat and why that sun can burn us or why birds chirp and how the ear works to enable us to hear that chirping.

Another critical component of the representation conception is that the self is always taken as the subject and the world outside the subject is always taken as the object. These two, subject and object, are distinct entities linked together by representations of the object framed in the consciousness of the mind of the subject and while anthropocentric properties may assist in developing a representation of the object they are considered secondary because they offer only a subjective or contextually-located experience idiosyncratic to the subject herself (Benner & Wrubel, 1989; Leonard, 1994; Taylor, 1985). Therefore, the conscious mind of the subject can develop a

disengaged representation of the body as an assemblage of parts and traits that while providing experiential access to the external world are ultimately under the control of the conscious mind and exist only as representations of that mind; the mind is always separate from the body and the external world regardless of subjective or contextual experience (Leonard, 1994; Plager, 1994). Therefore, the primary concern of the representation conception is epistemological, i.e., how do we come to objective explanations for how we know what we know.

Heideggerian Phenomenology

Interpretive or hermeneutic phenomenology as conceived of and developed by the German philosopher, Martin Heidegger (1927/1962), was a reaction against the 17th Century conceptions of the mind being distinctly separate from both the body and the external world. For Heidegger, the question was ontological – what does it mean to be a person and how is the world intelligible to us as all - and he criticized the representation conception for taking a such a narrow epistemological view of understanding the person and the human experience (Leonard, 1994). It is important to note here that while the critical questions for Heidegger were always ontological he was not completely against the representation conception but rather was an advocate for its appropriate application, i.e., its use in studies where human meaning and interpretations do not matter as in the study of why the sun radiates heat (Leonard, 1994). For Heidegger, the person is never thought of as dualistic entity of mind distinct from body and thereby autonomous from the external world. Rather, the person is always situated in and embodied by a world of shared background practices, taken-for-granted meanings, and cultural and linguistic understandings (Leonard, 1994; Plager, 1994). Subjective experience is an integral part

of how the person is in her world and cannot be separated from how she understands and interprets the situations she is in. As the individual operates in her daily world she does so through engaged, practical activity in a meaningful context. She does not encounter her world through abstract and deliberative or intention-driven thought but rather through non-reflective understanding and interpretation of her self in her world (Benner & Wrubel, 1989).

...deliberative, abstract thought is not the only way in which people encounter the world. In fact, one would not know what to do with such abstract, conceptual thinking if one were not situated in a meaningful context. But it is easy to see how one could believe that all knowledge was reflective knowledge, because whenever one stands outside of a situation, one is in a reflective position. Heidegger's concern was to illuminate what of knowing occurs when one does not stand out of the situation, but is involved in it (Benner & Wrubel, 1989, p. 41).

World. Humans are always already situated within or *thrown* into world (Dreyfus, 1991; Leonard, 1994). For Heidegger, world is defined as the cultural and linguistic practices and the shared relationships and skills that constitute a person's being. The self is made up of the world in which she exists and this world is made up of her self; Heidegger called this Dasein or being-in-the-world (Dreyfus; Leonard). The idea of Dasein or of being-in-the-world in an active sense is, for Heidegger, the original or primordial way we exist in the world (Dreyfus). As the hyphenated English translation indicates being and world are inextricably linked; world presupposes Dasein in that world exists before Dasein enters it. Through Dasein we dwell in or are inhabited by the world in such a way that we do not see how it shapes and molds us over the process of our lives (Benner & Wrubel, 1989; Dreyfus; Leonard).

When we inhabit something, it is no longer an object for us but becomes a part of us and pervades our relation to other objects in the world...Heidegger...call[s]

this way of being-in “dwelling”...Dwelling is Dasein’s basic way of being-in-the-world (Dreyfus, 1991, p. 45).

World is so inherently constitutive of the self, that we do not notice how it influences how we are in it. However, it is the qualities of world – the shared cultural knowledges, historical contexts and common language – that allow the things that matter to show up for us whether they are experiences, feelings or interpretations. World defines the possibilities of what will or will not come into our lives, and therefore, we are never totally or radically free to do what we want as in the representation conception; we only have situated freedom defined by the world that we are in.

This is based on the concept of being *thrown* or *thrownness*. We are thrown into a particular cultural, historical, and familial world and that will determine what choices and opportunities present themselves to us as possibilities or things that matter (Dreyfus, 1991; Leonard, 1994). For example, the familial world into which I was thrown is one in which the common practice and shared experience is to go to college and frequently pursue advanced degrees. In the context of this familial world obtaining such a degree is a thing that matters or shows itself as a concern to us; the college degree is significant in an original way, i.e. the college degree matters to my family not because we are intentionally driven for to it be a concern but rather, like world, it exists as a concern for us before we can articulate specific feelings or opinions about obtaining a college degree (Benner & Wrubel, 1989; Leonard; Taylor, 1985). Therefore, it is not surprising that the possibility to continue my education at the doctoral level presented itself as a concern for me, as a matter of original significance (Taylor). In fact, higher education is such a shared public understanding in my familial world that we are only called upon to truly

notice it should someone in that world NOT go to college. Therefore, what is a non-reflective concern in my family - going to college when one graduates from high school – becomes apparent should someone do the opposite. Then, we, as a family, would stand back in a reflective and theoretical stance postulating why this individual is not going to college. Heidegger referred to these reflective and non-reflective stances as modes of being.

Modes of Being. Heidegger's philosophy describes Dasein living in the world in engaged, unreflective practical activity or the *ready-to-hand* mode (Dreyfus, 1991). In the *ready-to-hand* mode our grasp of the situation is immediate and non-intentional as we are being-in-the-world. To take up the example of college and my being-in-my familial world, as a primary and secondary school student I was not intentionally making the choice to get good grades so I would be accepted to a good college; rather, I was non-reflectively involved in being a good student because I had my familial world's background understanding that going to college was of original significance (Taylor, 1985). I did not need to be intentional because I had an immediate grasp of the situation and the situation's meaning to me based on the world in which I dwelled (Dreyfus). This mode of involvement in the world is radically different from the representation conception where all of our behaviors are intentional and strategically driven (Benner & Wrubel, 1989; Taylor).

The second mode of involvement in the world is the *unready-to-hand* mode. In this mode Dasein is in breakdown (Plager, 1994). Something has occurred in the world that interrupts the smooth flow of non-intentional activity and suddenly the normal way in which we engage with our world is unavailable to us (Dreyfus, 1991). In the case of

going to college, were I to receive a failing grade my senior year barring me from entering university that coming Fall, I would quickly be in breakdown. This would be a disruption in my untroubled activity and I would need to reflect upon the disruption, i.e., what a failing grade means in the context of my familial world. The taken-for-granted understandings I had of this world would require re-interpretation to come to new understandings of the situation itself, of my feelings about the situation, and of the immediate actions necessary to return me to the non-reflexive *ready-at-hand* mode; Dasein's primordial way of being (Dreyfus).

As I reflect upon the disruption of the failing grade in my ordinarily untroubled world and what must be done about it, I have entered the *present-at-hand* mode. Here Dasein is in theoretical reflection and intentionality becomes important (Dreyfus, 1991; Plager, 1994). In this mode of involvement, I have stopped studying, stopped panicking and am trying to understand my situation in an intentional and strategic fashion. I become objective in that I want to find a solution to the disruption so that I may return to the *ready-at-hand* mode of being-in-the-world. While I am never completely detached from the emotional content of this situation, as my emotions are important to how I understand and interpret the disruption, in the *present-at-hand* mode I am aware of my engagement with the world; the understanding I seek is explanatory as to how the failing grade occurred and my interpretation is intentional in that I must overcome this so I can continue to on to college.

Modes of Being, Interpretation, and Concerns. As discussed above human beings are always engaged in non-reflective, meaningful activity (Leonard, 1994; Plager, 1994). As we dwell in our day-to-day world, we understand our selves in the world non-

reflexively. It is this effortless understanding that allows us to directly grasp the meaning of our world and have things show themselves as concerns to us (Benner & Wrubel, 1989; Dreyfus, 1991; Leonard). However, it is through one aspect of our understandings, interpretation, that the practical activities of our lives become apparent as concerns or matters of significance for us; through interpretation we come to develop, albeit mutable, feelings, thoughts and attitudes about the situations we are in and the understandings we have of those situations (Plager; Taylor, 1985). Central to our interpretations and therein, our understandings, are the emotions, thoughts and feelings we have about our situation or our experience. The understandings we have of our experiences and the interpretations that arise from those understandings are not independent object representations but are situations complicated by and intertwined with human emotions such as guilt, love, shame, anger, anxiety.

As an illustration of this, I turn, for the last time, to the hypothetical example of going to college. As a secondary student I was non-reflexively preparing for college; my understanding of this concern was immediate. When I received the failing grade my senior year, my understanding was turned upside down and a new interpretation of my understanding of this aspect of my world was required. As I was thrust into the *present-at-hand* mode in an attempt to resolve the breakdown, I was re-interpreting how I understood my future, i.e., life after high school. I did this not only by rationally looking for a solution to my breakdown but through feelings of failure, guilt, shame, anxiety, and ambivalence. My emotions guided the interpretation of my situation and through this interpretation I could formulate how I felt about it and then have some grounds on which to find a solution. My feelings about this breakdown were what led me to develop new

concerns and ultimately uncover a resolution my family and I could live with. It is important to note that interpretation does not just occur in *unready-at-hand* and *present-at-hand* modes as illustrated in this simplistic example, rather we do this continually as we move from one situation into another with our past interpretations and formulations organizing what will reveal itself as relevant, as significant in the new situation (Dreyfus, 1991). Furthermore, understandings and interpretations of being-in-the-world do not occur in context-free environments but are intrinsically linked to world and the temporal nature inherent in Dasein.

Temporality. To be a being constituted by the world means to be a being constituted by temporality. Temporality is not linear, context-free time but rather a sense of time comprised of what concerned us in the past, what matters to us now, and what will present itself as important to us in the future. Temporality is experienced or lived time, in that it is “the time that appears to speed up when we enjoy ourselves, or slow down when we feel bored during an uninteresting lecture” (van Manen, 1990, p. 104). Therefore, temporality is not context-free but linked to the shared cultural and linguistic practices and background understandings we have of our world and how we are in it. Through temporality we make sense of our experiences in the past as they relate to our present and as they give shape to our future. Our experience of time as being-in-the-world opens or delimits future possibilities for us (M. Gudmundsdottir, personal communication, January 25, 2006).

For example, in the case of one of the pilot study participants, Darryl, a permanent injury to his left leg two years ago redefined his possibilities both in terms of a livelihood and in how he saw himself as a man. This was traumatic for him. In the injury

his way of being-in-the-world as a physically strong and athletic man and his concern of being able to defend himself or someone he cared for had been altered. Darryl described how after the injury he tried to develop new concerns, a new way of being in his present and in his vision of the future but in this narrative he articulated how he could not reconcile the manner in which the injury occurred (the past) and the deformed state or “crookedness” of his leg (the present) with how he would live his life under the influence of the former two (the future).

I was kinda real positive about – even though I was injured, and even though I knew I wouldn’t be the same, I was positive in the fact that I wanted to heal as best I could. I was positive in the fact that, even though I wouldn’t be the same, I wanted to try to be, to get myself together as best I could...one day I got out of the shower, and I looked at my ankle and I noticed it was crooked. And that’s when I initially kind of gave up...I was already borderline depressed over it. And that kinda drew – I allowed that to kinda draw me back down, even further, in depression. And I immediately ran – did something I’ve done before. I ran to the drugs. And this time I hit them even harder. Uh. You know, I – I hit them even harder (Darryl, PS:IV#1).

Darryl was concerned with finding a new way to “get myself together” but both his former sense of self and what mattered to him as significant were lost making new understandings and reinterpretations of who he was before the accident and who he will be in the future, after the accident, difficult, painful and perhaps impossible.

The Fore-Structure of Understanding. The final Heideggarian notions as they relate to the interpretive process are that of a fore-structure of understanding and the hermeneutic circle. The fore-structure of understanding is the pre-understanding(s) with which the researcher approaches her project (Dreyfus, 1991). There are three components of this fore-structure. The first is fore-having, the taken-for-granted background or that which is already understood. In fore-having situations are familiar to us because of our background practices (Dreyfus; Plager, 1994). My background

understanding as a nurse practitioner gives me some understanding of what the health care problems for parolees are. The second component of the fore-structure is fore-sight or the perspective from which the interpretation is undertaken. With fore-sight there is a point of view from which to make an interpretation (Dreyfus; Plager). Having worked with parolees in a clinical setting for close to a decade my point of view is that increased health care access would be helpful to their reintegration. Finally, fore-conception is comprised of the expectations or pre-conceptions the investigator already has about the interpretive project including both the questions and the answers (Dreyfus; Plager). For example, as I began my pilot study, I was attached to the pre-conception that all the participants' narratives would be clear and succinct stories about their experiences of health care. I believed this because my work with parolees had always been as a nurse practitioner in a structured clinical setting; the parolee and I focused on his medical problem and worked together as provider/patient in an attempt to resolve it. However, upon changing my role from clinician to researcher, I realized I had only accessed one small part of the parolee's lived experience, that of him attending a clinic for a health problem; the other varied aspects of the parolee's life world were not illuminated for me until I completed the pilot project. Therefore, the researcher's awareness to her own fore-structure of understanding or pre-understandings is crucial as it is her fore-structure that orients to the project and situates her within the hermeneutic circle.

The Hermeneutic Circle. The hermeneutic circle represents the moving back and forth between the part and the whole of the interpretive project and between the primary fore-structure of the researcher and what is being revealed in the data. It is important to enter the circle in the right way and this done through proper orientation to the fore-

structure as well as to the phenomena of inquiry (Dreyfus, 1991; Leonard, 1994). While in the hermeneutic circle, the commitment of the researcher is to remain true to the text and honor the participants' lived experience. There is no "privileged", atemporal and ahistorical view in the hermeneutic circle. The researcher is as co-constituted by her world and her temporality as is the participant. Neither can stand outside history (Leonard, 1994). For me, the proper orientation has been in relation to my growing awareness of the many cultural, historical and social contexts and discourses (Cheek, 2000) that inform and constitute the world in which the participants and I live and awakening to my own positionality as a person of privilege and how that influences the project itself and the representations that come from it.

In their article, "Authoring Social Responsibility", Pilcher and Juneau (2002) discuss how privilege comes through in interpretations. The challenge lies in avoiding collusion with the dominant power structure of which I am a member. I take seriously the authors' call for researchers "to become more and more responsible for creating narratives that frame class privilege or lack thereof as the foundation on which individuals make sense of the worlds they negotiate" (p. 716). My greatest struggle over this course of my doctoral program has been how to do this, i.e. challenging the dominant power structures through my dissertation research while staying true to the underlying assumption of hermeneutic interpretation that in the everyday practical activities of the participants the significance of their lives as framed by the project can be uncovered and then understood (Plager, 1994). I feel that part of the answer lies in continual engagement with the text and practice with interpretation but also in challenging my privileged position through reflexivity (Pilcher & Juneau). Additionally, through the interview

process I have an opportunity to hear the participants' experiences of the power structures within which they are situated whether those structures are in prison, in a clinic, "on the streets" or during the interview. As discussed in Chapter Two, understanding disciplinary power and its operations from the vantage point of the former prisoner can illuminate the marginalized position in which he is placed in relation to positions of privilege and dominance and how existing along society's margins may impact his ability to successfully reintegrate into his community.

The Concept of a Person

I propose that media and political discourses help shape the representation of the criminal as monster within the public sphere; these representations also influence how society will respond to him. Indeed, the representation of criminal as monster has its roots in the earliest history of penal reform. Foucault (1977) describes the 17th century perception of the criminal as one who has breached his contract with society at large, a contract that he himself freely entered into, and therefore must be punished by those in society who have honored their contracts.

Indeed, he is worse than an enemy, for it is from within society that he delivers his blows – he is nothing less than a traitor, a monster. How could society not have an absolute right over him? How could it not demand, quite simply, his elimination (Foucault, 1977, p. 90)?

This perspective grew directly from the 17th century representation conception of subject/object relations; the criminal, the subject, has broken the law, the object, and must be penalized (Foucault). Moreover, as a result of his law breaking he loses his right to personhood and is now conceived of as something else, a traitor, a monster; his right to representation within society as a citizen has been lost and he must be removed from and punished by the society of which he was once a member (Foucault, 1977).

Taylor (1985) in his chapter, “The Concept of a Person” draws attention to the power of the human consciousness in its ability to frame or conceive of representations such as the upstanding citizen or the amoral criminal. Representations within this consciousness are ahistorical, atemporal and acultural; they are context-free. These representations demonstrate one universal or master truth through which all of human behavior can be analyzed and explained. Taylor counters this notion with *original purpose*. In this he means that humans have concerns or things that matter going on as background before they can articulate them as representations or as concerns or understandings. Taylor also takes issue with the separation of anthropocentric properties from conscious experience that was an integral part in the evolution of the natural sciences in the 17th century. He states that emotion cannot be treated as an independent object because it is so often intertwined with understanding. Through the articulation of emotion we come to understand the situation we are in or understand it in a different way (Taylor).

What is most salient in this discussion of the representational theory of human consciousness versus human agency as “openness to certain matters of significance” (p. 105) is the power given to specific representations in U.S. society. Although these representations that give form to one part of our consciousness are, supposedly, unfettered by a “background of significance” (p. 108), they are actually informed by a fore-structure (Dreyfus, 1991; Plager, 1994) that seeks to maintain a dominant power structure that is racist, classist and misogynistic. An example of this is that of the popular media and political representations of the criminal or what I refer to as The Monster Discourse (Farrell, 1996). Pop cultural representations of the criminal glamorize,

commercialize, and sexualize him. It is this shaping, marketing, and selling or *mediatization* (Kleinman, Das, & Lock, 1997) of the criminal image that provides permission to ignore the actual destructive forces of the Prison Industrial Complex. Movies, T.V., music, and some literature poke fun at criminals, as they are not real. These media representations give those on the outside a choice of seeing or not seeing what happens when a person is incarcerated. Popular media representations of what happens to a person inside the prison, neither include nor allow an examination of the larger social contexts in which incarceration takes place such as unemployment, limited education, difficult family life, poverty, drug and alcohol problems, violence, underfunded legal representation and pervasive institutional classism and racism in the law enforcement, legal, educational and health care systems (Cadora, Swartz, & Gordon, 2003; Chambliss, 1994; Golembeski & Fullilove, 2005; Harlow, 2003; Lynch & Sabol, 2001; Lynch & Sabol, 1997; Petersilia, 2003; Solomon, 2006).

Perhaps even worse than media representations of the criminal, are the political ones. The political and legislative world uses The Monster Discourse to dehumanize and then demonize the criminal. Through this dual process of dehumanization and demonization the criminal is no longer viewed as a human being. Rather the criminal becomes a representation of a monster incapable of understanding and interpreting himself and his world; with this move the criminal is no longer due respect that is due all persons – criminal or not (Taylor).

To make someone less capable of understanding himself, evaluating and choosing is to deny totally the injunction that we should respect him as a person (Taylor, 1985, p. 103)

The criminal as monster is a dangerous representation that is clearly grounded in the background practices of domination and control and becomes not just the representational content of our consciousness but possesses power in its ability to fuel unarticulated emotions such as fear and/or uncertainty. The dehumanization of the criminal opens up the possibility of being harmed by this monster; it becomes a thing that matters to us and through our emotional responses we formulate an understanding that this criminal threatens our livelihood and must be banished from the non-criminal society. This is a political representation ostensibly grounded in factual observation, in rationality, about what should be done about the criminal that actually derives its strength from individual agents' unstated emotional interpretations. Background culture and history cannot be escaped and in the U.S., part of that background is the use of 17th Century notions of rational man to play on the deepest and most irrational feelings. By feeling and understanding the criminal as monster the idea of individual human agency is protected while forsaken the agency of the criminal.

It seems to me then that this ambition to follow natural science, and avoid anthropocentric properties, has been an important motivation of the representation view. It gives us an important reason to ignore significance, and to accept a performance criterion for agency, where what matters is the encompassing of certain, absolutely identified ends (Taylor, 1985, p. 109).

One purpose of this dissertation research is to problematize the Monster Discourse (Cheek, 2000) this discourse. Incarcerated and formerly incarcerated people are not just insensitive thugs or “sociopaths” with no capacity for insight. Their biographies are complex and complicated by their thrownness and the world in which they are constituted but also by how the state and the media frame representations of the “prisoner identity and the morality that is attached to it via the distinction between good

and bad selves” (Skeggs, 2002, p. 53). The allure to explain behaviors through a paradigm of natural science provides a foundation for the Monster Discourse, i.e., the rationale for incarcerating people as a solution to society’s ills. The natural science paradigm also is not necessarily the most practical way to understand what actually would impact a person’s reintegration in a positive and effective manner.

Phenomenological Understandings

Phenomenology is interested in a person’s understandings of a specific phenomena and the emotional content that makes up that understanding. This specific understanding or “situation-description” (Taylor, 1985) is the only access available to the phenomena under study and even then will never be fully or completely graspable (Benner, 1994a; Lawler, 2002). Therefore, emotions and feelings as anthropocentric properties help us understand the situations we are in and, if these properties are integral to our understanding, our interpretation and perhaps our ultimate explanation, then we cannot study human behavior and human situations without them.

For example, as I entered the doctoral program I came with the fore-structure of understanding that biomedical services are useful to parolees in their reintegration and that providing more of these services could be a cornerstone of the solution to integration – My fore-structure at its root was a representation conception. Through my pilot study, I came to learn that focusing solely on the health care system and the parolees’ experiences within that system limited the exploration of other problems present in the parolee’s world such as disenfranchisement from family, lack of affordable housing, and limited employment opportunities as well as untreated addiction disorders and the impact of institutionalization. Attempting to document through my research that more biomedical

services would solve the problem of reintegration (my representational view) did not take into account what the experience of biomedical services for the parolee might be. It did not acknowledge that the parolee may have had unpleasant past encounters with physicians or nurses - a feeling that the parolee may bring to his next health care encounter. My representation conception of "more health care as most helpful" did not consider what is significant for the parolee, what matters to him now, what has mattered to him the past and what will matter to him in the future. In my representational view, I defined the parolees' agency as a thing driven by performance criterion, i.e. if a parolee (the subject) needed health care (the object) and it was accessible he would utilize it; his understandings and interpretations of past experiences with health care services were not of primary relevance. However, by understanding or gaining access to the parolee's vantage point on and experiences with health care I can come to know health care, its efficacy and the participants' lived experiences in a different way. To further illustrate the importance of the individual's experiences and interpretations to this research project (and in the study of human behavior and experience), one of the pilot study participants related his experience of a trip to a local county hospital.

She says, "well you got any health insurance?" I said, "I don't have nothing... I am completely lost. I am foreign in this place here. I've been in prison for 10 years. And this place has grown. They built stuff on it. They got me goin' upstairs and then downstairs." The people that were there were nice, you know...She told me, "look this is what you got to do. You can't see anybody here. You got to go to the, uh, a meeting place. I'm gonna take you there and I'm gonna talk to one of my friends and he's gonna... You're gonna need to get this insurance before you can see the doctors." So, I went. She introduced me to her friend. She said, "stay right here." (Paul, PS: IV#1).

Paul had gone to the hospital to get care for his hepatitis C. He had no insurance and had just been released from prison after a ten-year sentence. It had been a very long time

since he had been in the free world and while he was at the hospital, it overwhelmed him. The foreign-ness of the hospital and his feelings of being lost and foreign himself, informed his understanding of how he was to use the system, how the system worked and his role in it. Paul left the hospital without receiving care, even though it was available and there were people willing to help him through the system, and then relapsed on to heroin because the situation was so stressful for him.

As Paul described this situation in the interview, he related it through his responses to the situation; this is how he understood the situation and how he provided access to it. Paul acted intentionally toward the situation in terms of deciding whether to stay at the hospital. However, much of the choice he made around what to do did not come from a criterion based in how he should perform but was moved by his interpretation of the situation he was in. Through his narrative, Paul does what Taylor describes as telling the situation at the hospital in its significance for him; he grasps the situation holistically in that his feelings, cognitions and actions happen simultaneously (Taylor, 1985). The listener gains access to the experience because "we can usually understand how someone feels when he describes his predicament, because we normally share the same sense of significance" (p. 107), i.e. the listener too, holistically grasps the description of Paul's situation.

This is why phenomenology was appropriate for this dissertation project. The researcher or interpreter can share in what has meaning for the participant because she is given access to the significant components of situations that are commonly shared such as feeling lost or like a foreigner. Through the interpreter's representation of that experience others can also gain access to the experience. It humanizes the interpreter in

that she experiences the situation in its significance to the participant. Certainly, the access to Paul's experience is indirect and filtered through the researcher's fore-structures of understanding and by what he chooses to tell but Paul's situation-description was experienced on intellectual and emotional levels as well as on a level that was unarticulated or not so easily described; this is what makes it matter to us (van Manen, 1997).

Through new and different interpretations of how health care impacts individual parolees a new or different understanding of how health care is and is not helpful can be elucidated. As in the case of Paul, being able to access the health system of his own accord was helpful, i.e., he decided the same day that he wanted to go to the hospital and he was able to go. Yet the size of the system was overwhelming for him. He was not ready to encounter it after just having moved from prison - his home for ten years - to the free world. The representational notion of "more health care as most helpful" is problematized through Paul's narrative. Suddenly, the absolute conception of health care as being the most important thing in a parolee's integration became less absolute. Were I to remain in my representational stance, I would have missed the "peculiarly human motivations" (Taylor, 1985, p. 109) like feeling lost that gave the significance to Paul's experience and provided me with a deeper understanding of what a person confronts entering the free community after long prison term. Through the pilot study I entered the parolees' life worlds in a different way; I was no longer looking at them as a clinician but as a researcher and an interpreter. This allowed me to encounter the participants and their life worlds more holistically as well as understand more profoundly that health care is only one possible aspect of their reintegration to the free community.

Creating a Post-Modern Research Text

The Postmodern Influence. In her chapter, “Situating Postmodern Thought”, Julianne Cheek (2000) offers an introduction as to what postmodern thought is and its influence on the 21st century research project. For Cheek postmodern thought is characterized as conceptually unstable in that it does not represent one grand or unified theoretical position (Cheek, 2000). Rather, postmodern thinking is diverse, divergent and often conflicted. Postmodern positions arise from modern thought in that these positions seek to critique and challenge the assumptions of modernity.

For example, one of the principle notions of modern understanding is that history is always progressive, moving forward in both a linear and positive way. This forward progress occurs as a result of all of society working together in an organized and collective fashion. Postmodern thinking rejects this notion and challenges the idea that we collectively agree upon what the common good for the nation state is and are all working together to achieve that good. Instead, postmodernism embraces a “theory of intellectual and societal discontinuity” (Cheek, 2000, p. 19) and acknowledges the existence of multiple perspectives and understandings for any condition of social reality. To think in a postmodern sense is to have an awareness of the constructed nature of society’s “truths” and to begin to dismantle these truths and view them from different vantage points (Cheek, 2000).

Postmodern thought is reflexive thought that forces the writer or researcher to uncover her positions, agendas and pre-understandings that may not be overt in the project at hand. Through reflexive thought that the truths we possess about a subject, e.g.,

“more health care as most helpful”, can be discovered as partial, not representative of an entire phenomenon or as the experience of that phenomenon in totality. There is no one master narrative or truth that unifies us all. Human experience and the reality that comes from it are located in the broad array of cultural, social and linguistic practices and perspectives present in the worlds we inhabit. The postmodern research project seeks out these multiple perspectives of a phenomenon and works to create a representation for the public space that has some degree of verisimilitude while being cognizant that the resultant representation is only one of many (Cheek, 2000).

The Phenomenological Project. The phenomenological project possesses many of the same sensibilities and sensitivities as does postmodernism. There is a concern about the underlying motivations and agendas of the researcher, there is an attention to the myriad understandings of a phenomenon, and there is a commitment to represent those understandings as ethically and truthfully as possible. The research project is taken up with the knowledge that the project will never get at a whole or universal truth about a phenomenon but will only capture discrete aspects of it (Benner 1994; Cheek, 2000). The process of reflexivity is critical to the phenomenological project as a means to address the pre-understandings of the researcher and as one component of methodological validity.

The goal is to study the phenomenon in its own terms, and this requires being critically reflective on the ways that any one set of prescribed methodological strategies, personal knowledge, and social context create a theoretical and perceptual access that influences understanding (Benner, 1994, p. 99).

The researcher or interpreter must be attuned to the vocalized experiences of the participant as well as to what is not vocalized or silent in the participant’s narrative (Benner). The interpreter can never escape the influence that her own taken-for-granted

background and positionality place on the project both in terms of the analytic process and in the co-constructed process of the interview. She must be constantly aware of the differences between her self and the participant, the other. This is an aspect of reflexivity as well as an important component of the interpreter's ethical stance, i.e., to be true to what is happening in the text (Benner).

Because human worlds are historical, cultural and linguistic we can only grasp the experience of those worlds through situated or specific aspects of the lifeworld (Benner, 1994; Lawler, 2002). We understand the other, for this project the male parolee, through specific conditions of his lived experience. The researcher can only understand the conditions of the other's experience through dialogue that is co-created in the interview process. Within the phenomenological interview, the narrative or the story is what gives the interpreter access into a phenomenon. It is important to note that the narratives themselves do not provide direct and immediate entree into the participant's experiences but rather are devices for interpretation and representation (Lawler) both for the teller, i.e., the participant, and for the listener, i.e., the researcher. The listener influences the representation of the narrative as much as the teller does. Over the course of my doctoral studies, I have grown to understand more deeply the co-created dynamics of the interview. I have begun take more seriously the question of how my positionality as a privileged person, as a nurse, as a student researcher and as a white woman influence the participants' representations of their lived experiences. It is important for me to be clear about how my cultural assumptions and background influence the project. My fore-structure of understanding must be patent while dwelling in the experiences of another (Benner).

The researcher makes explicit as many assumptions as possible prior to beginning the study and establishes boundaries to the lines of inquiry for the study, but these must be held tentatively and allowed to be challenged, altered, extended, and transformed by what is learned in the field (Benner, 1994, p. 105)

That initial questions can and should always be challenged is a fundamental discipline of phenomenological interpretation or the analytic process. Interpretive analysis is about continually challenging and evolving the researcher's assumptions and interpretations (Benner, 1994). The analytic drive is to go deeper and deeper until what is most hidden in the text is revealed. The interpretive analysis seeks understanding and the creation of meaning from what is said and not said in the participants' narratives. For me, this analytic process is a form of honoring the participants' experiences. It also a means of challenging the Monster Discourse as, through the interpretive process, I come to know the depth and richness of the participants' lives; they become more to us than one-dimensional monsters as depicted on T.V. and by the body politic.

As discussed above the narrative and the resultant text are the primary data for the phenomenological project and the focus of the analysis is interpretation. In her book, "Interpretive Phenomenology: Embodiment, Caring and Ethics in Health and Illness", Patricia Benner (1994) describes "engaged reasoning in transitions" (p. 101) as a central component of interpretive analysis. To be involved in engaged reasoning in transitions is to be engaged with the text in a process of questioning and reasoning that allows for changes to appear as well as common themes and patterns to emerge. Through engaged reasoning the researcher keeps track of her thinking, her interpretations, when the interpretation changed and why the shift in interpretation occurred (Benner). Engaged reasoning occurs through involvement with the text both as a holistic piece and as

specific parts within it; this is the practice of interpretive phenomenology – an active engagement between the whole text and its parts. Critical to the process of engaged reasoning is writing and rewriting. The continual reading of the text and writing about it illuminates deeper levels of understanding, uncovers aspects of the phenomenon and offers a form of validity in that changes in interpretations and understandings are well documented (Benner; van Manen, 1990).

Phenomenological Validity – Mantic Meaning

Phenomenological understandings are what ideas feel like (van Manen, 1997, p. 367).

This is a concise and beautiful statement about the central aim of the phenomenological project. It comes at the conclusion of van Manen's (1997) article, "From Method to Meaning" but it encapsulates his discussion throughout the article regarding semantic and mantic meanings in the research text and in the interpretive project itself. In creating phenomenological understandings within a text, the interpreter does not strive for succinct summations and conceptualizations of the phenomenon under study but rather works to create semantic (thematic) and mantic (prophetic, what is unseen but felt) meanings from the text. It is the tension between the semantic and the mantic meanings in the text and how those meanings arise that give the phenomenological research project its potency. Without this tension the text feels empty, as it is powerless to break through the taken-for-granted qualities of daily life (van Manen). To achieve a phenomenological analysis that instantly illuminates the unseen meanings of everyday life the researcher can access the five textural or mantic features of a text: lived thoroughness, evocation, intensification, tone and epiphany (van Manen). It

is important to note here that this is not the sole way of constructing a powerful research text (Chase, 2003; Lawler, 2002). It is, however, the one that has the most meaning for me as a framework for authoring a text that touches the reader on both an intellectual and an emotional level.

Lived thoroughness contextually locates the phenomenon in the everyday world so the reader recognizes it experientially, i.e., the reader shares the experience of the phenomenon with the participant. Lived thoroughness places the reader in the middle of the participant's reality so that the reader may grasp the participant's concerns as in the case of Paul who was lost and feeling like foreigner in the setting of a large hospital; the grasp, however, is always partial. *Evocation* brings the experience of the phenomenon "vividly" to life so that it becomes available to the reader as a thing upon which to reflect (van Manen). *Intensification* uses language to thicken the layers of meaning deeply embedded within the text. Words are carefully chosen and literary devices such as alliteration, consonance, and sentence structure are employed to enrich a lived reality and the interpretations that come from it. For me, DW's telling of his crooked ankle is a beautiful example of the "acoustic richness" (van Manen, p. 358) that can come from the intensification of language. His use of language and repetition allows the reader to access and understand Darryl's situation in a meaningful way. Through his use of language the positive way with which he initially faced the world was understood as only a superficial layer to his profound sense of loss. As he described his crooked ankle, the reader gained an understanding of why he returned to his old ways, back to the drugs.

Tone is the voice of the text. Tone is what addresses the reader and provides both the concrete or cognitive purpose of text as well as strives to reach the reader's non-

cognitive modes of knowing (van Manen, 1997). For example, the tone in Darryl's narrative is quite tragic as he described his attempts at learning how to develop new concerns for himself after his injury but was unable to do so. It is through tone that the interpreter can realize the transformative effect of epiphany within the reader. *Epiphany* is the ultimate aspiration of the phenomenological project. Epiphany occurs when the text transforms the reader and the meaning within the text is suddenly clear to the reader on a pre-cognitive level. In my brief analysis of Darryl's narrative presented in this paper, I tried to illuminate the unspoken meaning of Darryl's experience so that the reader would begin to grasp the significance of his injury non-reflectively (van Manen). While, this example was very unformed, it demonstrated what I hoped to achieve with this dissertation project: that through my interpretive writing the reader would arrive at an intuitive meaning of the participants' interactions with the health care system while on parole. The meaning of the experience would reverberate within her and, hopefully, create an epiphanic effect. It is through this epiphany that certain aspects of the parolee's experience become recognizable to the reader as similar to her own therein humanizing the parolee in a new way.

Although I have presented the mantic features of the text as separate concepts, in the actual writing of the phenomenological text these textual figures are intertwined with one another; they are conjoined and in tension with the semantic aspects of the text as well. The mantic and semantic components of the text are not separated but rather give life to one to another. Through the skillful application of language and responsibility as both author and reader, the researcher creates a text that illuminates what is not seen in the daily taken-for-granted aspects of the phenomenon in a way that is both conceptually

useful (semantic) and deeply understood (mantic). Therefore, the challenge of phenomenological validity lies in the interpreter's ability to create a text that possesses lived thoroughness, evocativeness, intensity, tone and epiphany (van Manen, 1997).

Conclusion

...if we return to my discussion above of our emotions, where I said that they incorporate in a sense a view of our situation. To experience an emotion is to be in a sense struck or moved by our situation being of a certain nature. Hence, I said, we can describe our emotions by describing our situation (Taylor, 1985, p. 107)

...the phenomenologist does not present the reader with a conclusive argument or with a determinate set of ideas, essences, or insights. Instead, he or she aims to be allusive by orienting the reader reflectively to that region of the lived experience where the phenomenon dwells in recognizable form. More strongly put, the reader must become possessed with the allusive power of text-taken, touched overcome by the epiphanic effect of its reflective engagement with lived experience (van Manen, 1997, p. 367)

Over the course of my doctoral studies both Charles Taylor (1985) and Max van Manen (1990, 1997) have influenced my understanding of phenomenology as philosophy and as method. It seems fitting to conclude this section with the above quotes as they exemplify two important points of phenomenological understanding. The first is that it is through the emotional content of our thoughts we come to understand the situations we are in and the concerns that present themselves within those situations. To study human behavior and human experience is to study the anthropocentric properties of an experience and the understandings that come from those properties through narrative interpretation. The second point of phenomenological research is to create a meaningful and valid interpretive text that orients the reader to understandings that are not immediately available within the text. The interpreter as author encourages the reader to reflect upon the allusive or indirect qualities within the text and through that reflective

engagement the reader comes to profoundly and intuitively know the aspect of the lived experience under study.

Research Design and Methods

Study purpose and specific aims. The purpose of this phenomenological study was to understand how health care access affects the community reintegration of male parolees. The specific aims were to: 1) examine the health beliefs and practices regarding general health care and specific medical conditions from the perspective of the parolee; 2) identify the perceived barriers and facilitators parolees encounter in their efforts to access health care services in their communities; 3) describe the perceived impact of health care access on community reintegration from the parolee's perspective; and 4) identify specific events while in prison or on parole that may have affected the community reintegration of the parolee, in addition to health care access.

Design. Interpretive phenomenology guided the conduct of the study and the analysis of the data. A prospective interpretive design with repeat interviews with 17 individual male parolees was conducted.

Sample and Setting

Participants. The sample was comprised of 17 men aged 40 to 65 years. The participants' average age was 48 with the youngest being 40 and oldest 62. They identified their health problems as hepatitis C, HIV/AIDS, diabetes, hypertension, coronary artery disease, depression, anxiety disorder, bi-polar 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. Two of

the participants had disability benefits for medical reasons and one received disability benefits as a result of his bi-polar disorder. 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 to two times (range 1 to 5 parole supervisions). Fifteen of the participants completed two interviews 90 minutes to two hours in length. Two of the participants were lost to follow-up after leaving the facility where the study took place. At the time of the interviews participants had been in the community an average of 5 months (range 2 weeks to 24 months). Participants were excluded from the study who were actively psychotic as they were unable to give informed consent.

Recruitment. I received permission from a 32-bed transitional housing program for men on parole located in northern California to recruit study participants. The program enrolls approximately 80 to 90 individuals per year. The Program Coordinator of the program was in support of this research proposal and assisted with study recruitment. I also attended house meetings and presented the research project to the residents. Posters with information about the project and contact information were posted at the site. A \$20 per interview incentive was offered to participants. Interested individuals discussed the goals and specifics of the study with me. If an individual chose to participate, written informed consent was obtained prior to the first formal interview. The goal of the study was explained during the consent process.

Setting. The individual interviews were conducted at the program.

Procedures

Data Collection and Analysis

Data Collection

Individual Interviews. Seventeen participants were interviewed twice approximately two to three days apart. Two of the participants were unable to participate in the second interview. The short intervals in between interviews were due to the high relapse and rearrest rate amongst the participants. A total of 32 interviews were completed. All interviews were audio recorded. Individual interviews included reflexive and narrative questions. I also kept field notes and a reflexive journal. Field notes were recorded immediately after the interviews and entries in the reflexive journal were completed alongside the data analysis.

The background and specific aims of the study were addressed over the course of two interviews. The first interview addressed the history of the informant's incarceration and included questions regarding health beliefs and practices (specific aim 1) and perceived barriers and facilitators to health care (aim 2). Content included reflexive questions regarding the history of the present illness/es and barriers and facilitators to health care as perceived by the informant. Narrative questions regarding health beliefs and practices and experiences accessing or not accessing health care were asked. The second interview focused on the perceived impact of health care access (aim 3) and specific events in prison or on parole that may have affected reintegration (aim 4). Reflexive questions addressed the informant's perception of how health care access may have affected reintegration and if health care was perceived as beneficial to reintegration. Narrative questions focused on specific events in the life of the informant that may have

impacted his ability to complete parole. Narrative questions focused on events in prison, on parole, within the informant's family or social network, and/or successes the informant may have experienced.

Interview Schedule. Interviews consisted of reflexive and narrative questions. The purpose of reflexive questions was to create an opportunity for the participant to reflect upon the knowledge and understandings he had about his lived experience (Chesla, 2005; van Manen, 1990). Reflexive questions allowed the participant and the researcher to reconstruct the meanings within the lived experience as they related to prison and parole, health and illness, and health care access and community reintegration (van Manen). Reflexive questions were asked about the informant's health beliefs and practices regarding general health care and specific health conditions, and perceived barriers and facilitators to health care access. These questions permitted exploration of the participant's ideas and knowledge about health, illness and health care access. Reflexive questions also allowed the participant to discuss the history of his incarceration and his ideas and understandings of the community reintegration process.

Narrative questions invited the participant to narrate current or past experiences. Narratives captured the informant's knowledge, strengths and skills gained through the lived experience (van Manen, 1990). For example, "Have you found a way to take care of your health problem(s) without regular health care? If yes, how did you learn to take care of yourself? Can you think of a specific story about how you learned to take care of yourself?" Narrative accounts were stories of everyday life that uncovered the participant's situated understanding organized by the social world he inhabited. Narratives served to explicate the elusive or unstated aspects of the lived experience (van

Manen, 1990). Narratives were large complex stories of several events as well as brief, concise stories of a single occurrence (Chesla, 2005). Narrative questions about the person's experiences with the health care system, and the perceived impact of health care access on community reintegration were asked. Additional narratives about specific events in prison or on parole that may have affected the participant's reintegration were also elicited.

For both sets of interviews, the least structured approach was employed. Participants were encouraged to narrate an entire incident without interruption. Probes were used to facilitate the informant's complete narration of the experience. As with all interpretive interview procedures, individuals had the right to refuse to answer any question.

Data Analysis

Interpretive Analysis. Analysis of interpretive data was done via thematic analysis and narrative analysis. Thematic analysis was parallel to but not separate from narrative analysis. Both thematic and narrative analyses relied upon the concepts of the hermeneutic circle, pre-understanding as a starting point for interpretation, and the comparative nature of the project (Chesla, 2005; van Manen, 1990). The hermeneutic circle represented a holistic interpretation of the text. Inherent in this interpretation was a detailed reading of the text. Interpretive analysis was characterized by a continual examination of the whole text, then its parts returning to the whole text once again (Chesla, 2005). Pre-understanding was another aspect of the hermeneutic circle. It exemplified my understanding of the text from an initial awareness to the current knowledge and theoretical perspectives of the phenomena under investigation (Chesla,

2005). Comparison of cases was central to interpretive analysis. In this project, a “case” was one informant (with two interviews) and his responses to health and illness, health care access and community reintegration. Once a case was understood in its entirety, it was compared to other cases. Comparative analysis elucidated the patterns of similarities and differences among the cases. These patterns formed the foundation of the descriptive findings.

Thematic Analysis. There were three components to thematic analysis: (a) the holistic approach, (b) the selective approach, and (c) the line-by-line approach (van Manen, 1990). The holistic approach was used to capture the text’s overall meaning. The selective approach focused on areas of the text that represented revealing or essential qualities of the phenomena being studied. Finally, line-by-line analysis was a detailed reading of the text that clarified any hidden or yet unrecognized aspects of the phenomena (Chesla, 2005). The three levels of thematic analysis ensured a complete examination of the text was done from its totality to its subtleties. Themes about participants’ health care practices and beliefs and their perceptions of the barriers and facilitators to community health care access were revealed. Findings regarding how the participants perceived the impact of health care access on community reintegration were also uncovered. Themes also emerged about specific life events that informed the participants’ life in the free community and reintegration process.

Narrative Analysis. A holistic content approach was used for the narrative analysis. This approach focused on specific aspects of the narrative: (a) the situation’s context and background, (b) how the situation unfolded, (c) the narrator’s emotional tone and expression throughout the narrative, and (d) the narrator’s retrospective reflections of

the situation (Chesla, 2005). Concerns apparent in the narratives were also explored. For example, did the narrative express the parolee's concern about being ill and having no access to community health services? Interpretations of these concerns provided an understanding of how the participants' care for and live with chronic illness while on parole. Narrative analysis also reviewed the text in regards to: (a) the demands that the problem placed on the individual, (b) the concerns expressed in the individual's statements and actions, (c) skills and resources used by the individual to solve the problem, (d) actions taken and rejected in solving the problem, and (e) the ultimate resolution (Chesla). Holistic interpretation of multiple narratives from an entire case identified general patterns of meanings, concerns and practices for that individual. Narrative similarities within and among cases increased the power and complexity of the interpretation. The narratives revealed the strengths and skills of the informants regarding their health care practices. Narratives also revealed the challenges and struggles encountered by the informants while trying to access health care in the free community.

Rigor in the Proposed Research. Furthermore, a reflexive journal was maintained in order to document transitions in thinking and conclusions made about the data. The reflexive journal and continual process of writing throughout the data analysis was what Patricia Benner (1994) described as "engaged reasoning in transitions" (p. 101). It was a central component of this interpretive analysis. To be involved in engaged reasoning in transitions was to be engaged with the text in a process of questioning and reasoning that allowed for changes to appear as well as common themes and patterns to emerge. Through engaged reasoning I kept track of my thinking, my interpretations, when the interpretation changed and why the shift in interpretation occurred (Benner). Engaged

reasoning occurred through involvement with the text both as a holistic piece and as specific parts within it. Critical to the process of engaged reasoning was writing and rewriting. The continual reading of the text and writing about it illuminated deeper levels of understanding, uncovers aspects of the phenomenon and offers an additional form of validity in that changes in interpretations and understandings were well documented (Benner, 1994b; van Manen, 1990). I also shared aspects of the analysis with my advisor. This collaboration was useful in providing new insights and challenging my understandings about the analysis. Additionally, I employed five independent readers to review the findings chapters of this project. Two readers were unfamiliar with the subject and research methodology, one reader was provided housing and supportive services to homeless and formerly incarcerated individuals, and other was a doctorally-prepared researcher quantitatively examining the health care needs of parolees. The final reader was himself a formerly incarcerated person and recently completed his mandatory parole supervision. The readers provided commentary on the clarity and impact of the project as well as raised questions about the findings that further enhanced my thinking about the specific results and the project in general.

The primary means of ensuring validity in this proposed dissertation is grounded in van Manen's (1997) mantic meaning as described in his article, "From Method to Meaning". Mantic meaning was concerned with elucidating the phenomenological understandings within such a text. Here, I worked to create semantic (thematic) and mantic (prophetic, what is unseen but felt) meanings from the text. It was the tension between the semantic and the mantic meanings in the text and how those meanings arise that, hopefully, gave my project its potency.

Management of Data. The software program, ATLAS-ti, was utilized for management and analysis of qualitative data. Audiotapes were transcribed verbatim. Electronic backup and paper copies of data were maintained. All audiotapes, electronic and paper copies, field notes and the reflexive journal were kept in a locked file cabinet in my home office of which only I had the key. The data key for the participants' study identification numbers were kept in a location separate and secure from the audio recordings, field notes and reflexive journal. Any electronic data was protected with a password and stored in a secure network. Furthermore, once the interviews were transcribed and the study was completed, the audio recordings were destroyed.

Potential Limitations. Because older and younger men were not included in this investigation, the results have the potential of reflecting only the experiences of middle-aged men. This study only included individuals paroled to Northern California and may not be reflective of other areas. It was limited by total participant recruitment from one site. All participants were actively seeking an improvement in their circumstances; the perspective of those who were not currently engaged in the process of change was not represented. These results may not be generalizable to those still actively involved in a criminal and correctional life. Additionally, while the centrality of drug use in participants' lives was apparent, a comparison group of men with addiction disorders who were not involved in the legal and correctional system was not possible in this study. Future research is warranted to address the differences in engagement in the health care system with those who have a history of substance abuse versus those who have been incarcerated. This study also did not include women or foreign-born individuals and will not adequately reflect the reintegration needs of these groups. This study was the first

step in understanding the reintegration experience from the perspective of middle-aged male parolees and should be replicated with other incarcerated and formerly incarcerated populations.

Risks and Benefits. No adverse events occurred as a result of participating in this study. There were also no direct benefits. However, study participants may have benefited from their participation in the research in that they had the opportunity to talk about their health care and personal experiences while in prison and on parole. They may have also benefited by taking part in a project designed to contribute to the understanding and improvement of their situation. This study was associated with minimal risk and had potential to enhance understanding about the health care needs and services that are beneficial to the community reintegration of male parolees.

Every effort was made to protect the participants' anonymity and confidentiality via the use of numeric identifiers and disguising distinguishing characteristics in any reports. Finally, a Certificate of Confidentiality from the NIH was obtained to add a further layer of protection for any sensitive information the participants' may share during the research process.

CHAPTER 4: CORRECTIONAL SYSTEM EXPERIENCES AND ADDICTION PRACTICES

Introduction

This chapter will discuss the correctional system experiences and addiction habits of the participants. Understanding the roles that the correctional system and addiction disorders play in the participants' lives is essential to explicating their health care practices and beliefs and often cannot be separated from their health concerns. Therefore, this chapter will focus on participants' incarcerations and drug addictions. The first section will address the processes by which the participants become habituated to the correctional system. Section two will address the addiction practices of participants and how these practices structured and supported their time in the free community. These findings reveal that drug use frequently overshadowed health concerns and prison served as a respite punctuating time on the streets marked by alienation, social withdrawal, and failure. Throughout this chapter narratives will provide evidence of the co-mingling of participants' correctional experiences and addiction disorders with their understandings about their specific illnesses and their lives in lives in general.

Correctional System Experiences

Individuals do not shift seamlessly from prison to parole to reintegration but frequently repeat the same cycle of prison, parole, reincarceration for long periods of time. Participants articulated the repetitive quality of the correctional system experience in their narratives. The following section elaborates the primary ways in which participants' became accustomed to the dehumanizing and severe conditions of the correctional system that would ultimately evolve into a dependency upon the system.

After multiple and prolonged incarcerations participants recognized that the prison provided resources, structure and support unavailable to them in civil society. Perhaps most detrimental about such dependency were the habituated adjustments participants made in order to initially tolerate the bleak conditions of prison life. These adaptations were needed in order to cope with the erosion of personal power and agency, the loss of privacy and dignity, and the continual threat of violence that were inherent aspects of the incarceration experience.

Necessary Adaptations

Participants responded to the demands of the correctional environment via necessary adaptations. These adaptations were practical and psychosocial responses to the harsh conditions of prison life. Three primary adaptations were revealed 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 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 two themes are presented together. Aggression was characterized as an adaptation to the violent conditions of prison life. An aggressive or predatory stance towards other inmates provided a form of self-protection and ensured some semblance of status within the institution, i.e. the aggressive inmate was not disrespected or taken advantage of.

Acquiescence and Inaction. Mark, a 62-year old Puerto-Rican American, had been diagnosed with Hepatitis C virus (HCV), depression and SUD-heroin. He had a

long incarceration history beginning in New York State in the late 1960's. At the time of the interviews he had been in the free community for one month after being discharged from an in-custody drug treatment program. Mark had been in California since the early 1980's and spent much of that time traversing between prison and the free world. He was able to achieve some sort of stability for brief periods of time in the free community but the majority of his time on the streets was characterized by drug use, isolation, and feelings of hopelessness, worthlessness and inertia. Although Mark's upbringing and childhood had been difficult and defined by loneliness and alienation, his time in the correctional system solidified his sense of his life as meaningless and ineffectual. These feelings were related to having to forsake his personal ethics and moral agency and acquiesce to the correctional institution's violent and coercive practices. Mark described this loss as having his "moral values" taken from him.

R: ...And I seen guards over there beating up on guys, you know what I mean? Blood all over the floor, you know? And then they trying to clean it up. They had me going to the, to see the internal investigation unit, something like that. Had I seen what...what happened when they beat up this white kid, and they were mostly Mexican guards, you know? And they beat him up. They almost killed him. It was in the papers, and they said that he fell. [Chuckles] They - that's the way they fix things up all the time. But we went down there, and I told her, the special investigator, I said, "Listen...I didn't see, I didn't hear, I don't know ... I'm in jail. These people in here can do whatever they want with you," you know? And nobody would know the difference, you know? You know. And never nobody would - they might question it, but who's to say different, you know...they have the upper hand...So they can get away with murder. And you, and you have to be on your P's and Q's for that, you know? 'Cause it can happen anywhere in, in California, you know, in these pens. And they can blame it on a inmate. You know? But they create that. You know? They create the insecurity, you know? They, these people, they take their moral values from them. Whatever - you have anything good in you, they'll take it from you. You know? (P4: Mark IV#2 Line 459)

Like many participants, Mark observed that the correctional institution employed violence, the threat of violence and the power to obfuscate violence as a means to silence

and unnerve inmates. This put Mark in a position of insecurity and inaction for fear of retaliation from the correctional staff or other inmates. His desire to assist with, defend against or bear witness to harm to another inmate was often muted and denied as speaking or acting on the behalf of another inmate would always have negative consequences. This social withdrawal and the muting of emotional responses to violence and harm done to others were adaptations to prison life that became embodied by Mark.

In the above narrative Mark was powerless against the guards both in attaining any sort of justice for the young inmate and in protecting his own life. With the loss of his moral values also came the loss of his personal sense of responsibility. Mark wanted to speak the truth of what he knew about the incident but his moral accountability had been replaced with fear and the basic instinct of survival. The situation Mark found himself in was futile. The system had created this feeling of instability and uncertainty as a means of control by evoking a sense of helplessness, fear and paranoia in Mark. Mark was driven to inaction for fear of retaliation and this, in his view, was how the correctional system took his personal sense of values and accountability from him. He could no longer do the right thing. Instead he was forced not only to look away but also to collude with the perpetrators of the crime and with the system itself.

In a subsequent narrative, 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 heart attack and death of another inmate. In this narrative Mark was hospitalized in the prison's skilled nursing facility. He was treated there after falling off his bunk and suffering 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... So I finally went and sat down and laid back down, and ... this guy (another inmate) walks down. See, the guys that have AIDS up there, they live there. In the, in the medical ward, right? And they're the ones that do all the work up there... Like clean up and stuff like that. So one of the one guys with AIDS that was cleaning up the hall, he got up to the guy's door, right? And he starts, "Man, ... this fuckin' ole man, ... He's makin' doo doo on the floor...", ...and he gets the guard. And the guard comes, and they open the guy's room. He was dead... So that's what 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. Like... for instance, me, since I was across the guy, they made me sign papers.

I: What were you signing?

R: Like saying that if, if 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 the people that was around... maybe two or three other rooms... they had the people (other inmates) to sign papers too that they didn't - 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? (P4: Mark IV#2 413)

This incident was traumatic for Mark. He had witnessed other brutality in prison but this was different, perhaps worse. Mark was forced to participate in a conspiracy around the death of someone whose life could have been saved had the system not been so neglectful. As with the young inmate beaten by the prison guards, Mark saw the suffering of another human being and was unable to do anything about it even after the fact. He was in a moral paralysis resulting from the institution's protectionist and bureaucratic processes. Mark had the sense that the man across the hall might have been

saved had the cell door been unlocked or a staff member more quickly alerted to his distress. Mark also saw his own susceptibility and endangered position in this other inmate - a man of similar age and circumstances. Mark's vulnerability and powerlessness contributed to his understanding of how his own moral values had been stolen from him. Concomitant with this loss were feelings worthlessness, hopelessness, and failure. For Mark, the alteration in his moral principles signified an impotency in his ability to act on behalf of a fellow inmate while knowing that the other inmate was impotent as well; moral or right action was pointless and acquiescence and inertia, the smartest and safest way to proceed.

Robert, a 40-year old African American with a seizure disorder and addiction to crack cocaine, also articulated a sense of acquiescence and inaction in response to the prison system's inattention particularly in regards to addressing his health care 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, you know what I mean, and they kinda downplayed it, and I kinda went along with it. [Laughs]
 I: And why do you think you went along with it?
 R: It made it easier. It made things easier...because whenever you have to - like I guess in prison or in jail, whenever, you know, they have to stop what they're doing to take you to medical and all that, it makes more work on them, so it makes more work on them, 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. (P10: Robert IV#2 10:4 106:108)

Robert did not believe he was morally bankrupted by his prison time but his complicity with the system shaped how he managed his health problems. While incarcerated Robert did not receive more than perfunctory evaluations and his medication

was prescribed thoughtlessly. Robert was aware that the prison health system was not seriously addressing his seizure disorder and he accepted this. Robert had no power either to resist the prison health system's disregard of his seizure disorder or to effect any change around his care. 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. Therefore, Robert acquiesced and did nothing. Additionally, Robert was not acutely or seriously ill making it easier for the system to dismiss his health problems easy 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. Like the prison itself, Matthew used violence and the threat of violence to maintain some semblance of control over his surroundings and his own personal safety.

R: ... And I can say when I first went in, prison made me a very violent person. You either go and prey on someone or you gonna be the prey... it 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 P number (his 3rd conviction), I still had some mental issues that I was dealing with. I didn't never get myself really any time on the street because I got comfortable with prison.

E: What were the mental issues that you were dealing with?

R: Being locked up so much...seeing a lot of things that fucked me up, you know? On my E number [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. What the fuck have I gotten myself into? To where a week later, I'm still fucked up. 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.

I: So part of the way that you learned how to manage in prison was that you learned how to be violent against others.

R: You have to. You...would prey on someone or they would prey on you.
(P26: Matthew IV#2 26:4 82:102)

The first time he saw someone stabbed, Matthew was shocked. While everyone around him looked the other way during the stabbing, Matthew was shaken. He knew that he had to acclimate quickly to the commonplace violence and the inertia of the other inmates was he to survive. It took time before he was inured to his violent surroundings both in the sense that he would not act or respond to the violence happening around him and by the fact that he was not afraid to be the perpetrator of such violence.

Adapting to the amorality of prison life did not come naturally to Matthew and although he learned over the course of several incarcerations how to be violent this means of survival left him emotionally and mentally disturbed. 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; he buried his inner responses to what he was doing in order to keep himself safe.

Louis, a 50-year old white man, further articulated the necessity of choosing to be predator versus prey in his own experiences of institutional violence. Louis had been in the community for 10 months at the time of the interviews, the longest he had remained in the free world since his late twenties. His health problems included anxiety, depression, hepatitis C and an addiction to heroin. He had also lost his right hand in a work-related accident over twenty-years ago. He spoke to the liability of developing relationships with other convicts. Louis believed that there was no benefit from and usually some risk in trusting those around him, as there were no selfless exchanges in prison. Louis was reflexive in this narrative and did not speak specifically to what he had done and what had been done to him in order to obtain what he needed whether it was

something for comfort or for his own survival. However, this passage illuminated the isolation and alienation from others and the readiness for aggression as a necessary adaptation to prison life.

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, but... I could say this today, that I've hurt a few people... Anyways, 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. You know what I mean? 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? ... And the way I look at it is if I wouldn't have done a couple things that I did, 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. Which is true... I mean don't get me wrong. I'm not saying I killed nobody. 'Cause I never did. But I'm just - I hurt a couple people, just like I've gotten hurt before, you know? (P14: Louis IV#2 14:16 367:377)

Louis intimated that he had been violent towards other inmates in order to stay alive while incarcerated. Over the course of both interviews, it became clear that Louis had been party to multiple episodes of violence and he was conflicted by his actions. However it was 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 and impish man missing a hand – all things that suggested he would have been a target in prison.

I've been doing time for a lotta time, a lotta years. So I just built up this thing. I've been caught off guard a few times, where it really hurt me, because something happened where if I would have been more aware of what's going around me, I wouldn't have been hit like that. I seen my life come in front of me probably about three or four times already. By not paying attention. So I really try to be - be aware of my surroundings. And if I'm not comfortable around something, in a room or whatever and that, I'll either get outta there, real quick... I'll even start sweating, sometimes... And I don't like it. It bothers me. (P16: Louis IV#1 16:10 345:349)

Throughout his narratives Louis articulated fear and paranoia of his surroundings and other people as result of the aggressive behavior and attitudes he developed to manage his time in prison. While there most likely was some truth to his allusion that he had harmed others in order to stay alive, Louis' anxiety was also an expression of how threatened he felt by the predatory quality of social relations in prison. He could trust no one, leaving him isolated and withdrawn from social interaction with his fellow inmates. The isolation and distrust he experienced increased his anxiety, as there was no one he could turn to for reassurance or protection; he had no personal relationships.

Conclusion. The preceding narratives illuminated three adaptations to the correctional environment. Each adaptation was a way in which participants managed and protected themselves against the coercive nature of prison life. However lifesaving these adaptations were within the context of the correctional facility, they became sources of emotional distress and despair as participants forsook their personal agency and ethics in order to cope with their incarcerations. The correctional institution hardened the participants' moral and emotional responses. As a result, participants experienced social alienation, anxiety and hopelessness. Over time, these adaptations, and the emotions attached to them, were embodied by participants and impacted how they functioned in civil society. Participants' in-prison adjustments and alterations to themselves made their transition to life in the free world arduous; frequently a return to prison was a welcome thought in the face of the rigors and demands of free society.

Dependence

Complicating participants' situations further was that, after multiple incarcerations, they had become immune to the indignities of prison life and comfortable

with its exploitative atmosphere. Therefore, participants accepted the ways of the correctional system, and prison ultimately became the one they place where they themselves felt accepted. Prison offered a familiar respite from the outside world but was an overwhelming and unwelcoming place to be. Participants described their apathy towards their lives on the streets, their inability to relate to others in a positive way, and their acknowledgement of prison as one of the few places where they belonged. Over time, participants not only accepted the rigors of prison of life but grew dependent upon them as well.

Dependence occurred when participants relied on the correctional system to meet basic needs of daily living, needs that they could not meet independently, e.g. food and housing. The correctional system provided the framework on which participants structured their lives and without that framework many were unable to manage their lives particularly in the free community. The patterns of dependence revealed in the data were 1) reluctant acceptance and 2) complete reliance. With reluctant acceptance, participants did not want to acknowledge their acceptance of and reliance on the dehumanizing practices and protocols of the correctional institution. Yet, they were aware of their inability to succeed or even to remain in their home communities for long periods of time. Mark, Matthew and Louis provide salient examples of reluctant acceptance. Complete reliance was the understanding 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 participants were unable to see beyond their experiences of prison and parole. Luke and John clearly articulated this kind of reliance upon the system.

Reluctant Acceptance. Mark, Matthew and Louis most clearly articulated the processes by which they reluctantly accepted their lives as inmates and their resultant inability to craft lives for themselves in the free world. In the following narrative, Mark described how he grew to accept the dehumanizing and embarrassing procedures of prison life such as communal showering.

I: And do you feel your moral values have been taken from you?

R: Well, let's say like when you take a shower with a hundred men? You know? ... you have to overlook a lotta that stuff ... There's a lotta people that can't deal with that in prison.? They...wash themselves in their cell...Because they can't - they don't know how to deal with that. (P4: Mark IV#2)

Privacy in prison was non-existent and the communal shower was one of the most glaring examples of this. Mark was herded into a shower stall with other men. They jockeyed for position and had physical contact with one another in order to clean themselves. Personal bathing habits normally completed alone and respected as a private activity in the free world were laid bare before other men, many of them strangers or individuals one would have wanted to avoid on the streets. Showers were mortifying and humiliating to such a degree that many inmates could not cope with the physical proximity necessitated by showering in a small and confined space.

I: How did you deal with it? How did you deal with those things?

R: What I've been doing, going to jail since a long time, and, and now it doesn't bother me. I just try to take it out of my mind... I kinda look at it as part of the process...Like when they give you a strip search and the cavity checks and all of that, you see guys that really...looking at them and their makeup that they, that they, they never had this experience before. They don't know how to act...

I: But it seems that, for the most part, you learn how to deal with it.

R: Yeah, and you're immune from it...the thing is that you expect it.

(P4: Mark IV#2)

The dehumanizing processes of prison life, e.g. cavity checks, were no longer mortifying or humiliating. Mark had become inured to the denigrations of incarceration.

The loss of privacy at the most basic level was no longer a punishment or even very troubling. Mark had been in the correctional system since the 1960s and the cavity search was part of the routine. He knew how to handle it unlike other inmates newer to the system, who balked at the indignity of being so invasively touched. Mark disassociated or removed himself from what he experienced in and out of prison. He understood that the system did not care about him as an individual. He was no different from any other inmate and was treated with same processes and procedures as everyone else. Although Mark had accepted prison's continual inspection and surveillance as part of his life, it was another way in which his moral values were taken from him by the institution; he was no longer allowed dignity.

The loss of Mark's moral and self esteem both in regards to his capacity to look out for and support other inmates and to his personal sense of dignity had become an embodied quality of how he related to the world in and out of prison. While he did want something better for himself he had also disengaged from what happened to himself on the streets. Mark's sense of his own self worth and personal identity had been shaped and limited by his experiences in the correctional institution; this, in turn, informed his experience and understanding of street life.

I: And do you think that for you that experience is what makes life so difficult on the streets?

R: Yeah, sometimes...because you don't care. You get outta those places (prisons), it's just like you don't care. And if you keep going back, it's like you, you know already what the routine is. You know what they're gonna do to you.
(P4: Mark IV#2)

However unnerving and denigrating his experiences in prison may have been, it was the correctional system that had given him some semblance of stability and community.

Mark belonged there unlike on the streets where he drifted alone and isolated. Mark's

time on the streets was influenced by waiting to go back to prison, to go back to the accepted routine.

Mark also expressed a sense of isolation and not caring about himself on the streets. Although he does not overtly state this, his time on the streets was spent waiting to return to prison – the one place that provided him with structure and a sense of his self he did not have in the free world. For Mark, the alienation he experienced in prison persisted more deeply on the streets than during his actual incarcerations.

I: So how do you see yourself in relation to all this time that you've done in prison?

R: Uh, really. I've been doing this since I was 15...Everything that I do in the street is like a reflection kind of my life in prison, except...it's mind-altering, you know? Everything that I want to be and I would like to be I can't be. And maybe I just set barriers on myself...Maybe I'm too, not impatient or patient...But I just don't care. Most of the time...Because I know nothing good is gonna come of it.

I: You don't care about yourself and your situation?

R: Yeah. Most of the time on the street I don't care. You know, and, and when I think about it, I reflect on it, and I go somewhere and sit down and think about it, ... I ask myself...why I'm like that...Like I talk to myself, like the man in the mirror...And I can't see anything good of it. And, and the same thing is like with my family, my daughters and my grandkids, and the way I was brought up with my stepmother and stepfather. I think about that, you know? 'Cause I was always alone. And, and - with my daughters and my grandson, and stuff like that, I stay away from them...Because I, I think that I'm a bad influence. Even though they've never seen me put a needles in my arm, or seen me doing anything bad, wrong, I still feel that I'm - that I might injure them in some way, that something of me might...rub off on them. And, and I wouldn't, I wouldn't want that - I wouldn't desire that for anybody, to be like me...I think it, it's a waste. Of a life.

(P4: Mark IV#2 532)

Mark's life had been marked by solitude and isolation created both by himself and by others. He had always felt on the outside of things and his street life was a distorted reflection of his life in prison. While Mark was incarcerated he was able to obtain his GED, was employed as a dental technician, and maintained his recovery; he had success in prison that he had been unable to achieve in the free world. Such success in the

community seemed impossible to him. And were it possible, Mark's interior sense of himself had been weakened to such an extent that he could see nothing good coming from his life in the free world. He believed he had nothing of value to offer his family and might even be contagious, spreading his bad habits and behaviors to them. His concern for his family was evidence that Mark remained morally engaged but represented how conflicted he was. Mark did care about himself and possibly saw some goodness within him self. However, this positive self was so deeply buried under his sense of hopelessness and worthlessness that he could not access it. Instead, he avoided participating in his own life and continued to doubt its own value.

R: You know, when I read the paper, I like to read the obituaries. And yesterday I read the obituary, and there was something in there about a kid 18 years old. He died in a car crash. And another family, they [died], it was in the paper too. The whole family died in a car crash...And I said to myself, why they gotta die? Why can't it be me?...I would gladly give my life so they could live...Maybe there's hope in them...Maybe there's something there that, that uh - maybe could motivate them...Get them together...And not be the way I was...
(P4: Mark IV#2 532)

Mark was in a bind. Despite his distrust in the correctional system and his distaste for being incarcerated, prison provided Mark with a structure and access to things that he did not have on the streets. Prison offered him opportunities to occupy his mind not available to him in the free world. While incarcerated he was able to use his time in a productive and positive manner. There was an ease to prison life that did not exist in society at-large. Furthermore, in prison Mark was not alone; he had social and human contact that he did not have on the streets. Therefore, what happened to him on the streets did not matter; he had accepted the correctional system as giving shape and meaning to his life.

Matthew had also reluctantly accepted his repeated incarcerations. The following narrative described how he had grown accustomed to the impersonal quality to prison life. Matthew's familiarity with the routine did not soften the sense that he was unimportant as an individual, merely another inmate being herded from one location to the next. However, his feelings of personal insignificance paled within the confines of his cell where the basic need for fresh air and unrestricted movement went unmet. Even the briefest exposure to fresh air was both a priority and a welcome reprieve from the severe conditions of the correctional facility.

S: For me, I've learned to adapt to prison. And I'm not saying that I'm institutionalized, but it's like once you go enough, you know, you know the procedures. You know what to expect, what you got coming, and what's not allowed. Having to be pack muled around, in the form that they do, through the escorts and everything else, you feel worthless. You feel like you just going through a cycle...In the first stages going to prison you're locked up for 23 hours a, I mean 21 hours a day, and you just want to get out that cell. Because the cell moves in on you, really in a small box. And you really don't know until you do like this, stretch your arms, and this is how big the cell is. This is one wall, and this is the other wall. So you know, any fresh air is wanted.
(P26: Matthew IV#2 26:2 24:26)

Although he did not consider himself to be institutionalized or traumatized, he was disturbed by his prison experiences. For all his effort in disconnecting emotionally from his prison life, he brought his anger and powerlessness with him to life in the free community. Matthew's indignation and need for respect stemmed from how little control he had and how poorly he was treated as an inmate; his violence, 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.

I: So how is having to turn all that stuff off, how does that affect you when you come out?

R: You know, okay let me put it to you this way. When I first went I seen a lot of things, and you know, it affected me. It affected me in two ways. One, I survived. And it could never be as worse as the first time, you know what I mean? When you see a person with a piece of steel in this side and coming out the other side, I freaked out. And I'm thought I was a hardcore person. But to initially see that, fucked me up, you know? ... [and] 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 that 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. (P26: Matthew IV#2 26:6 164:170)

Prison had affected Matthew psychologically and socially. As discussed previously, Matthew both witnessed and perpetrated institutional violence. This violence hardened him and was a poignant example of his own mortality. In prison Matthew was powerless to protect and care for his own life; his life was in the hands of the institution and the other inmates. Matthew's reaction to his circumstances, while more overtly exploitative than most, was an expression the pervasive influence of the correctional institution on his life in the free world. He could not shake the practices of prison life and to a degree was disinterested in doing so. Learning how to survive in prison had been his greatest success and he had no other practices or behaviors to help him meet the requirements of free society. Reincarceration, release, and rearrest had become the familiar patterns of his life.

Matthew articulated further his acceptance of the prison life with the sense of community and familiarity it offered him – a thing not commonly found in the free world.

R: ...And then it's like as time goes by per se a week, I'm okay with where I am. I've adapted to my surroundings ... I'm starting to walk around with a smile and laughing at being back in prison. That prison ain't that bad.

I: And what is it that makes you smile.

R: You start meeting people. You start to see old guys you did time with, you know, periodically off and through the years and you know the stigma, or the thought that I'm back in prison is gone. Now I'm waking up and I'm comfortable, got me a cup of coffee, a cigarette and I'm okay. Actually I've mentally lied to myself to say that I'm okay with being in prison. That, you know, time to take a shower I'm being told by someone else to eat, everything is being controlled by someone old, someone else, and I become okay with that. So I know that's an issue and a problem that you know, I can wake up and say that this ain't such a bad place. (P:26 Matthew IV#2 26:8 194:200)

Although he was comfortable with his return to prison, Matthew acknowledged that his happy consent of being back in the correctional facility was not right. For all of the familiarity and comfort being on the inside brought him, Matthew was still confined within the institution. Once again he had no control over his life and was in an environment where his safety and security were not guaranteed. The choices that he may have taken for granted at home, e.g. when to take a shower, when to go to bed, were no longer under his purview. Additionally, Matthew had to convince himself that the prison life is, to a degree, the good life.

Louis also articulated the discordance between not wanting to belong in prison while knowing there was no place for him in free society. In this narrative, Louis described what happened to him in the two weeks before he was released from prison – a period known institutionally as S time or pre-release. During S time, Louis had to stop working, he could no longer access the store and spent the majority of his time in his cell; he was being prepared for reentry into the free community.

R: S time is two weeks before you're ready to go home...They stop you from working. They pull your gate passes. In other words, you're just in your cell...In other words, 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. Like I said, S time. I just - 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. 'Cause I don't ha- a-, I don't have anybody out here that cares for me, so it's like I'll go ahead and use drugs, and I'll go back.
(P:14 Louis IV#2 14:12 240:257)

For Louis, S time was a stressful and frightening time. The sense of isolation and alienation he experienced generally was glaring as he reentered society. On the streets, Louis was anchorless. In prison, while anxious and paranoid about his safety, he was in an environment that was somewhat controlled; it was known. On the streets, a different host of threats awaited him as he encountered unfamiliar people and places. Prison provided him with 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 do this for himself and he had to do it alone; the plans he made, the things he looked forward to disappeared in the reality he faced on the streets. It was within this context that Louis went back to using drugs and waited to be returned to prison. While Louis was concerned about what would happen to him the free world, he was unable to act on his own behalf. His life in civil society had an uprooted quality and in a sense he was paralyzed by his own fears and the demands of life in his home community. Therefore, at a certain point and however undesirable, reincarceration became the most available and most comfortable option.

I: And you're feeling all these things?

R: Yeah, 'cause I don't - when I'm using drugs, I don't feel no - no really no depression. I don't think about the Hep C. I do think about going back to prison because I know I'm out here doing wrong. So . . .

I: But is that enough to stop you from using? Going back to prison?

R: It hasn't before. Well, because I don't know - it might sound weird, but I don't have nowhere to go out there. So. It's like sometimes I think - it's just another place to stay.

I: Prison?

R: Yep. I get fed. I got a bed. But. I'm trying not to do that no more. I'm hoping I don't go back. You never know. But when you don't have nowhere to stay out there, like I don't, sometimes you just don't care. 'Cause I don't have nobody out there, just the people that wanna give me drugs, or do some of my drugs. I don't have no real friends. People say they're my friend, but they're not no friends. So I don't know. Sometimes I just get that - I don't - you know, I don't care. (P14: Louis IV#2 14:4 78:83)

In the above narrative Louis described the intense emotional content of his time in the free world. His worries and concerns were impossible for him to think about and he used drugs to manage his anxiety. Louis expressed ambivalence about his circumstances. His drug use concerned him because he did not want to be reincarcerated. Simultaneously, Louis' addiction disorder was a means for him to violate his parole and return to the institution. He did not want to rely upon the system to take care of him while knowing he had no other choice. Prison was not merely a place to go, for Louis it was the only option; there was no other place that would take care of him so completely. Furthermore, his life on the streets felt pointless. He had no place to live, no place to go and no one to care for him. Louis felt isolated and alone and although he was reluctant to accept the correctional institution as his primary caretaker he could not deny the truth of it.

Conclusion. None of these participants accepted the dehumanizing routine of prison life willingly. Acceptance occurred after several incarcerations and with the realization that they could not make a life for themselves in their home communities.

Concomitantly participants understood that their acceptance of the correctional system as the centering force in their lives possessed its own futility. Other than survival on the most basic levels there was no point to a life of repeated incarceration, yet it was it was place of familiarity, community and to a degree success. Therefore, participants had accepted correctional life as their primary way of life however much they resisted it.

Complete Reliance. Luke and John were completely reliant upon the system to take care of them both in prison and on parole. Any efforts they made towards establishing a stable life in their home communities were thwarted by their addictions disorders and criminal activity. Both men recognized the tragedy of their lives in that they did not have the capacity to improve their circumstances independently and the correctional system was the primary source of positive improvement. At the time of these interviews, Luke and John each had less than two months on parole and their impending discharge concerned them. They were uncertain as to whether or not they could survive outside the system. Neither man questioned or resisted the structure of the prison as necessary to their lives; they knew that it was. In the following narrative, Luke articulated his dependency on and appreciation of the correctional system in his life.

Luke was a 44-year old white man with Bipolar Disorder, Type 2 Diabetes, Hepatitis C and a methamphetamine addiction. He had been involved in the correctional system since age 12. He had three prison numbers – two in Florida and the present one in California. His story differed from other participants in that he had been receiving SSI benefits and Medi-Cal for his diagnosis of Bipolar Disorder for the past 13 years. Luke was a well-trained and experienced electrician. He had both financial and professional resources, yet was unable to remain out of prison for more than 18 months at a time.

I: What happens post-release?

R: I get out. I usually go back to work. I'll [get] the things I need if I need them, 'cause I have access to a little bit of money by then. I'll get a van, tools or the advertisement. And I'll have a place to stay, ... So when I come out, even if I don't have the big money to get my own apartment, there's some place I know I can go. ... So I come out. I immediately, since I haven't tried to quit drugs, will party. I'll just go back into my same life. It's natural, and you don't kick yourself for it. You're looking - I guess you're - yeah, you are looking forward to it. 'Cause that's what makes you feel good. Start partying. The only negative things that come along down the line, for me, ... for me it's - starts going bad when - when the health side starts going bad when my feet start getting numb (due to his diabetes). I'm not taking care of myself. I get angry, or, or, or very verbally aggressive, because of, you know, lack of sleep, whatever. And then it starts really going bad when, when I know I have to test. I go in and test dirty. And then he's (his parole agent) calling me up ... - I gotta go and do these meetings or go in this program. Or then I stop going to see him because I'm dirty, and he'll just lock me up. So there it's where it really goes bad. ... 'Cause I don't want to go back. There's a difference between want and desire. I don't want to go back, but apparently don't desire it [staying out of prison] because I give them dirty tests. So now I'm homeless. Or I have things, a van, friends, and a little bit of money. But that money goes like that [snaps fingers] when you gotta a big drug addiction... Isn't that stupid? So now you're out of the work force. You got no income. Your money runs out. Your addiction's way bad. Your health is bad. Your relationship's all bad, because you, you know, anything good needs to be taken care of.

I: How long does that take you normally?

R: That usually takes me between - from getting out to going back? Anywhere from four months to a year and a half. (P:11 Luke IV#1 11:17 280:287)

Luke had immediate access to housing, employment and health care upon release.

He had the necessary trappings for successful reintegration. However, he had never been able to achieve long-term stability in either his home communities of Florida or the Bay Area. Although Luke was able to gain short-term professional and financial success, his time at home was overshadowed by his drug addiction. Using drugs was the sole focus for Luke and that which resulted in his ultimate return to the correctional facility. There were indicators of problems, e.g. his physical and mental health deteriorating and positive drug tests, but Luke chose to ignore these signs. What little positive gains he made towards a free world life were lost as his drug use continued. He was aware of the

habituated quality to his life and while it was a thing that he no longer desired, i.e. returning to prison, he was unable to alter his course. The correctional system gave shape to his life; he knew when his health would deteriorate, when he would test positive for drugs, when his parole agent would reincarcerate Luke for a violation of his parole supervision. He could predict what would happen and yet could not see beyond it, even with optimal resources and access. He depended upon the institution for the restoration and maintenance of his health after a prolonged period of disregard for his physical and mental health.

R:...I just - maybe that is depression, that I just gave up. I was gonna do whatever makes me feel better, and willing to go back to prison for it? That's sad. That I - that is sad, you know, that I'm willing to do something that really harms me in health side and in living side. I'm willing to go out and do drugs. Maybe feel better today, and pay for it in prison? And when I go to prison, the health care there is the best thing. The confinement there is what I need. The sobriety there is what I need. Nothing bad has come from going back to prison for me. To be mature about it. I uh - you know, I'm -honestly, it'd be kinda weird not having parole breathing down my shoulder, or looking out for me. Being Big Brother. (P11: Luke IV#1 11:19 318:331)

Luke stopped caring about himself in the free world. He saw his situation as futile and would do what made him feel better in the moment even though the pay off was very short term if at all. He could not find or achieve the structure he needed in civil society that he received from being in prison. This was particularly poignant because Luke had never experienced any negative effects from his time in prison; he only received the benefits of health care, sobriety and a confined location separating him from the pressures of the free world. At the time of the interviews, Luke had only 52 days left of his parole supervision. He expressed concern at what his life would be like without the continued institutional surveillance and supervision that had become the primary stabilizing influence in his life.

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. There's - prison can be helpful. It can be. And you're gonna live in an environment where you're gonna learn to interact with people. You have to interact. You're gonna learn to go to work on time. You have to if you wanna get out. There's things that you have to do there that you don't have to go on the streets. And it makes you somewhat be more responsible and be a man. And there's great people there. There's great knowledge. I mean there're some really smart people there that they're done, for whatever reason that sends them there. I believe there's a couple guys in there with a matchbook and some bubble gum, they could get us to the moon. McGyvers.

I: Why do you think that, 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 do your laundry. You just have to fold it and put it away. You don't have to go out and get a job. It's gonna be provided for you. You have to go on - 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. OK? And when they say, "OK, you need to go to domestic violence counseling." OK, that might take you out of your work. You might have to do that three nights a week, \$365. Or you might have to go to a drug class, from 9:00 in the morning till 2:00 at night. You know? To stay on the street. You can either do it, quit your job and do it, or go back to the pen. Or um - let's see. All kinda different things. They're not just - 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. (P12: Luke IV#2 12:9 143:150)

In this narrative, Luke described the social nature of prison life. In prison he found both his drug-free and his intellectual community. He was engaged 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 he 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 civil society; the institution did this for him. The burdens of life in the free world living were no longer his to carry. Therefore, he was able to maintain some semblance of a contented life during his incarcerations that he could not do in his home community. He describes his inability to care for himself in the following narrative.

I: How do you - how do you take care of yourself and your health problems?

R: I don't remember ever on the street, other than in an emergency situation, taking care of my health. I didn't buy shampoo for my psoriasis or creams. I wouldn't even buy toothpaste. I, I don't know if I can be that much information for you on that issue 'cause I couldn't - I couldn't do my laundry, and I had to go to a friend's house to chip off (borrow from) them to get laundry done. I'd go to another friend's house to get food. And as life has progressed and I've somewhat prospered, with a fiance and stuff, she's always - even though she's worked with me, she's always took good care of me. We do things together. Like I help her with laundry or dishes, but she always fed me, worried about my health care. Things like that. I don't take care of myself...

E: If you didn't have her around how would you take care of yourself?

R: CDC takes care of me. If I don't have people around me like that, then - I guess, you know what? It's easier to go back. It's some place to have three hots and a cot, call it what you want it. You don't even recognize it as that, but that's where you end up. It's because you can't take care of yourself, and you're not taking care of yourself, not taking care, having a job, getting rent paid and dadadada. So you're out here or they're gonna go get you. You know, the car with the light on top. That's my ride.

E: Is that an OK way to live for you?

R: It's not OK, no. But it's not bad. You know, like I said, I become numb.
(P11: IV#1 11:16 266:279)

Once again, Luke reiterated how he relied on CDCR to take care of him. Prison was his caregiver when no one was available to care for him in the community. His circumstances were not ideal but they were not unacceptable either. As a result of his mental illness, Luke was unable to care for himself. He wanted to connect with his circumstances in a meaningful way but did not have the emotional capacity to do so. There was a profound despair in Luke's experience.

John was a 47-year old Mexican-American. His health problems included Hepatitis C, herniated discs, and an addiction to heroin. He had three prison numbers and a long history of incarceration in Segregated Housing Units (SHU or SHU program) or solitary confinement. While in the SHU, John was locked in his cell 24 hours a day with one hour of exercise, also in a confined space, two to three times per week. Inmates were assigned to the SHU primarily based on gang affiliation and institutional violence. Once an individual was assigned to the SHU program, he would always be incarcerated in the SHU. John was impacted by his time in the SHU and the prolonged periods of isolation made the intrinsic social quality of life in civil society painful for him to manage. Although he wanted to participate in the social nature of free world life he had little capacity to do so and thus his isolation and alienation from civil society was further exacerbated.

R: ... That's another problem... because I, I just don't really like being around people. But lately I've been really kinda like ah, you know, it sure would be nice, you know, to do some other things. But, I don't know, I'm kinda grumpy lately. You know? I don't really got a girlfriend or a relationship because I don't want one right now, you know, 'cause I have to take care of myself right now. ... 'Cause I sure don't want to go that other route (back to prison)... Yeah. [Long pause] ... Yeah. Yeah... I mean I'm discharged in February, so I gotta leave from here, and it's kinda scary... like I said, I really - this place (the drug treatment program) is - it's, it's, it's a blessed place, to tell you the truth. You make it what you want to. It's self-help. But 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... And I feel like I'll be a burden, a burden on my family, because, I do wanna go ahead and get this SSI and get my little place... And get my little place, get a little responsibility... I may be working a little 26 hours that I'm allowed to work on the SSI to do something, you know? And keep me, keep me going, and I'm gonna continue going to NA meetings, 'cause that's one thing that I know I have to do.
(P17: John IV#1 17:10 174:184)

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. John had been involved in the correctional system for over 30 years and with his impending discharge he would lose the structure that had defined his life for so long. The completion of his parole term signified a loss of structure and resources he would not otherwise have; he had become dependent upon the system to define and chart the course of his life. He could have stayed with his family but John knew that he did not fit into the daily rhythms of his family's lives.

His impending discharge from parole also represented a rejection from his primary way of life and from his community. All his time in SHU, all of his commitments meant nothing to either the correctional institution or free society. John was hurt by this rejection and mourned the loss of his familiar life. He was also uncertain as to how to move forward in his life. He knew what he was supposed to do to achieve some stability in the free world but John was embodied by an emotional paralysis that made seeing beyond his discharge date, beyond the life he knew almost impossible.

I: So - and then you also are getting off parole in February, which is kind of, I would think, it's a little bit scary too. [...]

R: Yeah, yeah. I mean a lotta times to tell you the truth, parole saved my life. You know what I mean? That's real talk.

I: And how did it save your life?

R: Because I go up there, and I use, and I just - I mean I'm a extremist. But then, again, and then I'll get - I know better not to catch no cases, so when they do come get me, it's just for a PAL warrant, a parolee-at-large. So then I'll go back to the system to regenerate my health...When I was healthy. 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.
(P17: John IV#1 17:17 335:348)

In addition to providing the fundamental structure to John's lived experience, the correctional system, most specifically parole, saved his life. Repeated parole violations allowed John to return to prison and restore his health after a prolonged period of drug use and street life. Because John only served six to eight month terms for parole violations rather than longer sentences for new criminal convictions, John was able to maintain both his criminal activity and his addiction disorder. Prison provided a respite from the violence and harsh conditions of the streets and protected his health and his life. 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 street and drug life. Without the correctional system John doubted his capacity to survive.

Conclusion. The 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 their lives as participants were overwhelmed by the rigors of free society and entrenched within their drug addictions. Additionally, participants embodied adaptations and attitudes, e.g. inaction and aggression, required for survival in the institution but ineffectual in civil society. They were conflicted by what they had done and had become in order to cope with the demands of correctional life. The amoral and

coercive nature of correctional life, in combination with its dehumanizing protocols, left the participants fractured and estranged both from themselves and from society.

Estrangement from civil society made wanting and achieving successful reintegration difficult. Therefore, participants often utilized the correctional system to compensate for their failure to attain any sort of stability in or connection with the free world. A period of incarceration served three 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 respite from excessive drug use and criminal activity. Participants were well prepared for institutional life but severely limited in their capacity remain in free society for extended periods of time.

Addiction Practices

The majority of the participants were reincarcerated for crimes related to illicit substance use. Although participants sold drugs, they were most commonly rearrested for having a positive drug test or absconding from their parole supervision knowing that they would test positive. Participants acknowledged that their drug use had become unmanageable and wanted to address their addiction disorders in order to break their habitual pattern of release, rearrest, reincarceration. In addition to providing a means for re-imprisonment, drug use supported participants in the following ways by providing: 1) a means of emotional engagement and social connection; 2) a method for managing psychic pain; and 3) a respite from free world pressures. Participants' need for emotional engagement and social connection was defined by a sense of fun and community, a need to avoid isolation and loneliness, and a desire to escape the joylessness of life. The wish to forget or bury painful feelings characterized the management of psychic pain as drug

use eased emotional distress due to circumstances such as the death of a family member and extreme loneliness. Finally, participants' addiction practices, provided relief from free world pressures as getting high enabled them to forget about their problems and the demands on their lives.

Emotional Engagement and Social Connection. Although Walter had used drugs since his adolescence, his addiction disorder did not come to fruition until his twenties. Walter, a 51-year old African American with glaucoma and partial blindness, described his introduction to heroin and then cocaine as carefree and fun.

R: ...Man, Lord...I was using coke too. Plus I started...I was tootin' hop...heroin... And I - and I was selling coke then. The hop was keeping me up. Everybody else was going down on it. It was a downer to them, but it reacted differently to me. It kept me up...Kept me hustling. You know? And - like I was saying - then I...left it alone. I stopped. I was going to this club...I used to be partying there, boy. Lord, it used to be all night long. Golly, ooo. Man, I used to go in there. They had the upstairs and downstairs, food tables and everything. It was mixed club, gay, everything, all night. It was the spot. Oooo, boy, boy, boy, I had some fun in that place. So uh. I started tootin'. My boy had some coke, and I was tootin' coke. I was saying, this ain't too bad. You know? I was tootin' it. Then we started like putting it in a cigarette, smoking it [mocks inhale], flames being this high off the ceiling. It be turning black and everything [laughs]. I said God [mocks smoking], smoking so much...Get that rush, you know, and you get on the dance floor start dancing and partying. All the time I had bad eyes too now, see? In the '90s my eyes was bad, but I never tripped on it. I'm thinking about partying and dancing. That's the least thing I wanted to worry about but...I would take my medication. (P22: Walter IV#2 22:13 300:313)

Drugs increased his energy and enhanced his ability to sell drugs and celebrate with his friends. Walter sensed that his lifestyle may have impacted his physical disability but drug use subsumed any of his concerns as he focused on having a good time. Drugs also alleviated any concerns he had about his health problem – almost complete blindness and glaucoma as a result of a childhood injury. Walter's initial motivation for using drugs was that they were entertaining and enhanced his time with his friends and at nightclubs.

For Walter, drugs were not a crutch to manage his insecurities or cope with interpersonal relationships. Throughout both interviews Walter described the loving and caring relationships he had with friends and family members. Furthermore, during the interviews it was apparent that Walter was a positive and emotionally intact person. However, cocaine was the social trend and Walter was not able to stop merely because the drug had fallen out of fashion.

I: So why do you think you used drugs for 30 years?

R: I don't know. It was a fad. Everybody was doin'.... People was doing it, drugs. And I didn't ever like weed that much. I never liked drinking. So I had another little crush, I guess, with coke. You know? All the other drugs, I never liked it. I never really, you know, it wasn't - the coke, I liked it.

I: And what makes cocaine so different?

R: It was a fast drug, you know? It was like, you do it together, the high don't last long, but it was just...It was a fad. I think...I got into it just like that...I got tied into that...I got caught into that. Now. (P22: Walter IV#2 22:15 372:387)

What began as an entertaining trend progressed to addiction. Cocaine was unlike any other drug Walter had tried. It was exciting and inherently social. Walter was ensnared in the fast pace and life that accompanied cocaine, even though the drug's effects were momentary. His long-term involvement with cocaine would ultimately lead Walter, at the age of 40, to his first incarceration. In this narrative, however, Walter reminisced about his love affair with cocaine.

Steven, a 55-year old African American, also described the attraction of cocaine. Cocaine was glamorous, exciting and easy to use. With cocaine came female companionship, something Steven wanted and needed. As he articulated in other narratives, Steven was desperately lonely and wanted nothing more than a meaningful relationship with a woman. He believed that such a relationship would save him from his social and emotional isolation and increase his chances of success in his home

community. In the following narrative, Steven described how he was drawn to cocaine because it was inherently connected with women, sex, and money.

E: So what's the attraction of cocaine then? How did that happen?

S: First it's, the things that's associated with cocaine that kind of excites me. Women, the sex, the money, and at that time everybody was doing it. You know, just about everybody was doing it. That was like the thing. It wasn't like everybody was trying to stick a needle in their arm doing heroin. Cocaine was the thing at that time. And that's what I think it was. And by me being a sucker for a woman, so. I just think that's it. (P27: Steven IV#1 27:9 164:191)

Cocaine lifted Steven out of his desolation providing an instant circle of friends. Getting high enabled him to connect with others.

S: Because of, I guess because of the pain, or the feelings that you feel when you're alone. And then if you got drugs, everybody wants to be with you. So that's why I used to have a tendency to be generous with the stuff. Just to have the people around me. Because when I have it I have a lot of it. That way I don't have to, I won't have to be alone, and I got people that want something what I got. So I guess that's what I look at it and I think that has a very very important factor of being alone. I don't want to be alone no more, I really don't. But I just don't really know how to also open myself up to-I'm learning-to people that I just, maybe I wouldn't say dislike, but it's hard for me. It's really hard for me. It's not easy for me to open up and to show affection to a lot of people. (P28: Steven IV#2 28:8 234:234)

Cocaine freed him from his solitude and allowed him to give and receive affection and intimacy. When actively using drugs, Steven had access to feelings that he did not otherwise know how to experience. He overcame his insecurities and for a moment, however transient and insincere, was the center of attention, the person everybody wanted to be around. Using drugs and sharing drugs with others was a primary way Steven coped with his desolation.

Luke also used drugs to feel less isolated. His addiction allowed him to engage emotionally with the world around him – a thing he could not do on his own. Luke's life had been hampered by a pervasive and constant joylessness and drugs enabled Luke to

feel. Luke described his extreme anhedonia throughout both interviews but here he articulated the impact of having no emotional connection with anything in his life.

I: What is your motivation for stopping using methamphetamine? Is there any?
 R: Methamphetamine were - you could call it a hammer. Whatever you want to call their drug or stimulant is what is making my life better, feeling my feelings, 'cause I don't feel nothing. I mean where I have the lack of feeling in my life. I can look at a little boy on a big wheel. Oh, that's cute. But, or I'll go to the Dollar Store and buy some dollar kites and go out and get them to fly and give them to the kids. Oh, that's nice. That's it. I mean there is nothing there. I can be driving to work thinking, "Is this all there is to fuckin' life? I grew up and this is it?" The guy over there I'm looking at, with three kids, and they're laughing and joking, and I'm like, "Dude, you got all them bills." Something's missing...I ponder this stuff. I'm willing to look at it. I'm not in denial about anything. It is what it is. By our standards, our society and, you know? I'm a failure. I'm a successful failure, I'll tell you, repeatedly. But I'm OK with that. (P11: Luke IV#1 11:20 351:357)

Actively using drugs improved the emotional quality of Luke's life. Without them he traveled through life knowing he should be feeling something but was unable to do so. He knew there was something wrong with him particularly in regards to others. He saw the lives of others as filled with meaning and wondered why he could not have the same experience. Therefore, drugs offered a simulacrum of an emotionally meaningful experience. Because he was devoid of any sort of feelings, he believed he would never meet the established standards for life in civil society; he had failed in some way. It was not clear if Luke believed that in spite of this failure he still had a modicum of success in his life or if he believed he had been successful only at failing. Nevertheless, Luke resigned himself both to the emotional vacuum in which he lived his life and to drugs as his only means of living beyond the emptiness.

Management of Psychic Pain. In addition to increasing access to the social and emotional aspects of life, participants' addiction disorders allowed a means to cope with painful experiences and circumstances. Drugs offered a respite from the sensations of

loss and regret and provided a hiding place from participants' vulnerability and desolation. In the following narrative, Walter described how his substance abuse muted his suffering over the deaths of his mother and sister.

R: That's another reason why you get high. It cuts off all the, you know, blockage of all the things, the pain you're going through. Certain things you don't have to be facing. You know what I mean? You eliminate it.

I: Is that the case for you?

R: At one time I, I think it was. Because when I lost my sister, when I lost my mother, shortly after I was getting high, and I really never - it, you know, for a while I was sad. You know, worrying about why they had to go. And then when I started getting high, it was like I wasn't thinking about it no more hardly, you know? The pain was gone, and I was moving on. You know what I'm saying? It helped me move on.

I: Did you really move on though? Do you seriously believe that?

R: It was a hallucination of moving on. That's what I'm really think I'm saying, wanting to say. It was a hallucination of moving on, but I really didn't move on. I really still miss them, you know? And I wish they were still here. But I think for that time, in that era, you know what I mean? Them years?

(P22: Walter IV#2 22:1 8:14)

Although drugs blocked his psychic pain, it was a temporary situation. Walter could not avoid his feelings entirely and carried his despondency over the loss of his mother and sister with into the future. Drugs provided Walter momentary relief from his psychic pain. They made it easier for him not to feel things although his addiction ultimately only slowed, and not prevented, the grieving over his mother's and sister's death. Walter was never able to avoid his feelings entirely. However, at the time of their deaths, drugs provided relief from the anguish of their dying.

Steven also used drugs to block his psychic pain in general and obfuscate his limited capacity to handle difficult and tumultuous feelings.

R: ...And right now I just don't know, only way I know how when I was feeling shit when it didn't go right I would go get loaded. And kind of right now what I'm doing, when I get to feeling shit, all I got to do is call 911. I'm going to a hospital and next thing I know, I got at least ten milligrams of morphine going into my system within the next 30 minutes. So that masks it. And then after I get that, I

will wait an hour-doctor, I'm still feeling pain. And I might get another four. So, you know, when it comes to feelings I just don't know how to- (P28: Steven IV#2 28:18 463:481)

Steven's need to self-medicate via emergency room morphine stemmed from his inability to cope with his distress and sadness about the circumstances of his life. Because Steven had atypical angina and a long history of cardiac disease he could enter any emergency room complaining of chest pain – whether literal or figurative – and receive opiate treatment. This particular addiction practice alleviated Steven's psychic pain and brought him out of his alienation into the busy social world of the ER. Additionally, his drug use veiled his incompetence at managing difficult feelings and moods. Actively using drugs protected Steven from closely examining his life. He did not have to acknowledge that he was unable to handle the agony and suffering that accompanied embracing his feelings. In this sense, drugs protected Steven from having to face his failures.

Managing Free World Pressures. Participants used drugs to manage the pressures of life in free society. Drugs enabled them to forget about their problems and eased the burdens that life in their home communities entailed. Participants could put the things they must do – whether it was going to a doctor's appointment or paying a bill – off for another day. Drugs allowed participants to cope with life on the outside by not coping with it at all. Mark articulated this idea in the following narrative.

R: I was out there messing around. And when you're using drugs out there, you, you, you neglect yourself...You don't really care...Dope is an escape...It's easy to, to uh, like you, I would say, wash away your, your problems...Especially with heroin...And I can, I can forget the problems of the world, my problems...And like I like to, how you say, put things off...So I always say there's a tomorrow. I'll do this tomorrow. You know how you say, procrastinate? ... And tomorrow I'll do it. But tomorrow I don't do it. I just keep the same routine, until the, until I get back into prison again... (P3: Mark IV#1 3:12 381:389)

For Mark, using drugs was a primary way of being in the free community. He broke free from the confines of his life on the streets through drugs. His addiction practices were the means with which he actively coped with his separation and withdrawal from society at-large. When actively using, Mark did not consider how adrift he was and therefore could avoid facing his continued alienation from civil society. He could continue this pattern of procrastination until he was rearrested and returned to prison. In essence, drugs were a method in which Mark could return to the place he belonged – the correctional institution.

Max's addition disorder was more clearly a case of using drugs to manage his financial strain.

S: No, yeah, I was late. You know I got in; I didn't start using dope until I was 22.

E: Why did you start using at all then? What happened?

S: Well, I got in a car wreck...Everything was working out for me...I was at work and I got in this accident 1982, then my truck that I was driving I got rear-ended by this lady and almost rear-ended another lady in front...And so I had been on disability (as a result of the car accident), wasn't making ends meet, and so I started selling dope...And people that I dealt dope for, they always used to tell me, don't get high on your own supply. I started getting high on my own supply. Things got all bad...I got a divorce and lost a lot of things. But the dope kind of took over my life for 20 something odd years. And that just got bad, you know? So I just didn't take care of my health, didn't take care of my back after that accident. (P29: Max IV#1 29:19 369:381)

Max, a 47-year old white man, began by selling drugs as a means to ensure financial stability after a car accident left him unable to work regularly and legally. The shared belief among drug dealers cautioned against becoming addicted to their product. However, Max was unable to do this. What began as a way to increase Max's access to regular income, and address his specific financial problems, became a problem itself.

Therefore, Max's stress management technique became inherently stressful. Over the course of his addiction, Max lost everything to the pursuit of his addiction.

Participants disregarded their responsibilities in the pursuit of drugs but Luke was an extreme case of this pattern. When actively using, he let everything go and, his health, housing, employment, and family, fell away from him.

R: I didn't have health problems on the street. That's not even - it's not a problem if you don't think about it. You know? If you got aches and pains in your life, then you medicate. You're medicating with all kinds of stuff. You're just living for the - you're not worried about taking care of your kids, or your ex-wife that's struggling to feed them and house them. You're not worried about a car. They can come get it if you owe on it. You're hiding it. You're not worried about shelter. You're spending all the money on drugs. You're not worried about health care. You don't have any health. You don't care...

E: Is that part of your reason or your motivation for using drugs, is that you don't have to care about things?

R: That's a good question. Actually, when you're, when you're - for me anyways - I have no responsibilities. None. When I'm homeless in the street, I don't gotta pay no light bill, no car payment, or nothing. And I can just live for the day. ...I definitely don't worry about my health care.

E: It seems like it's an awful tradeoff though in a way.

R: To a sane person.

E: But it sounds like maybe there's some peace in it for you...

R: It's a lack of feeling for me. ...There's no salt on my food of life. You know? There's no color. Everything is black and white for me without drugs, it seems like. It's the lack of feeling. You know, like my ex-wife, "Hey, you want to go to the beach?" "No, here. Go take the kids." "Do you want to go camping?" "Here." "Go see 'Titanic'?" "Here." "You want to do an ounce of dope?" "Yeah!!!!" And that's a shame. I see people doing regular stuff, and they're getting a kick out of it. And that just compounds the depression. What the fuck is wrong with me? So a lot of times I just quit thinking about it. (P11: Luke IV#1 11:6)

Luke grasped the madness of his substance use disorder but was reluctant to let it go. Drugs were the one way in which he could validate his existence. His acknowledgment of how outside he was of his own life exacerbated his feelings of alienation and this depressed him. He knew something was not right within him, but outside of drugs, was at a loss as how to fix himself. In the midst of his addiction, Luke

did not matter to himself; he stopped caring about anything other than procuring and ingesting drugs. Perhaps ironically, the one thing that offered him some sort of connection with the world was also what destroyed his tenuous engagement with it. Drugs were the fundamental way he accessed his feelings but inevitably separated him from those feelings as well.

Conclusion. Participants' addiction practices allowed them to cope with their lives in the free world. While drugs may have initially provided excitement and entertainment, they ultimately became the primary vehicle through which participants managed the difficulties in their lives. Drugs provided a brief respite from painful feelings, desolation and despair as well as way to engage with the emotional content of life. While their addiction practices were effective in addressing participants' psychosocial needs, they also viewed their drugs habits with a sense of regret and doubt. Therefore, as much as their addiction practices had assisted them through challenging and desperate circumstances, participants sensed how their lives had been limited by their substance use disorders.

Chapter Conclusion

Participants felt they were irrevocably changed by their correctional system experiences. They were both traumatized and disempowered by their incarcerations. Participants had grown accustomed to the correctional system's control over their movement and activities and had abdicated their personal agency to the institution. Participants believed that forsaking their personal power was the most practical and safest way to cope with prison life. While participants struggled with the harsh environs of correctional life, prison also provided opportunities for success and community not

available in the free world. Therefore, while participants did not always want to reenter prison, they perceived their incarcerations as a time of stability, sobriety and engagement with their health.

The balance participants achieved during their incarceration was lost upon reentry into the free world. They faced homelessness, isolation and poverty in their home communities and had limited ability to cope with the demands of civil society. Their personal agency was decimated by their time in prison to such a degree that they were unable to independently and effectively structure their time and activities – things required for successful reintegration. Therefore, participants soon returned to drugs and eventually prison as a means to cope with their failure to live successfully in their communities.

While participants' addiction practices helped them cope with the pressures of free world life, the actual efficacy of their drug habits was limited; their addictions became the sole focus of their lives rather than a support mechanism. Drugs offered participants a means to access feelings and emotions they did not know how to experience otherwise and offered transient relief from their loneliness. However, their addiction disorders inevitably stunted their emotional growth and limited their ability to find new ways of coping effectively with life in civil society. Participants' addiction practices constrained their capacity to succeed on the outside over the long-term. Their drug habits inevitably led to rearrest and reincarceration. This cycle pattern of drugs and imprisonment curtailed participants' emotional development, impacted their capacity to successfully manage stressful circumstances, and delimited their possibilities for stable lives in their home communities.

CHAPTER 5: BARRIERS AND FACILITATORS TO HEALTH CARE ACCESS

Introduction

This chapter will present the barriers and facilitators participants encountered in their efforts to access health care in the community. The introductory section of this chapter will define the meaning of the barriers and facilitators to health care as illuminated by the data. The second section will address barriers to health care access. Barriers to access included restraints around the financial and administrative components of health care and difficult interactions with health care professionals. Structural and social barriers limited participants' access to care and discouraged them from a long-term engagement with the health care system. The final section of this chapter will address facilitators to health care access. Facilitators included medical professionals' demeanor towards participants and a relative ease of access to clinics and ancillary services. Facilitators encouraged participants' involvement in health care and interest in their own self-care.

Social and Structural Barriers. Participants articulated structural barriers as financial and administrative limitations that made access to adequate health care services difficult. Financial restraints limited health care choices and participants felt resigned to substandard care via safety net health care systems, i.e. county hospitals and clinics. Once participants gained entrée to the system, their care was frequently delimited by administrative and bureaucratic constraints. These barriers discouraged access even when participants were motivated to engage with the health care system.

Participants described their negative interactions with medical providers as the predominant social barrier to health care access. The poor treatment they received on the

part of clinicians created feelings of skepticism and distrust. Participants' negative experiences with health care providers engendered a sense of estrangement from the medical world. Additionally, the uncaring professional demeanor influenced participants' own interest in their health problems. In many instances as a result of disaffection from health care practitioners, participants chose to not seek follow-up care for their physical and mental concerns.

Social and Structural Facilitators. Clinicians' caring professional demeanor proved to be the most salient facilitator in participants' initial and continued motivation to access medical services. Participants described their clinician encounters as positive, respectful and effective. Through the concerned efforts of their medical providers, participants were able to resolve their problems as well as have the opportunity to develop trusting and meaningful relationships with their clinicians. These relationships encouraged their continued involvement with health care.

The primary structural facilitator was the removal of structural barriers. Easily accessible clinical locations in combination with convenient ancillary services and access to payment sources, allowed participants to have their problems assessed and concerns addressed in an efficient way. Such access to clinical services facilitated participants' follow-through on necessary evaluations and supported their interest in managing their health problems.

Structural and Social Barriers to Health Care Access

Participants did have access to health care in the community. However, their access was limited by social and structural barriers and was often considered substandard. Participants' engagement with health care services was sporadic. Their street and prison

lives impacted participants' capacity to access care in a regular way but the multiple barriers they encountered when actively seeking health care was discouraging; their motivation for seeking further assistance from health care was dampened by such barriers. 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 of participants were disaffected by the health care system in part due to social and structural barriers.

Structural Barriers to Health Care Access

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 believed they received marginal care from this system and were resigned to such care as a result of their financial situations; had they been able to access care outside of the safety net system they would have. Participants felt stigmatized for being poor and as if they were confined to substandard care because of their social circumstances. They were disempowered by the dearth of other health care options available to them. They had limited control over their health care status as a result of their poverty and their ability to access only the safety net system. Participants' responses to the financial barriers they encountered also led to feelings of apprehension and futility. They were concerned about the gravity of their conditions and how those conditions would impact their reintegration efforts and their lives in general. Additionally, they felt powerless to address their concerns via the safety net system of care they were assigned to as a result of their poverty.

In the following narrative, Robert, a 40 year-old African-American, articulated uncertainty about his health status. Although the idea of a major illness disquieted him, it was his inability to access life-sustaining treatment as a result of his financial status that troubled him more.

R: ...I be hoping I don't get nothing serious wrong with me. You feel me? 'Cause how can I get it taken care of? So suppose I had a kidney problem? You know what I mean? I couldn't afford a kidney transplant. You know? If I could even afford it. I be hoping that that don't happen to me.

I: Is that a big worry for you?

R: Yes. It is, because I - I be having pains in my stomach. You know what I mean? That be scaring me. I'm listening to my mom, right? And she be like, "You better take care of it." And I don't want them to tell me something [bad]...I [don't] want them to tell me something I just couldn't get it dealt with. You know what I mean? 'Cause I - you need a kidney transplant or some kinda organ transplant, and I can't get it, and I don't want to have to live with that. [Laughs] You know, I think about that...because I couldn't. Am I right? If I couldn't afford it, I couldn't get it. Am I right? (P10: Robert IV#2 10:14 260:294)

Robert was frightened by how little he understood his symptoms and the possibility that he could be seriously ill. The idea that he would require unaffordable medical treatment overwhelmed him. He wondered about his personal capacity to manage a disabling health problem in addition to his concerns about access to proper care. Robert wanted reassurance that his ailments could be resolved easily and economically. However, the health care system was unable to assuage his concerns. In the preceding narrative, Robert articulated how the medical care he received was ineffective in addressing his concerns or resolving his problems.

R: ...OK, I guess I could share this with you. Like sometime when I use the restroom, right, it take me a long time to pee. You know, and I share with that. [They] say it might be your prostate. Right? So, as you know, [that] scare the shit out of me. I don't want prostate cancer. But it's been an ongoing problem...what I'm trying to say is I never got a complete physical, even at the doctor, because you know how you go to the doctor...and they be like, "Well, is there anything else?" Well, I think it's just like beside manner when they be saying it because they don't ever follow through on what else I be talking about.

Like I was saying with you about my stomach, I be like, “I have a stomach problem,” and I tell them about my urinary problem, and...they kinda like, “Oh, is that right?” And they steady be writing you, but they never say anything about it or doing anything about it. And I never had a complete physical where they take, you know, like I see on TV [laughs]. You know what I mean? I never seen somebody get a complete physical, but my mom keeps telling me she had one, because she’s had a complete physical. She has her own doctor...A few doctors now, ‘cause I guess she had to go through the steps, because she has the Medicare to cover certain things. But now I know I need to have some stuff checked out...And by me bringing this little thing I bring to the doctor, like I have a pain over here sometime, and what’s over here?...It may be even gall bladder or something, but right up under here it’s hurting bad, and I share that, and I don’t ever get no results. It’s like, “Oh, it’s nothing,” or something like, you know, so they - if the doctor telling you that, don’t trip off of it. I don’t trip off of it, but it still be pain...So I’m like it just can’t be nothing, but what can I do? You know what I mean? It’s not like I can go and request certain tests, and I can’t pay for that shit. [Laughs] (P10: Robert IV#2 10:14 260:294)

Robert shared his symptoms with clinicians on several occasions to no avail. He believed the clinicians were not interested in addressing his problems further. He felt his concerns and symptoms merited a thorough and in-depth assessment in the moment, however, clinicians considered Robert with no more than a cursory glance. Perhaps more injurious was his sense that physical pain and discomfort were dismissed as clinically meaningless. Unlike, his mother, who had access to insurance and several care providers, Robert had no options outside of the safety net system of care; he did not have the financial means to purchase the care he needed. Robert felt excluded from a higher standard of care because of his poverty and this engendered feelings of anxiety and powerlessness over his health and his circumstances.

Robert’s personal presentation may have added to the problem. He presented vague, unlinked symptoms that appeared potentially bogus. His experience suggested that he did not have the skill in self-presentation necessary for successful interactions in a busy public hospital. A crisp and coherent symptom presentation may have elicited a

more active diagnostic response from clinicians. However, Robert was quite naïve medically and could not present himself in a manner that was better suited to the system of care in which he sought help.

Paul's treatment options were also restricted as a result of his financial situation and uninsured status. Paul, a 42 year-old African-American, suffered with pain and immobility in his knees caused by osteoarthritis. He had surgery in the past to decrease his pain and immobility and, at the time of these interviews, Paul was considering a total knee replacement of his right knee. He doubted the ability of the county hospital to perform such a surgery without damaging his knee further. Additionally, he grieved the loss of his knees' former function and mobility; for much of his life Paul was athletic and physically fit. This positive sense of his self had been curtailed by the pain and disability in his knees.

R: To be honest with you, I am at the point with my knee where I know it can never be back like it was. I would just like to have surgery, get it cleaned up as best it could...cause I'm financially not stable, I'm not financially stable to do it, to get the adequate medical treatment...and my knee being part of CDC (California Department of Corrections), you know what I'm saying. They have the best union, the best benefits there is right now. Why can't I get the proper medical help? You tell me I'm ward of the state. Okay, I'm ward of the state. Well, can I get some help then this time, you know. I mean this was bad. I can't go to certain hospitals to get, to help my knee for it. I can only go to one hospital and that's the county hospital, you know. And, that's a bummer, 'cause you know, I know numerous bone specialists that deals with sport issues, sport medical problems but you're not financially situated that means you go in a cell (to prison). (P 6: Paul IV#1 6:12 68:82)

Paul was excluded from optimal treatment due to his poverty and his criminal history. He was doubly stigmatized for both being poor and a convict. His sense of disenfranchisement from the medical community was exacerbated by his perception that the correctional officer's union received the best benefits in the state. Union members had

a variety of choices for health care, while he was resigned to only one inadequate system. It felt unfair to Paul that his options were so disparate from those of prison employees, as they both were, in his mind, members of the same system. Paul felt penalized for his financial and social circumstances. His punishment included not only incarceration but assignment to substandard medical care as well. In following narrative, Paul elaborated on his concerns about the treatment he would receive via the county hospital.

I: And you don't think that the knee replacement would make it better?

R: It could make it better, but it also could make it worse.

I: How could it make it better and then how could it make it worse?

R: See, 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. That's how it could be worse. And...with that situation, that's a major limb of your body. 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. It's a lot worse, you know, 'cause therefore I would have to go to the county hospital, and they like, they ain't like when I was working, I coulda done got it at a hospital where...they got a sports doctor that specialize in that type of a field. And that's why it's something for me to contemplate. And I haven't really made my mind up...And I don't know if I really want to do it yet.

I: So if you had insurance you'd feel more comfortable that you were getting better care?

R: Basically, that's true because society right now - money talk. Insurances and hospitals, you know, if 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. And it's, it's real hard. It's real hard because you got a lot of pre-med students going to the county hospital where they're learning. And that's something I really got to contemplate on. You know? (P 8: IV#2 8:3 13:22)

The surgeons and physicians at the county hospital had recommended a right knee replacement for Paul. Paul was skeptical of the surgeons' skill and competency in performing such a procedure. He believed he was at risk for a failed operation and a worsening of his disability. Paul's life had already been hampered by his condition, and a limp or deformity resulting from a botched procedure would only aggravate his situation. Furthermore and as he articulated in another narrative, Paul struggled with his self-image

as disabled and immobile, and any further deformity would make this struggle more obvious, more public.

Paul felt trapped by his circumstances and powerless to alter them. Although he knew the decision to have or not have the surgery was his to make, he saw no hope in either option. His capacity to regain any sense of himself as a strong, capable man or engage in the practicalities of successful reintegration such as gainful employment was delimited by his current physical limitation and how he chose to resolve it. Paul's apprehension in making such a decision arose from his belief that he would not receive adequate treatment at the county hospital. However, he was limited in his choices because of his uninsured status.

Insurance and financial stability would have afforded him access to specialists and expert care. Through such upper-tier care, he believed he would receive the most sophisticated surgical procedures and physical therapy. Without such care, he risked being worse off than he was currently. Furthermore, he was in pain and he questioned the county system's ability to resolve his suffering. He did not want the health of his knees or his potential future success to rest in the hands of an unskilled clinician; he did not want to be practiced upon. Therefore, Paul was uncertain as to whether he wanted to make his self and his knee vulnerable to the county medical system.

Conclusion. Robert and Paul were stymied by their limited health care options. Both men believed that appropriate evaluation and treatment could effectively address their concerns and physical limitations. However, as a result of their poverty, they were disallowed participation in private or insured medical care. Their assignment to the safety net system was both stigmatizing and worrisome. They were excluded from accessing

more comprehensive clinical services and because of this believed their problems would go unaddressed and untreated. This exacerbated their anxiety, as undiagnosed, potentially serious illnesses and poorly managed chronic conditions would further complicate their current situations and hinder opportunities to achieve long-term stability in their home communities.

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. Participants articulated these barriers as an inherent part of the substandard care they received as a result of their uninsured status. In the face of these administrative barriers, the cost of accessing care was not equal to the benefits participants experienced in receiving it. Therefore, participants' ailments often went undiagnosed and untreated.

In the following narrative, Paul articulated the indifferent treatment he received after a recent hospitalization surgery. At the time of these interviews Paul had had emergency surgery on his right foot. He was discharged from the hospital without a pair of crutches and this impacted both his healing and safety.

I: how do you feel people have been in terms of helping you get the care that you need?

R: Nonchalant. You know?...I keep dealing with all the tape, the paperwork tape that...the hospitals is running me around back and forth on. You know, like the day I get out from surgery, they didn't give me no crutches, no cane or nothing [laughs]. You know? And I'm like, man, how am I supposed to walk?

I: 'Cause you couldn't put weight on your foot.

R: Yeah. Couldn't put no weight on my foot. So then when I do go back up there for the next exam, the doctor who did the surgery, he's like, "Where's your crutches at?" I said, "Man, they didn't give me none." He blew a fuse...he was very hot about that.

I: And what did he do? I mean he got mad, but what else did he do?

R: He found out who the individual was that did my discharge paperwork and...he's like, "Man, ain't no way y'all are supposed to let this man outta here

without no crutches or a cane.” I knew I was supposed to have them and I told them, you know? But they like, “Well, it’s not on your paperwork, so,” I went, wow, OK. So basically...I’m just taking it as it is...By being denied medical treatment before inside institutions, and everything, I just learn how to, OK, well,...maybe if I just keep pushing them, pushing them, somebody will get me in and do something about it. And that’s all I can do. That’s all I can do, you know? That’s all. (P 8: Paul IV#2 8:6 37:48)

The hospital staff’s indifference to Paul’s situation threatened the healing process of his foot and placed him at risk of falling. The physician had ordered crutches for Paul but the staff was unable to find the order. The physician’s instructions could have been misplaced or not included in the discharge planning but the staff did nothing to discover what had happened. Furthermore, the staff seemed disinterested in rectifying the mistake despite Paul’s obvious immobility. Paul left the hospital without the necessary supplies. It was not until the follow-up with the physician that Paul received the crutches. The doctor advocated for Paul in way he could not do for himself.

Paul believed his strategy for dealing with recalcitrant medical staff was to push them until he had resolution. However, in this instance, he accepted the staff’s shabby treatment of him and left the hospital without obtaining what had been ordered specifically for his problem. Excessive paperwork and indifferent staff were inherent to both the prison and safety net systems of health care. Paul was disempowered by his repeated and ineffectual dealings with these systems. Despite his idea of himself as his own champion, he was unable to advocate for himself. Paul’s needs could only be addressed by someone of a higher authority, i.e. the physician. He allowed the physician to speak for him in a way he could not; this was how Paul navigated the safety net health system. He relied on the power of others to ensure the adequacy of his 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 two decades earlier. For a time John managed his pain and immobility with heroin. However, in the last few years as his pain worsened, he engaged the county health care system. He received appropriate diagnosis and treatment in addition to building a case for permanent disability income and insurance. During this time, he was reincarcerated for 12 months on a parole violation. Upon release he reconnected with the health care system and hoped to resume his disability case only to learn his medical records could not be located within the county hospital.

Prior to his arrest John was to begin physical therapy for his back and his disability paperwork was to be filed. He had the support of the health care system. However, with the loss of his medical records his case or any memory of it no longer existed. His records were his means of communication with medical staff and the larger social security system; without them he was excluded from any conversation about his health condition.

R: ...They lost my records in the county hospital so I can go forward with my SSI to get...therapy and stuff like that. So now they say I have to go all, through the whole shebang again, get the x-rays. You know, x-rays don't show up really, no back chronic pain or arthritis...So then I have to go back into the MRI again, and that's where it showed that I had the arthritis in my spine. And I'm not [laughing] really looking forward to doing that, but I know if I have to in order to get, 'cause I can't work. I, I can't do no hard labor, physical. I can get on the phone and be a telecommunicator and all that. But that just seems like, you know, I don't know. But anyway, I want to try to get this SSI so I can get, get my necessities, my place and stuff like that. You know, that's my goal, while I'm kinda here, and I'm waiting to hear, to hear the approval or disapproval of that in a couple months. But...before I got busted...I was supposed to go to a therapist in Fairmont. And they're not saying none of that right now 'cause they lost all my records, so I can't follow up...you know, . . .

I: That must be frustrating.

R: Yeah. Oh, yeah, it is, because I really ain't trying...to go over there for a good eight to ten hours over there at County. I'm not really looking forward to that, doing that again, because these people, like I said, sign a waiver to go get the records, and then all of a sudden the records are not there. You know what I mean? I'm like wow. It's not been long, you know? I do this year and out violation, it hasn't been really too long since - where the heck is my records? So the other day I went to SSI again, to the initial process, and I signed like six waivers, you know, so I guess they're gonna shoot some more, the waivers back. (P17: John IV#1 17:3 37:42)

Without documentation his reengagement with county health services was blocked and his problem de-legitimized because there was no medical "proof" of it anymore. Through the carelessness of the system, John had to repeat the required evaluations. This was an idea he did not relish, as the waits at the county hospital were long, demanding an entire day of his time. In addition to losing access to needed medical care, John had fallen behind in his effort to achieve financial independence via disability benefits. This was the only way John could attain some semblance of stability and successfully reintegrate into his home community. His employment opportunities had been restricted due to his injury and though he was aware opportunities for desk jobs were available, these seemed to him a remote idea, almost impossible to grasp. Therefore, his only option was build his medical record anew.

R: Yes, I had a MRI, yeah.

I: But you, but those have been lost also?

R: Yeah. Yeah. I mean the doctor showed me where - I even talked to a specialist...And he showed me the x-ray and he showed me the part of the spine... that was affected, you know, with the arthritis...and then I would complain about my legs, you know what I mean? Stuff like that. But not as bad. You know, but now they're getting bad. They're getting worse. And like I said. I haven't seen a real doctor...since then, you know?...I just hope that they do dig up them records, 'cause I really don't want to go back there (to the county hospital)...if I have to, I will. You know what I mean? And I should, I should, but I just, like I say, I signed a waiver already to Social Security the other day, and maybe they'll, you know, being it comes from Social Security, maybe they'll

look a little deeper, 'cause I believe they just didn't lose my records. I really do.
(P17: John IV#1 17:14 264:270)

John questioned whether his medical file had truly been lost but rather misplaced or misfiled by medical records staff. However, he as an individual patient was powerless to force the records department staff to look more carefully. He hoped that a letter from the Social Security office would draw staff's attention to the importance of his documentation; he relied upon the agency's power to advocate for him. John wanted and needed to participate in health care services yet an administrative mistake made it seemingly impossible for him to move forward with his case and his life as integrated member of the community.

Robert addressed another administrative barrier to care: long wait times for clinical services.

R: You know, the reason why I don't want to go to the county hospital, the reason why I say I don't go to the county doctor[s] a lot, the truth is it takes so long...it's like ridiculously long...I went to a doctor before at the county and waited so long that I just said fuck it. You know what I mean. This happened a number of times. Last time I was here, I went. I pulled my muscle lifting weights. I pulled my [shoulder] and it was like it wouldn't stop hurting, so I went to the county. I went about like 9:00 in the morning, and it was still about like 3:15, and I went from - I did the paperwork. I seen the person who did the financial thing, where they put you on that - and then they say [go to] acute care...It was like, man, then I had to be back on my pass at 4:00 (he had to return to the drug treatment program), which I probably coulda stayed, but I was tired of sitting up in there. [For] just my shoulder, I'm just gonna relax. I'll come back another day...

I: So you never even got the visit.

R: No. Nuh uh, I never . . .

I: 'Cause the waiting was so discouraging.

R: Yeah, it really is. (P10: Robert IV#2 10:11 218:232)

Robert waited for over six hours to be seen for a musculoskeletal injury without success. The prohibitively long wait disheartened him and he finally left before he was clinically evaluated. Robert had other responsibilities to attend to and it was clear that the

county hospital was not going to accommodate Robert's commitments by seeing him in a timely way. Robert left the hospital without receiving treatment for his injury. The excessive time spent waiting made what care he might have received not worth his effort. He had given up on the safety net, despite his motivation and interest in accessing and receiving care. Had he not had to wait so long and so fruitlessly, Robert may have been willing to participate in health care more regularly. However, in this instance the health care system was not only unable to provide him with treatment but had wasted his time as well.

Timothy, a 47-year old white man with Hepatitis C, chronic low back pain and SUD – methamphetamines and alcohol, also articulated long wait times as barrier to accessing health care.

R: ...And it's hard out there to get medical attention, especially when either, you know, see, you've got the scale, the poor and middle class and the rich. OK? There are a lotta programs out there for the poor. You know?...OK, let's say for hypothetically [sic], it's like you can't starve in the Bay Area. There's always somewhere to eat. Always. And the medical thing, in a sense it's like that. In a sense. You just have to...do the leg work for it and...I guess to get back to like the difficulty - to go through medical attention or seeking it is, like I said...having the patience and going through it...Like I say, I wish it was like it the universal thing (universal health care), man, you know - without a doubt, that would be a great. That would help not only I, but a thousand other people that were in the same position that I am...just the thing is, man, like it's time consuming in a sense...There's a lotta clinics...you know, where you can go seek medical attention. But like on my part, it's the time consuming thing. You know?

I: So the time it takes to access health care is a barrier for you.

R: It's hard. It is, man. Not really because of my work schedule. It's just the fact of waiting there, waiting and waiting. You know, waiting...

(P19: Timothy IV#1 19:9 288:315)

Timothy was aware that his options for health care were limited to county-run clinics and hospitals. While a variety of programs were available to him as a poor person, these programs were overburdened with others in similar circumstances. He knew

he was on the outside of the care available to individuals of higher socio-economic standing – a system of care potentially less overcrowded and more efficient. Timothy was not angered by his assignment to a lower-tier system of care but he chose not to participate in it because it was too prolonged. Timothy saw the protracted wait time for services as a waste of his own time; energy expended with little in return. As a result, his chronic conditions went without evaluation and treatment.

Luke, a 44 year-old white man, also discussed the difficulty in accessing care without health insurance. Although he received disability benefits and Medi-Cal as a result of his mental illness, Luke had periods where his coverage lapsed and he had to resort to the county hospital and clinics. In the following narrative he clearly articulated the substandard care available to him as an uninsured person. Services available through the safety net health care system felt second-rate. The physical location of the clinic was often not conveniently located and the clinic itself, overcrowded. The clinic's staff, administrative and medical alike, were frequently unprofessional and unskilled. Luke believed, in essence, that safety net care was not only inaccessible but inadequate as well. Therefore, and with the exception of emergencies, he was not motivated to access services in a consistent way.

R: No. Health care is not offered to me on the streets. If I wasn't on Social Security, I didn't have my paperwork right till just recently, health care is not available. Or readily available to a person that's living on the street. I mean you can go to a clinic. Over in Oakland, get on a bus, dadadadada, do whatever you gotta do to get there. It's a free clinic or whatever, so you're gonna have the lower percentile of, percentage of the classes there. A lotta stuff you gotta deal with. The people are gonna be - it's not near the quality, the professionalism, and you're not motivated to go through all that, unless it's something major going on in your life...(P11: Luke IV#1 11:5 78:87)

Luke did utilize emergency services in a somewhat regular, albeit inappropriate, way. He discovered that managing his chronic illness via the emergency room was effective and easier than accessing care from the community clinics.

R: ...I would go to the Emergency Room, and they'd give me Glucophage and some Insulin, and syringes for 30 days...And then they'd say, "OK, you don't got any insurance, go, go to a clinic." They gave me a whole list of stuff like that, but I'd never pursue it after that. I'd go right back into the Emergency Room, when things got tough like two months later. I'd be off the meds for like a month, maybe two months off, because I'd already gone through the 30 days, and go right back to the Emergency Room and it started getting bad. They, they dealt with it like twice like that, and they're like, "You need to stop this. Go take care of yourself, 'cause we're not gonna accept you no more."

I: And did that motivate you to do a little bit more?

R: No, it was just like when things got bad again, you know, instead of going to this hospital, I got referred to another. Let's go over to [this one] now. You know?

I: So you were just ER hopping.

R: Yeah. As far as I know, as a person without health care, if you're in the street, there's health care available, but you've got to pursue it diligently. You know? There's a place you're gonna have to go stand in line. I've never had to do that...But I think if it's a big enough thing, I would do it. Diabetes wasn't...And if I lost my insurance now, I, I think I probably wouldn't do that either. Knowing me... (P12: Luke IV#2 - 12:2 43:62)

The emergency room (ER) staff informed Luke that he was misusing its services and refused to see him in the future. This happened repeatedly and instead of arranging follow-up care with a clinic, Luke would find a new ER. As a result of his Medi-Cal benefits, Luke was not exposed to the safety net system to a great degree. He was privileged, as most of his clinical services were easy to access. He had not needed to make accessing health care his sole focus; he took his access for granted. Therefore, the idea of overcoming multiple obstacles to care was new to him and, despite his chronic illness, required too much effort particularly when the emergency room was readily available. Without his benefits, Luke's illnesses and conditions would go untreated and

he would rely on his habitual pattern of coping he articulated in Chapter 4: waiting to be rearrested and reincarcerated.

Mark, a 62 year-old Puerto-Rican American, experienced administrative barriers to care in his attempts to see a psychiatrist. In his efforts to see a specific physician, he was passed from one professional to another under the guise of process. He ultimately gave up in his attempts to access care and doubted the system's ability to address his needs at all.

I: And what other things do you do to take care of yourself and take care of your health problems on the street?

R: ...Nothing...I just, like I said, I procrastinate. I keep putting things off.

I: And why is that?

R: ...one reason is that half the time I don't trust the people. I have no faith in them.

I: And why is that?

R: Because I've seen so much BS, you know? I mean I used to go to the psychiatrist in the street. Or I was supposed to go to a psychiatrist. And everything was I had to go through this person, this person, this person, this person...to get to the person that I wanted to see. I had to go through ten different people before I got to see him. And so they, you know, they prolong me everything. See? So by the time I got to this guy, me calculating in my head, it would be like two or three months. You know?

I: So you - did you feel like you were being just pushed off, or . . .

R: I was being manipulated. (P 3: Mark IV#1 3:25 808:831)

Mark lost interest in pursuing psychiatric care when he realized it would be months before he could see the clinician he wanted. He believed the system was using him and his mental health concerns were ancillary. It was apparent through the multiple procedures and layers of care that Mark was not a priority. This was hurtful. The system did not acknowledge his needs as urgent or even important and he felt excluded from the one system he had gone to for assistance. Mark grew distrustful of the health care system and this experience influenced his choice to pursue further care – which he did not. The emotional cost of participating in a system that did not acknowledge him or his health

care needs was too great. Therefore, his mental health went unattended and he persisted in his drug and street life without treatment.

Structural Barriers Conclusion. Participants felt stigmatized by the health care system for their poverty and social standing. They believed they were penalized with substandard care because of their marginalized circumstances. They worried that their health would be further compromised by inadequate treatment and an inability to afford life-sustaining treatment should it be required. As a result of their socio-economic status, participants could not choose another system of care and were powerless to make the safety net system respond to them in the way they wanted and needed. They were aware of their exclusion from what they perceived as higher quality care and this alienated participants further.

As a result of administrative barriers, participants were frequently unable to access the care they needed. Carelessness on the part of medical and administrative staff hampered participants' ability to resolve their health problems. Ineffectual treatment threatened not only their physical wellbeing but their opportunities for successful reintegration as well. Accessing care was a way in which participants attempted to take care of themselves, yet they were unsupported by the system itself in their efforts to obtain medical treatment. Excessive wait times and bureaucratic procedures discouraged participants from further encounters with the health care system as they believed the benefit of receiving care did not outweigh the cost of accessing it. Additionally, participants felt powerless to successfully advocate on their own behalves. They believed the health care system responded only to those with more power than itself and participants were no match for such recalcitrance and indifference.

Social Barriers to Health Care Access

Uncaring Professional Demeanor. Participants' willingness to utilize health care services was also limited by their social interactions with clinicians and other medical staff. They were often discouraged by medical professionals' attitude towards them and their apparent disinterest in treating their health problems successfully. Participants characterized clinicians' professional demeanor as lacking in empathy, cursory in their approach to participants' problems, and stigmatizing of participants' addiction disorders and circumstances. There was general feeling amongst the participants, that they were only an auxiliary part of the health care process rather than at the center of it. These aspects of clinicians' professional demeanor created feelings of distrust and a sense of estrangement from the clinicians they encountered and towards the health care system overall. Participants doubted both clinicians' interest in and capacity to address their health concerns and problems in a compassionate and thorough way. Their misgivings about their care attenuated their desire to seek further services from the health care system.

Mark most clearly explicated the sense of being discounted by the health care system and the suspicion that arose from such a dismissal. As he discussed in the following narratives, Mark articulated feeling forsaken by the clinicians he had gone to for assistance. This feeling of abandonment exacerbated his general sense of isolation and alienation from others.

R...But for every good one there's a thousand bad ones, you know? And I was on Methadone, and when I was on Methadone, you know, the doctors that were there and the clinicians, like you said, and everybody else that - most of the staff that worked there, it seemed that they didn't care. You know?

I: And what gave you that feeling that they didn't care?

R: Well, the way they...like I was on 80 milligrams of Methadone, and it seemed like all they wanted you to do was just come there and get the medication. You know? And so you had to meet like once a week with your counselor...And usually he only saw you for five minutes. And it was supposed to be like an hour or so. And he would only see you like for five minutes. "Oh, you can go. You got things to do, eh?" "Yeah," "Oh, well, get outta here," you know? Like they really wasn't into it, you know? (P 4: IV#2 4:24 350:361)

The methadone clinic staff's indifference towards Mark troubled him. He was not acknowledged as individual in his own right but rather being subordinated to merely another addict receiving a daily dose of methadone. This was evidenced in the brief amount of time Mark's counselor would spend with him; mandated hourly visits were cut short under the pretense of Mark's schedule. However, nothing would have pleased Mark more or reestablished some semblance of faith in the medical community had his counselor displayed an interest in Mark. Mark was ready and willing to accept both support and guidance, things he desperately needed, as he was unable to give them to himself. Therefore, to not receive concern from an individual's whose job it was to provide it further discouraged Mark's interest in his own problems and reinforced his doubts about his own intrinsic value. Additionally, the dismissal on the part of the counselor and the clinic itself engendered in Mark a general distrust of the health care community. It seemed impossible to trust a system that was unable to achieve its primary purpose – to care and assist those in need.

Mark's wariness of the health care community was amplified by the dispassionate stance of his psychiatrist. The physician's uncaring professional demeanor barred Mark from developing any sort of supportive or meaningful relationship with the psychiatrist.

R: Yeah, but let's say, for instance, the parole psychiatrist. I would never talk to - he, he doesn't even want to talk to me...So how can you have confidence in somebody like that and tell them about yourself when he's not really interested in

you?...He just wants you to come there and he gives you some pills and runs you out, you know? (P 4: Mark IV#2 4:17 169:171)

Mark questioned the psychiatrist's trustworthiness. Mark had no assurance that the psychiatrist would treat his vulnerabilities with respect and concern and the psychiatrist was indifferent to Mark's situation. This seemed particularly insulting, as Mark was not able to reject the psychiatrist outright. He had rejected Mark first.

The physician's intentional distancing from Mark gave rise to doubts about his competency as a clinician. It seemed unreasonable to Mark that a physician would write prescriptions so freely and without any confirmation of Mark's abstinence.

R: ...I don't know how he (the psychiatrist) got his license, where he go to school at, but he's not too cool. He'll give you anything just to keep you away [from him]....So I asked him, "Listen, I'm, I'm clean," and all of this and that, "and just give me," and he says, "Well, I'm going to give you medication for 60 days," or something, and "Oh, that's nice. That's beautiful." You know? That don't mean I have to take it. Sometime I don't take them. You know?
(P 3: IV#1 3:25 381:389)

Mark could lie to this man without consequence not because he was unaware of Mark's subterfuge but because he did not care. The psychiatrist's apathy towards Mark exacerbated Mark's own apathy towards himself. Any interest Mark may have had in managing his psychiatric problem was dismantled the psychiatrist's neglectful demeanor. Additionally, his distrust of medical professionals was more deeply entrenched.

R:...And sometimes you might come across somebody that is really helpful, is interested, you know? But by and large, you know, all the people like in the Methadone program over there, and they were - they don't care about anything. You know? So sometimes I shouldn't be that way, but I see somebody that's, does things one way, and I think that everybody does it the same way, you know? You know, so like one person, everybody pays. You know? One bad apple, all of them are rotten, you know? (P 4: Mark IV#2 4:26 402:403)

Mark's skepticism extended to the entire health care community. Although he acknowledged the presence of competent and caring professionals, encounters with such

individuals had been few in his experience. Mark recognized the narrow range of his perspective but given the predominantly negative tone of his past clinical encounters, it was difficult for Mark to believe that he should anticipate anything different. Therefore, Mark's estrangement from health care services increased and his addiction and psychiatric disorders went unattended.

Steven, a 55 year-old African American, also expressed doubts about his physicians' concern for and understanding of his circumstances. However, Steven's health problems necessitated regular clinical follow-up to manage his multiple chronic conditions. Therefore, his disenfranchisement from the medical community was not a totalized one. Furthermore, in the following narrative, Steven articulated his frustration with a new physician's desire to change his hypertension regime – one that had been successful in managing Steven's blood pressure for a long period of time. Steven was particularly bothered by this new physician's unfamiliarity with his clinical case. The provider did not respect Steven's knowledge of his health history or his status as an experienced patient within the health care system. The physician disregarded Steven's own expertise in favor of his own agenda. He seemed immune to the suffering a medication change would cause Steven; this exacerbated Steven's general distrust of physicians.

R: ...When it comes down to changing my medications...that's what really bothers me. You know I take a lot of blood pressure pills. So this particular doctor that I seen like two or three weeks ago, he don't even know me. I just got transferred to him. That's why I don't too much care for the VA doctors. He's gonna tell me, you taking too many pills, but it's controlling my pressure, so I want you to start taking lesser pills. And next thing I know, my blood pressure's high and I'm in the hospital. Because of my blood pressure's high an it's making my chest hurt...So he doesn't know...his history of me. And it's gonna take time for him to know it so I have to go back every week for blood pressure checks, I'm having headaches, so what he's telling me to take, I'm not taking it. I'm taking

what I've been taking to control my blood pressure, to have a good blood pressure like 120 over 66. It was perfect with the medication I was taking. It took a long time for them to get me the right combination of medicines for this to work. "Aw, you're taking too many pills." So you know, I was kind of pissed about him, pissed at him about it. But I said, I'm gonna take what I've been taking.

E: Did you say that to him?

S: No, I didn't tell him that. Because...I needed blood pressure medications. If I wouldn't comply, he wouldn't have write me out my scrips... This doctor don't know what he's talking about. And that really bothers me, with him. "Oh, you taking too many pills." It's gonna take a while for him to get to see that-well he's never going to really find out now, because I'm taking what I have been taking.

E: So you're completely have shut down to him.

S: Exactly. Because I don't want to be walking around here with my blood pressure high when I know three blood pressure pills is not going to work for me. And I'm taking seven, I've been taking seven or eight for a long time, just to get a good blood pressure.

E: Did he explain why he wanted to switch you to the other meds?

S: No, he says because I was new on his caseload, and he wants to get to know me, and he wants to see what works. I've been trying to tell this man, I tried to explain to him, that three blood pressure pills is not gonna work for me. I have chronic high blood pressure. I don't want to be walking around here with headaches at night. And I know when my blood pressure's high. So that's why I- and he's not the only one-that's why I don't too much care for what a doctor says.

(P28: Steven IV#2 28:1 14:30)

The physician's seemingly arbitrary change in the medications angered Steven.

His well-controlled blood pressure was hard-won and this doctor, unschooled in Steven's medical history, was dismantling what Steven had struggled to achieve. Steven tried several different regimens of medications without success and with troublesome side effects. It was not until he was residing in Seattle with his daughter that, together with his physician, Steven found an efficacious combination of medicine. He described this experience in the narrative below.

R: I been through so many different combinations of blood pressure pills. Some of them was constipating me, and I was still having high blood, my pressure was still high then I finally, I think I got this set up in, when I was up in Seattle, with a doctor there, finally got me on the right medicines. That got my blood pressure controlled. (P28: Steven IV#2 28:2 38:38)

The new physician threatened the balance Steven had achieved with his hypertensive treatment. However, Steven was not sufficiently empowered to relate his dissatisfaction to the physician and instead feigned acquiescence. In this way, he was able to access the necessary medications and continue to do what he wanted away from the gaze of his new physician. Steven was estranged from the health care system in that he could not relate to it from a place of equality. Physicians had power and control over his health outcomes and Steven worried if he challenged them his medical providers withhold treatment he relied upon not only to maintain his blood pressure but to sustain his life as well. Therefore, Steven was enmeshed in a requisite but unwanted relationship with his providers. He could not withdraw from the system, as his health was too fragile yet he was not capable of engaging with it from a position of strength and experience.

Instead he reacted to the physician's disregard with subterfuge. As a result of this response Steven never gained equal footing in the discussion over how his health conditions should be managed. The physician, too focused on his clinical agenda, was unaware of Steven's powerlessness in the face of a clinical encounter. While the encounter with this physician did not diminish Steven's access to health care services, it did reinforce his passivity in addressing his health care concerns with clinicians. Therefore, Steven's inherent distrust of this physician and physicians in general barred him from engaging more positively with his clinicians and limited his capacity to take charge of his own health.

Robert, while not overtly distrustful of or resistant to medical care, did question the competency of the care he received in the community. He suspected the medical system of holding back both resources and treatment in addressing his specific concerns.

He wondered why he had not received the care he believed his problems merited. The unknown state of his personal health and the medical community's inability to provide him with answers unsettled Robert. Furthermore, Robert felt judged and dismissed by the clinicians he encountered for having an addiction disorder. Robert wanted to have faith that the health care system would take his concerns seriously and address them thoroughly but his past experiences made such an idea difficult to believe.

R: ...Sometimes I don't think they're taking me seriously when I'm explaining these problems to them. 'Cause I get the impression, especially since I'm a drug user, you know what I mean? And a lotta times I won't even share that fact with the doctor...Because of the adverse response. It's been my experience that if you tell them you're a user, they don't take you seriously no more. They think you're in there to take some dope or something. You feel me? And I don't even take pills. So I'm like that's not even a concern of mine. You can't give me no crack, so [laughs] what would I be in here playing for?...But this is the kinda attitude that I get. You know? And it's like just take me more seriously. I'm gonna tell you I got a [problem with] my stomach, or whatever, I want it checked out...I want you to know that I really believe somebody to be thorough with an exam.

I: What does that mean to you?

R: ...I go in for an annual physical, right? And my experience being [that ain't] no physical, OK? [They check] my stomach, my back, check my temperature, you know what I mean? Ask me a few questions. Write something down and then that's it...So I don't know if that's right, but I don't feel that it's thorough. OK, if I tell you there's something wrong with my stomach...don't you supposed to take a little thing, put the cream on you, and take a picture and see in my stomach? I'm saying...I don't get that. I ain't never had it...And it's like I tell you about my joint pains. I don't know what they supposed to do, but I know they're supposed to do more than just say, "It might be arthritis," or, "It might be." OK, if it be arthritis, aren't they supposed to find out and try to prescribe me some medicine for it or something like that?...Cause I mean they don't, I feel like, honestly, they should let me know if it is or if it ain't. You know what I mean? I woulda never brought it up if it wasn't a problem. So you sit there and tell me, "Oh, yeah, it might be."...OK, yeah, now it might be, but I still don't know nothing. And that's been my experience in a lotta cases...(P10: Robert IV#2 10:15 334:347)

Robert believed he was being denied medical care and he was unclear to as why.

His treatment may have been the result of stigmatization the part of his medical providers, although he had a sense that the cursory treatment of his problems was the

clinical approach taken generally. Regardless of the reasons, Robert was frustrated by the inadequate treatment he had received thus far. He worried that something gravely wrong with him had gone undetected by his medical providers. Furthermore, he did not feel well and the clinicians he encountered were unable to provide him with solutions to his ailments or even explain their uncertainty about his possible diagnoses at the time.

I: So if there was something that you could do, what would that be?

R: ...what I would like to have is a complete physical. I know I got some stuff wrong with my stomach. It's not supposed to hurt like it does sometimes. You know what I mean? My back. And even my shoulder. I'm gonna give you an example of that. The time I told you my shoulder was hurting...It hurts all the time ...Sometimes I can barely lift my arm up...sometimes my joints hurt, and sometimes my fingers get clamped like this...And I share that stuff with the doctor, and they just shine it on...(P10: Robert IV#2 10:14 260:294)

Had the clinicians reassured Robert that his problems were both real and being taken seriously much of his apprehension would have been alleviated. It was the ambivalence of the clinicians and the perceived lackadaisical approach to his problems that heightened Robert's anxiety. The clinicians seemed unaware of the impact of their demeanor on Robert. Robert wanted answers to his problems and to feel well but his clinicians' persistent disregard of him made his efforts seem futile. He suspected he would never receive the treatment he needed and felt powerless to demand it.

Luke also expressed a feeling of being judged for having an addiction disorder and receiving inadequate treatment because of it. In the following narrative, he described the treatment he received in the emergency room when being treated for an abscess.

R: [Long pause]...I've gone in where they've broke out before (abscesses), and you have to have them lanced, you know, different places. And even though they (the hospital staff) know that's from like shooting drugs, they'll break out of your body right away, you have cellulitis, and so they're 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. You could see how, like if you go in to the ER, you can see how their pleasantness or something changes from when you go in there with like a cellulitis or something like that... (P11: Luke IV#1 11:9 140:151)

The change in the ER staff was palpable when they realized Luke required treatment for an abscess and cellulitis. The staff immediately assumed Luke was 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. It was as if the staff was punishing Luke for his immoral lifestyle and for monopolizing clinical time that could have gone to someone more worthy. Over time Luke had come to anticipate such reproaches as an inherent aspect of receiving medical care as a drug addict. However, as he articulated in the following narrative, the substandard care he experienced and witnessed others receiving initially shocked him.

R:...and it's a drug-related infection...And as soon as they see that, they're already not - you're not a paid customer. They already know you don't have a job, and there's a whole waiting room full of them. And their attitude goes from just mediocre to really in the dumps. I notice that they - they cut on my girlfriend one time on her leg, and, you know, she's a good looking lady, and the lady was not very pleasant to her. And, and I couldn't believe that. And this was a health care professional.

I: And you felt that she kinda judged your girlfriend.

R: Oh, yeah, and - well, when you go in with one injury, they'll put you in a waiting room, but if you go in with our type everybody's lining the walls. On beds. As soon as they find out you have cellulitis or, you know, an abscess, something like that, you're going on a gurney next to the wall. With maybe a little drape around you. If you have any other type of ailment that doesn't reflect drug use, you'll be in a little cubicles. That's a fact...And that was - that was, that was like an epiphany - that was like the third time we were there, twice for me and one time for her. I said, "You notice we're always on," she goes, "Yes, that's," over the years she had a husband that was a heroin addict. She said over the years they used to bring her husband and he would always be on these gurneys. That's the way they keep people. You know, I was like, "Wow!" (P12: Luke IV#2 12:11 193:216)

Luke was distressed by the clinician's treatment of his girlfriend. His girlfriend stood out as an attractive woman, not an unkempt drug addict yet she was not exempt from being categorized as a substance abuser. This was particularly disturbing for Luke as it was a clinician, not an ancillary staff member, passing judgment on his girlfriend. Therefore, in Luke's perceptions, the shabby treatment of drug users was accepted by all members of the hospital staff; even those with a professional mandate to do no harm.

The stigmatizing medical care Luke received included not only the interpersonal interactions with health care staff but the physical location where he was instructed to wait for treatment as well. Luke observed that he, his girlfriend and others sharing similar circumstances, were allowed no privacy or modesty. Such considerations were available only to the more deserving patients. The hospital staff's overt disdain towards and ostracizing of those with drug-related infections flabbergasted Luke. They were being penalized for having the wrong sort of health problem.

Timothy also reflected on the general lack of empathy and concern amongst medical providers – clinicians and support staff alike.

R: I guess, you know, if you're gonna be in the medical field, you gotta have the heart for it. You gotta have um. The patience, the understanding. In dealing with people. It's almost a combination of social worker, psychologist, psychiatrist, a combination of everything, and, you know, you get a lotta folks that don't even belong in that kinda field ...I don't know if they should take a class, take more initiative for the individual, if they're gonna get in that kind of field, to love that kind of field, be more humble with themselves instead of turning around and setting somebody off to the side...and the receptionist making the time...it should be on the patient, what time they can come in. Not when the doctor has. "Well, I can fit you in." No, no, no, no. This is my life here, man. I feel that this is the time I can be here. OK? (P19: Timothy IV#1 19:9 288:315)

Timothy was surprised at the dearth of individuals possessing empathic qualities, despite the importance of compassion and sensitivity when working with patients. He balked at the unpleasant demeanor of most health care staff and the arrogance of the health care system in general. These negative aspects were apparent to him in how appointments were made with little regard to his schedules or commitments. He was treated as an entity working in service to the physician. This angered Timothy, who believed the physician should work in service of him. The health care system respected neither Timothy's time nor his personhood. He felt unappreciated and excluded from the one system intended to care for both his health problems and his self.

Luke poignantly articulated this feeling of exclusion, of not being cared about by clinical staff in the following narrative.

I: Have you ever felt like anybody cared about you within the health care system?

R: Cared. Let's see. [Long pause] No, no, not cared. You know, demonstrate caring...people are not real caring...I can't quite remember anybody caring...It bothers me...There's gotta be somebody...I've um - I had a dentist that was not like you'd think a prison dentist would be. But he wasn't caring...He explained things to me. But that's the closest caring I've ever seen. I've seen interaction between the two, like a nurse and him, or two other professionals in the field that it seems caring when they work together. But they're talking over you when you're laying on the table, or they're doing their business, and they're pleasant amongst themselves, but it's not extended to you.

I: And how is that for you? Witnessing that?

R: Well, you don't have a lot of common ground to meet them on, you know? "How's your golf game?" You know? "Catch any bass this weekend?" That's what they're talking about. Their kids, Rugby and stuff. "Sir, we gotta draw some blood from you." "You gotta - we'll be doing your urinalysis," stuff like that.

I: So it's like you're not there.

R: It's part of the business, yeah. Can you fill those spaces in with caring people? You'd be looking for a very small group of people, going into those slots and have to care. Mother Theresa's gone. (P12: Luke IV#2 - 12:6 125:134)

Luke was disconcerted by the few experiences of being cared for he had had. He could not recall one. A dentist in prison had provided him with some insight about his

dental problems but the dentist's emotional interest and affection was directed towards his coworkers. It was patent that Luke was not a participant in the staff's exchange of pleasantries. Luke was one small part of a large machine that moved regardless of his presence in it. In essence, he had become a commodity; he was the thing to be operated on rather than the primary reason for the staff to come together at all. Luke's problems were what allowed the dentist to perform dentistry yet he received no acknowledgement for his role as patient. The gap between provider and patient was widened by the difference in the two men's social standing: the dentist a successful member of the free world and Luke, a mentally ill convict with an addiction disorder. There was no way their lives could intertwine to exchange more than a cursory greeting and clinical education as needed.

While Luke had not been treated poorly, he had not been cared for either. He questioned the existence of such caring individuals in the health care field. Therefore, he would continue to access clinical care for his problems especially while he was incarcerated but his expectations of empathy and concern for his situation on the part of clinicians would continue to be low. Rather than altering the degree to which Luke accessed health care services, the uncaring demeanor of most clinicians illuminated his general feelings of alienation and isolation not only from health care but society at-large.

Social Barriers Conclusion. The uncaring professional demeanor of clinicians and ancillary medical staff left participants feeling uncared for, doubtful of their clinicians' competency, and believing their needs were subordinated to the needs of the system. Clinicians' indifferent attitudes attenuated participants' desire and motivation to seek out health care because they believed they would always be treated shabbily. Participants

distrusted the clinicians and were skeptical about clinicians' ability to resolve their problems and treat them in an empathic and welcoming way. Participants' suspicion of clinicians and the clinical realm in general further disaffected them from the health care system and its professionals.

Participants also felt marginalized due to their addiction disorders and incarceration histories. In response the stigmatizing and uncaring attitudes of their medical providers, participants withheld information about their circumstances and conditions and chose to not seek additional care, further alienating themselves from the system. Participants held clinicians at bay from the conditions, e.g. substance use disorders, most directly affecting their capacity to reintegrate. Participants were unable to establish a long-term and trusting relationship with a specific clinician or clinic because they did not believe they would be treated empathically were they to reveal the circumstances of their lives. Therefore, participants' health problems and conditions continued to go unmet and any potential for the health care system to address problems specifically related to their reintegration was never developed.

Structural and Social Barriers to Care Conclusion

In response to the financial, administrative and social barriers to care participants felt that their concerns were not taken seriously as legitimate problems. They were frustrated by their lack of health care choices as well as being resigned to one inadequate system of care. They questioned whether the safety net system could provide the necessary and desired care for their conditions. Should they be able to access such care, participants wondered about the skill and expertise of the clinicians providing it. Participants wanted to engage clinical services to their benefit but they were discouraged

by the multiple barriers they encountered in their efforts to seek proper evaluation and treatment of their problems. Furthermore, participants were at a loss as to how to attend to their own problems and had accepted the possibility that their health concerns and conditions might not be resolved at all.

Participants' problems were discounted by the health care system both in the administrative and social barriers they encountered. They expressed feelings of futility and powerlessness as result of these barriers; it seemed pointless to expend the energy accessing health services when their problems were unlikely to be addressed. Participants felt excluded from the health care system, as if they were not a part of the dialogue around their own health. They were depersonalized by the care they received, as if they were commodities within the system itself. Accessing medical care seemed insurmountable and when participants did receive it, they could not be certain such care would either be compassionate or competent. As a result of the structural and social barriers to care, participants lost interest in seeking it and many of their health problems continued to remain untreated.

Social and Structural Facilitators to Health Care Access

Introduction

There were two primary facilitators to health care access: clinicians' caring professional demeanor and an ease of access to health care services. Clinicians listening to and respecting participants' experiences and effectively addressing their needs characterized a caring professional demeanor. Participants experienced caring professional demeanors in the correctional institution as well as in the community. Correctional experiences of caring were included in this analysis because they made a

difference in how participants understood and managed their illnesses. Participants experienced an ease of access to health care services in the following ways: clinical services were conveniently located, ancillary services, e.g. labs and low-cost medications were readily available, and there was access to payment sources. The elimination of these structural barriers allowed participants increased access to services. However, it was the caring professional demeanor that proved to be the strongest facilitator of participants' efforts in accessing health care and in taking an interest in their health problems. The attention, respect and appropriate treatment participants received as a result of their clinicians' caring demeanor ameliorated the difficulties they may have had in accessing such care.

Caring Professional Demeanor

There were three components of clinicians' caring professional demeanor: 1) demonstrated concern, 2) a respectful stance, and 3) the provision of relevant care. Demonstrated concern was characterized by the time clinicians spent with participants, their ability to listen and empathize with participants' problems and worries, and their capacity to make a human connection, i.e. share some of themselves with participants. The respectful stance with which clinicians approached participants, validated their individuality and personhood, legitimized their problems, and equalized the power dynamic between patient and provider. Through the demonstrated concern and respectful stances of their clinicians, participants felt included in the dialogue around their problems. They were partners with their clinicians in the care of their health and were the central focus of the clinical encounter; their needs were not subordinated to the needs of the clinician or system. These two aspects of clinicians with a caring professional

demeanor engendered feelings of trust within participants. This sense of trust encouraged further engagement with these clinicians and the possibility of a long-term relationship between participant and provider.

The third component, the provision of relevant care, was described as care provided in a timely and efficient manner. Clinicians were interested in addressing participants' salient needs and resolving their problems. The clinicians were organized and reliable and their care improved participants' circumstances. The receipt of such effective and meaningful care facilitated participants' access of further care, despite the structural limitations they may have encountered. They knew their problems would be resolved via their clinicians' competent efforts and therefore, overcoming structural barriers to care was not a waste of time.

Demonstrated Concern. Through demonstrated concern participants experienced understanding and compassion from their clinicians. Clinicians made an effort to know both participants' health history and their personal circumstances. The positive attention from their clinicians was important aspect of participants feeling that their concerns were addressed. Additionally, the positive interactions with clinicians were some of the few instances when participants felt valued for their individual personhood. Being cared for in general, let alone within the clinical arena, was rare for a majority of the participants.

Mark articulated the impact of demonstrated concern on his capacity to understand his feelings around a traumatic childhood event. While he was incarcerated Mark encountered a psychiatrist who took an interest in him and his problems. Although he was initially suspicious of her intentions, over time Mark grew to trust and confide in

her. This relationship was perhaps the most significant and meaningful health care encounter Mark had experienced in the course of his adult life.

I: ...what was significant about your relationship with the psychiatrist?

R: She was a - I didn't trust her... But after I seen her, I - three or four times, and I got kind of, you know, I thought she was for real then, you know?...because I don't like to talk about certain issues...and there was other things, issues that I had, you know, like I was raped when I was seven years old...I've always kept that to myself, because I didn't feel as though I was a man. You know? And uh, you know, it's always, it's always bothered me. And so I told her. And she said that was the best thing I coulda did...To stop keeping all of that stuff to myself...but I always still had that in me. I, I felt like a - my manhood was questioned, questionable. So, and then like when I deal with women in the street, I cut them loose right away...I don't hold onto hostages, you know? If they wanna go away, either you go or I go, you know? I don't get too involved in that kind of thing...but the doctor, she spoke to me about...along that line but, you know, brought up some other issues about that that were real helpful. And so I used to see her once a week.

I: what did she do that made you trust her enough to share this very heavy thing in your life with her?

R: I don't know. I don't know. It was just that I had seen her - I had known her before because I had been in that prison. And...whenever they lock me up, usually, they give me the medication, you know? So you have to see the psychiatrist in order to get any kind of mind altering drug, Prozac...The psychiatrist has to recommend it, not no ordinary doctor, you know? So, you know, I had talked to her before that, a coupla times, and then I left. So when I came back again, I saw her again, you know? And she says, "Don't I know you?" And, "Yeah." "Oh, yeah, you know. Tell me about it." But she gained a little bit of my confidence, and I was able to tell her things that I usually keep to myself that I never tell anyone. But she said that, you know, she said it, "The best thing you coulda did in your life was expose this, you know, try to bring it out, you know, and work it."

I: And did you agree with her? Did you feel that it was helpful?

R: Yeah...She was one of the few people that I trusted, put some trust in my life on, you know? And I knew all the time that if there was any help for me, it gotta come from somebody that was, you know, that knew what was, about the issue, you know? And I - and, see, she was a doctor of psychiatry, or criminal psychology. I don't know what she was, but she was good. And she made me see a lot of, a lot of - she didn't only let me talk; she talked to me. And she let me see the other side of the rainbow. You know? More or less.

I: And what was it about her talking that was helpful to you?

R: Well, she made herself like clear, like for real, you know? Like in the way she put herself in my position...She told me that she had had those experiences before with other guys, you know? And so she, you know, kinda broke it down, and I

felt comfortable around her. I still got her number. She told me if I have any problems in the street, you know, give her a ring, you know, not to hesitate. (P 4: Mark IV#2 4:16 128:165)

The sexual assault left Mark incapable of developing long-term or meaningful relationships with women and possibly impeded his ability to form any sort of friendships with men as well. This troubled him and was a thing he kept to himself for many years. However, he was able to reveal this to the psychiatrist who both supported him in his retelling and encouraged him to continue sharing what had happened to him with her. The psychiatrist consistently expressed concern for Mark's past experiences and current circumstances. Her comportsment towards him reassured Mark that she could be trusted to attend to his psychic pain. Perhaps most importantly, the psychiatrist remembered Mark from a previous incarceration. Her memory of him was an indication of his individuality both as a man and as a person; he was worth being remembered.

Additionally, the psychiatrist engaged Mark on a personal level, as if their meetings were more than clinical encounters mandated by the correctional institution. She not only listened to Mark but spoke with him as well. Her interest in Mark as a person beyond his psychiatric issues provided him with a feeling of hope. Perhaps for the first time, Mark felt he might be destined for something more than a life lived isolated and alone. In his meetings with the psychiatrist, he developed a meaningful relationship, a thing he had been unable to do in the past. Mark's sense of hope was in part due to the psychiatrist's concern for Mark but she also helped him understand what had happened to him. The psychiatrist was not shocked by his experience but rather willing to receive what happened to Mark in open and non-judgmental way; she helped Mark cope.

In his relationship with the psychiatrist, Mark experienced a human connection, a thing he had not found in his encounters with other health care providers. Mark's ability to trust in and connect with another person was critical to his openness towards receiving assistance from the clinical world. The psychiatrist understood this and took Mark's problems and his trust in her seriously. Furthermore, her concern for Mark extended beyond the correctional facility. She was available to Mark should he have problems in the free world. For the first time, Mark believed that someone cared about him; such caring both helped him confront a traumatic experience and gave him an idea of something better for himself.

In the following narratives, Steven also articulated the importance of being cared about as an individual person within the health care setting. Although Steven described having several caring relationships with and without romantic intimacy, the majority of his adult life was devoid of meaningful and emotional connections with others. Therefore, the role of registered nurse (RN) served an important purpose for Steven; RNs provided a degree of interpersonal closeness he would not have otherwise not had and they advocated for him in a way he could not advocate for himself. RNs provided affectionate attention and necessary protection for Steven. His relationships with RNs were how he managed as a patient and as an isolated and lonely individual.

I: Have you ever felt like anybody loved you or cared for you?

R: ...I've had two or three girls in my life that really loved me. And I know they did by-And I've had people that cared about me too. That I didn't have any type of (sexual) relationship with. I know that I can go to some of these hospitals out here and I have some of these nurses that care about me.

I: And is that something that's helpful to you?

R: Yes it is...It makes me want to go back to that hospital to get that type of attention. It really does. And if I feel like I gotta go to a hospital, I try to go to a place where the nurse is gonna know me by my first name. Not one nurse, but

two or three will know me by my first name. I don't want to go to, I don't like to go to strange hospitals. (P28: Steven IV#2 - 28:4 66:86)

Over the course of multiple hospitalizations and emergency room visits, Steven was familiar with many of the nursing staff in several different hospitals. The individual attention he received from the RNs made him want to return to these facilities for continued care. Perhaps the most important factor in his relationships with nurses was that the care and concern felt mutual. The nurses were willing to share something of themselves with Steven and took the time to connect with him on a human level beyond the confines of the nurse/patient relationship. His relationships with nurses were personal and welcoming. In a sense, Steven had created a space where he belonged and where he was special. He described the positive treatment he received from one nurse in particular in the preceding narrative.

S: ...And they call me by my first name-that makes me feel good.

E: They just call you Steven?

S: Yeah. Instead of that Mr. Smith. I don't want to hear all that. But see they know me, and they know I'm not gonna-and I might ask Rhonda (an RN) and I say, can I have some juice? I'm a diabetic. She know a little juice is not going to hurt me. And most of them say, "Oh, you can't have this. You can't have this until your components (lab work) come back." She already know it's not gonna hurt me. And that's what I like; that's what I like, you know? And I'm very respectful with her. She tells me about her three-legged dog. She's one of the best nurses that's in the system...

E: So what did Rhonda do that made you feel comfortable to let her get to know you?

S: Just through conversations like, I remember the first time I seen her. I was at the hospital and it's...very rare that you see a nurse with fingernail polish on her hands. And I said to her, don't you not supposed to be wearing this? And she said, "You know what? You right. I'm not supposed to be bringing this." So when...she came back she didn't have no nail polish on her hands. So I said to her, I said, you didn't have nothing else to do, but to go take that nail [polish] off your fingers. And she just started laughing, and ever since then we had a rapport because I was actually coming there like at least twice a month. So, you know, this is over a period of time. We just had got this rapport with each other. And she knows, she knows my history. She knows I'm allergic to... nitroglycerine. She knows that...and those little things matter. And she gonna make sure, even if

the doctor haven't wrote a order, she's gonna go get a order from a doctor, to give me the right medicines. And I like that about her. (P27: Steven IV#1 27:22 469:527)

Steven's relationship with Rhonda was a means for Steven to experience intimacy without the emotional liability of a committed relationship or friendship. She was a safe and convenient partner who cared for him completely asking little in return. Additionally, Rhonda was well versed in his medical history and communicated with his physicians to ensure Steven received the appropriate treatment. Steven trusted Rhonda's competency and her ability to speak to physicians on his behalf. When in Rhonda's care, Steven had a sense of security that not only would his health care needs to be attended but he, as an individual would be cared about as well. While it was not clear if Steven's positive interactions with nurses improved his health over the long term, such relationships were of value because they encouraged continued follow-up with clinicians who knew his medical history and understood his circumstances.

Louis, a 50 year-old white man, also expressed the importance of attentive and interested health care providers. In the following narrative, he described the positive impact that a clinician's caring demeanor had on him. Louis had no prior experience of such individual consideration and it shocked him.

R: The lady was - I forgot her name, but she was really helpful.

I: And why was she helpful? What was it about her?

R: Well, one thing is because she - she was real concerned about me, and she made sure, even if I would forget, she'd come get me. Or the day before she would put, by the name, a note, "Make sure you show up tomorrow." Because, you know, I had a problem where my memory's gone, and my eyesight, from drugs...So I told her about that, so she made sure that she gave me a reminder. And she was real helpful for me, I had a piece of paper, saying, "OK, I gotta show up to this tomorrow morning," so - and then the way she talked to me. It was like, she was real concerned. She came right over on the couch and sat with me. She didn't say any - didn't sit way over there, across behind a desk, and you know what I mean? She came over and sat with me, and she was real concerned about

me. That's the way I, I felt. And then for her to, to make sure I was there every meeting with her. 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." So I - you know what I mean? After a couple meetings with her, she sent me to that other guy, because she figures - 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. (P16: Louis IV#1 16:11 354:367)

While residing in a community shelter, Louis was able to see a therapist. Her office was in the shelter and she was accessible to all the residents including Louis. The therapist was not only physically accessible but took extra effort to ensure Louis remembered his appointments. She made herself available to Louis outside of their appointments as well. The therapist's approachability impressed Louis but it was her genuine concern for him and his problems that impacted Louis most greatly. During their encounters, she sat alongside him as they spoke; traditional symbols of the clinical encounter did not divide them. Her physical proximity during their visits gave Louis a feeling of trust that she was truly worried about him and that he could confide in her. He was assured that the therapist wanted to support Louis and find resolution to his problems. When she referred him to another clinician he believed her intention of obtaining a second opinion rather than wondering if she was passing him off to someone else. He attended the first visit with the second clinician and would have continued to follow-through with both providers had he not been rearrested. The circumstances of Louis' street and criminal life overtook his ability to remain in the community, but the demonstrated concern of the therapist was his first glimpse into the possibility of both understanding and coping well with his psychiatric problems.

Max, a 48 year-old White and Filipino American, experienced the caring professional demeanor of a nurse he encountered during his last incarceration. Max became acquainted with this RN while working as a medical clerk in the reception center for level 4 or the highest custody prisoners. He would assist the nurse with the initial physical intake for each prisoner. Over the course of their time working together, Max and this nurse developed a trusting and respectful rapport with one another. Max maintained the smooth flow of inmates coming for their exams and the nurse demonstrated concern in Max's family history and his own health problems.

R: [She] was...a very nice lady. She, we established a good rapport because... She was able to give me, instead of just being that nurse, you know, the R&R nurse, she was giving me [insight] on my health and everything like that, you know. I had told her about my mom, passing away of a heart attack, and you know heart problems and about her having diabetes and my sister, and she was telling me that I should check, you know, check that regularly because I guess it's, what's the word I'm looking for-like it can be passed on, you know? And so she was helpful in that way where if I had any problems with the other medical staff...she was there for me. You know, like, "Okay, if you have problems there don't get in no trouble, just come to work and I'll help you get your pills, you know. If you have any problems don't get no trouble, you know? Just come here." You have another resource to use instead of just like fighting a brick wall there. So she was real helpful to me. She would take my blood pressure, she'd ask me a lot of times, "How ya feeling today?" and it was a personal thing that she was, and so I was able to build a rapport with her that she wasn't just working there. And she was genuine with the people that came through and she'd see the bullshit that other people tried to run on her...So I kind of looked out for-because you can get some unruly people in there. I'd just lean over and tell them hey, you know, mellow out, because you ain't gonna accomplish nothing right now by getting upset at her; she's just taking R&R...So it was a good, real good work atmosphere for me and her being, like I said, her asking darn near every day, how are you feeling today, how are your meds working for you, you know, it made me feel real good. It was almost like having a personal nurse, you know? And every day they're checking up on you. "Did you take your pills today, you know? You gotta watch what you're eating, don't eat too many soups or nothing like that because of blood pressure and the salt. So you now, I really liked her...But it opened up my eyes about my medical, my health and stuff...So she opened my eyes about it, about that. You know, that I should really watch my health; I'm up there in age, you know and I enjoyed being around her. Having my own little

personal nurse. Even though she was everybody else's nurse, she would make that little extra effort, you know? (P30: Max IV#2 30:1 22:22)

Max was impressed by the nurse's consistent fairness and consideration with which she treated everyone, not only Max. She was not only kind but savvy to the sometime manipulative behavior of the inmates as well. Max looked out for her in this regard and diffused potential crises whenever possible. Therefore, as co-workers, Max and the nurse had an excellent relationship. However, the nurse also attended to Max's medical needs. She would check his blood pressure regularly and advocated on his behalf for medications or other necessary treatment; she negotiated the prison health system for Max. Her advocacy protected Max from the frustration and possible conflict when having to interact with the system himself. Additionally, Max benefited from the nurse's personal concern and attention. Although she tended to all of the prisoners, Max felt special as he received extra effort and energy from her that the other inmates did not. Through her caring demeanor the nurse encouraged Max to take an interest in his health problems and, upon release from prison, Max continued to manage his conditions in addition to seeking assistance from the community health care system.

Respectful Stance. A respectful stance demonstrated to the participants that clinicians understood that participants had lives outside of the clinical encounter. The respect that clinicians showed participants acknowledged participants' expertise in managing their own health conditions. When assuming a position of respect, clinicians also demonstrated that they did not need complete control over the outcome of the visit. The clinical encounter was a shared experience and clinicians together with participants came to an understanding about what was to happen in regards to participants' health.

Walter, a 51 year-old African American, articulated the concept of a respectful stance in an encounter with an ophthalmologist. Walter revealed to the physician that he had been using cocaine. Instead of reacting negatively or judgmentally, the ophthalmologist accepted Walter's drug use and accommodated his counsel to reflect Walter's current circumstances.

R:...I told my doctor, I said, "You know, I've been getting high." "Boy, you been getting high? On what?" I said, "Coke." He told me, he said, "OK, you need to just slow down, you know, just don't do it when you're taking your medication and stuff." He didn't ever tell me just stop, you know? I guess he felt like you just say something like that, the person ain't gonna just - just tell him to slow down, give me my medication, you know? It worked...that was a smart thing he did, 'cause, you know, I listened to that. 'Cause he coulda told me, just say stop. I wouldn't a' stopped. I just probably upgraded it. You know? Probably stopped the medication [laughs] and kept the coke going...Cause I mean that's how people - when you get high, that's how you react on things, some people...they do the opposite of what somebody wants you to do...they want you to just stop getting high...even though your high is what you wanna do, you know? And when they do that, you really rebel, and do the opposite...but yeah, he told me, and I started slowing down. Then like my eyes were always having pains in it. And so what I did, I started not getting high as much when I was having pain in my eyes...(P22: Walter IV#2 22:13 300:313)

The physician understood that Walter had his own life lived outside of and often no relation to the clinical world. Therefore, he did not demand that Walter desist from his drug use entirely. Rather he acknowledged his limited control over Walter's life and understood that an order to stop using drugs would have been perceived as that and immediately disregarded. Therefore, the ophthalmologist suggested Walter not use drugs when he was administering his medications. Walter appreciated his clinician's advice and recognized the physician's wisdom. The physician had recommended a self-care practice that Walter could be successful with. His advice was not a condemnation of Walter but practical information that Walter could employ if he chose to. The physician's respectful

tact was effective as Walter did limit his drug use, particularly when his eyes were in pain.

Craig, a 53-year old African-American, with HIV infection and hypertension, described his appreciation for the respectful stance his physician took with him. It was one of the reasons why Craig had confidence and trust in the care he received from his HIV clinic.

R: Excellent doctor. Excellent staff. So. I just feel I got a good doctor. He listens, you know what I'm saying? And if something seem to be wrong with me, he tells me I need to go have this checked out or do this...he takes his time with me. We interact pretty good as, you know, doctor-patient, so, and that's a good thing...I mean being that you the patient and they the doctor or the nurse, and you're the one with the problem, they should be able to hear your problem out and try to fix it. Wouldn't that be the right way? I mean instead of trying to say, "Well, this is what should be," you know what I'm saying? Instead of how some doctors can say, "Well, you need to try it this way," well, you might say, "Well, I think this might be working better for me this way," being that you the patient, and you the one that got to take the meds. So, my doctor, he seems like he, we kinda like listens to each other, you know what I'm saying? So we interact really, really well together, so. I mean that's why, the way I would want it to go for me. I mean I can't speak for no one else so. And if I'm having a problem, and I describe my problem, I would want you to kind of hear me out and, and if I probably say that this worked for me the last time, I would want you to, you know, more or less kinda go along with it instead of saying, "Well, I think this would be the best way to do this," you know what I'm saying? I mean to me I think that's the best way, for me. (P20: Craig IV#1 20:4 84:110)

Craig's physician listened to him and respected Craig's expertise regarding his own health. His physician was interested in Craig's ideas about how to resolve specific health problems. There was an open exchange of ideas between the two men. Craig was both included and respected as a key stakeholder in the dialogue around his health. The physician's respectful stance towards Craig equalized the power dynamic between them and engendered in Craig a feeling of trust that his concerns would be heard and treated as valid. Craig had the ideal clinical scenario: his physician both listened to him and

acknowledged Craig's knowledge about his health and his own life. Therefore, it was easy for him to develop a long-term and meaningful relationship with his physician.

Robert also appreciated the respectful stance of Planned Parenthood staff. He had gone there for treatment of a sexually transmitted infection, a potentially shameful event. However, staff responded to the fact that Robert had a health care problem, not a moral failing.

R: No, one time I went to Planned Parenthood... Yeah, and I went there, and it was kinda, you know, [I] filled out the paperwork and they gave me some little pills and it was over with... And the people are like more helpful. I mean, you know, it's like - they're kinda nasty at the county hospital. I mean they got attitudes, you know what mean?

I: What made you feel that they were more helpful?

R: Their attitude. I'm not paying or nothing like that, or they didn't talk down to you. That's kinda like - it ain't easy to go to a hospital and say I gotta disease from sex, you know what I mean?... They don't talk down to you. You know, it's like helpful, you know, if you have a question about it, filling out the paperwork or, you know what I mean? They take the time to explain. You know? What I could do besides just use a rubber. You know what I'm saying? Because other little things. I can't think of them right now, but I'm just saying they took the time. ... (P10: Robert IV#2 10:12 234:244)

The clinic staff took Robert's problem seriously and did not reproach him for being poor or having a sexually transmitted infection. This treatment differed from the county hospital where staff was often rude and unkind. At Planned Parenthood, the staff was helpful, as if they wanted Robert to have a positive experience with them. They provided Robert with relevant and useful information as well as treated him as an equal not a second-class citizen. While at Planned Parenthood, Robert was not rushed, his questions were answered and his problem resolved; it was the kind of interaction he had hoped for in all of his encounters with the county health care system.

Relevant Care. In providing relevant care clinicians demonstrated their commitment to resolving participants' problems both in the immediate and long-term.

Relevant care was not always directly related to participants' reintegration efforts but such care did improve their circumstances while in the community. Additionally, relevant care increased participants' interest in accessing further care and maintaining their follow-up appointments with some degree of regularity. In the provision of relevant and meaningful care, participants also believed that clinicians and medical staff went beyond the requirements of their normal duties and made an extra effort solely for the participants' benefit.

Frank, a 44 year-old white and Native-American man with bipolar disorder, described the extra effort his parole psychiatrist took on his behalf after being arrested for a parole violation. Frank had a particularly aggressive parole agent. The agent, in Frank's mind, made a concerted effort complicate Frank's situation. He felt harassed by this agent and ultimately chose to abscond from or not report to parole rather cope with the agent's continued abuses. When Frank was eventually found and rearrested he faced a 12-month sentence for absconding from parole.

R: ...Because-who did I have back then? -Agent Jones, big Black dude. Had the racist chip on his shoulder. And I was a White crankster. And he wasn't into that. He was part of the PAL (parolees-at-large). It was called the PAL unit...those are the ones that go kicking the doors; yeah they got the guns. You know the type, got the radio hanging off. I got stuck with one of those over there for a minute...Okay Agent Jones. Okay. I boogied (he absconded). But before I boogied I was going to POC, seeing Dr. Smith (the parole psychiatrist) and stuff, right? Okay. They caught me down the road, and he (the parole agent) tried to get me flat time (a year sentence)...Dr. Smith showed up and said yeah well when he was he was coming to see us, yes he was complying with-before he ran-he was complying with, you know, the POC. Which was really nice, you know? He didn't have to do that; he didn't have to go out of his way.

E: And did it make a difference for you?

S: Hell yeah. Knocked off four months, four or five months off that sentence...(P24: IV#2 24:7 704:756)

The psychiatrist took it upon himself to advocate for Frank during his parole hearing. He provided evidence that Frank had been meeting the mandated conditions of his parole, i.e. attending the parole outpatient clinic (POC) regularly and adhering to his prescribed treatments. The psychiatrist's testimony also suggested that Frank's decision to abscond was not solely based on irresponsibility or apathy towards the parole process and that, perhaps, Frank's rationale for absconding was reasonable. The physician's appearance at the hearing resulted in a reduction in his sentence, a thing that might not have occurred without him. His testimony was relevant and meaningful to Frank as it decreased his time in the correctional facility.

As a result of his bipolar disorder Frank had been involved with the POC for more than two decades. Mandated psychiatric care was a condition of his parole and, as Frank discussed in other narratives, critical to stabilizing his psychiatric symptoms. Throughout the course of his relationship with the POC, Frank had seen a variety of mental health professionals. In the following narrative, he described how POC clinicians assisted him in both managing his illness and improving his circumstances while in the community.

I: So who out of all these psychiatrists that you've had has been helpful to you, if any.

R: I've had a couple good ones and a couple bad ones.

I: And what made the good ones good?

R: They actually want to spend time, see how I'm doing, see where I'm...he'll (the psychiatrist) actually ask me "How are you doing? Are you screwing up?" You know. He'll, you know, "Is the Lithium making you this that? Do we need to have a run-in blood check?" All that other stuff.

I: So you feel like he's concerned about you.

R: Yeah. I, you know, I used to spend about 45 minutes, every couple weeks with him...He helps me; he helps me move my SSI paperwork; he helps me with the, you know. Like one of the side effects of the Lithium is it hits your kidneys really bad. So he writes me out a potty pass, he's going to write me out a potty pass. Because these groups (at the drug treatment program) last sometimes three hours, and they really frown if you go get up and go to the bathroom. Well they

(the program staff) 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...

I: So do you think that the good care that you've gotten at POC has helped you stay in the community?

R: Yeah, yeah, yeah... Yeah they helped me last time, and I was on it-I had what, 14, 15 years on one number? I'm going ten years on this number now. (P24: Frank IV#2 24:4 200:302)

The POC psychiatrists not only spent time with Frank and demonstrated concern for him but attended to Frank's practical needs as well. One particular clinician took responsibility for ensuring that Frank had some financial stability via disability benefits. The psychiatrist managed not only the procedural aspects of filing a disability claim but served as Frank's advocate throughout the process. He also explained to staff at the drug treatment program why Frank needed special accommodations as a result of medication side effects. The POC psychiatrist responded to Frank's situation and medical needs in a timely and efficient way. His care not only improved his immediate circumstances but helped Frank remain in the free community with the hope of discharging from parole as well.

Paul described two individuals at the county hospital who consistently provided him with relevant care: a medical records clerk and a physician. These two hospital staff members were both organized and reliable. They acknowledged Paul as an important individual, as if he was their central focus. In his interactions with both the clerk and the physician, he was the priority and his needs were not subordinated to their own or the needs of the system.

I: Did you ever feel like, wow, you know, that person really cared about me in this situation?

R: I can it's two, a couple people I met up there like that. I can honestly say that. There's two people I met up there, you know? This lady who work in the records, and the doctor, Dr. White, female lady. They're the main two that I have much respect for, much respect.

I: What did the medical records lady do that made you feel like you were cared about?

R: She...just makes sure all my paperwork was intact and everything...And anything I needed about my paperwork, she made sure I got it. She made sure I had it...and had it all in the right order. So in case if I want a copy of anything, she'll get it, from the first appointment I made, all the way up to I had the surgery, to the last checkup I had on my foot. Everything is right there. She always ask me, "Do you want to copy anything?"...And Dr. White, She always, she's just like...what do you want me, what's, what's happening? 'Cause the surgeon that did it, she already know about the hole. She said, "No, that shoulda, that should have never been there."...So she next week when I come if it ain't close up, she said, "No. We're gonna do something about this." She already said it,...'cause she said that shoulda never done that, been like that...Cause they know, she make sure, she making sure it's getting clean thoroughly when I come...Every time I go, she makes sure they want to x-ray to see if any infection set in underneath it. She been doing that every time I go until they took the stitches out...And so, you know, she like next week when I come, she said, "If that hole ain't closed up, you know, we should do something about that." Those two have been very helpful. You know, 'cause I go in, I ask straight out if she there. If she's not there, I tell them I'll wait. I'll wait till she come. (P 8: Paul IV#2 8:12 165:174)

Both staff members were attentive to Paul and anticipated his needs before he articulated them. In the case of the medical records clerk, she was ready at moment's notice to copy all or part of Paul's records. This reassured him that his documented medical history was both complete and protected. This was critical to Paul, as he discussed in other narratives, his medical records were how he communicated with medical staff; his records were proof that his problems were real. The medical records clerk understood the importance of his records to him and made the extra effort to ensure Paul's easy access to them.

In regards to the physician, she believed Paul. Her acknowledgment that the hospital made a mistake regarding his foot surgery legitimized his problems and validated his sense that he had not received the best treatment. Her actions allowed Paul some sense of power within the clinical realm, i.e. he knew he was right about his foot. Furthermore, she was committed resolving his problems in an expedient manner.

Through the efforts and attention of the clerk and physician, Paul believed he was receiving the best possible care, the care he deserved to receive. While their attention did not resolve his larger health issues, it did provide him with a sense that he could rely on two people to ensure he received the most relevant and appropriate care.

Walter also developed a meaningful relationship with an ophthalmologist and a registered nurse. They took care of his eyes for a year. During that time they became Walter's partners in maintaining the health of his eyes. The RN in particular made herself available to Walter and assisted him with whatever he needed in regards to his vision.

I: Can you tell me a little bit more about this relationship that you had with this doctor and this nurse, where you were kind of a team for a year?

R: Yeah, a team...I really appreciate how she (the nurse) was there for me, helping me when I used to come in there, and did all kinds of things. And gave me a number to call if I ever have problems with contacts or whatever, and you come in. One time the contact got stuck up...in the back of my thing (his eyelid). And I couldn't get it. And it was like - it was a rolled up one and it was like caught on the side of the thing, and I kept doing like this, and I still couldn't get it out. It was stuck. And I went, and she helped me. Flip my thing back and pulled it down with something, did something. And it was like she did, "Well, how did you get that done?" I said, "I don't know. Broke my eye, did something," you know? [laughs]...But she was so helpful with that. And my doctor gave me some money one time.

I: Oh, he did. What were the circumstances of that?

R: ...I had to get over to San Francisco for some reason and pick some money up, and I didn't have no way. So he gave me \$20.00.

I: Oh, wow! That was nice.

R: Yeah, it was nice. It was real nice. And I came back and gave it back to him, right? But it was shocking. He was shocked. "You don't have to give it back!" I did though. But, 'cause I felt like, you know, I had to. I had to give it back. So - and the nurse was laughing, "You shoulda gave it to me." She was so sweet, like that. It was cool. Think about it. I liked her. You know how you have a crush on somebody secretly? I had like a crush on her, I think I did, because of her attitude... You know, straight, fun, fun to be with. Just strictly business, but straight, just fun to be with. I think I got crushes on people like that. I just always say, "I'm gonna bring her a bouquet of roses."

(P22: Walter IV#2 22:12 290:299)

Walter had easy access to the nurse's services and support. She helped him with issues both large and small. Walter felt welcome there, as if he was part of the life of the clinic. On one occasion the physician lent Walter money for transportation. His generosity surprised Walter, as did the physician's pleasure at lending it. Walter also appreciated the RN's easy but professional style. She took her job and Walter's concerns seriously but was not afraid to laugh or be personable with Walter. There was a family atmosphere to the clinic and Walter related to this. It was this sense of fun and ease that attracted Walter to the clinic and these particular clinicians. The physician's and the nurse's attitudes and the meaningful care they provided facilitated Walter's regular use of their services.

Caring Professional Demeanor Conclusion: Clinicians' caring professional demeanor reassured participants that their concerns were legitimate and worthy of care. The empathic qualities of their clinicians instilled a sense of hope that their problems could be resolved. The relationships participants developed with their clinicians encouraged an interest in resolving their own problems either through self-care practices or continued involvement with clinical services. Clinicians recognized participants' expertise about their health conditions and offered choices rather than made demands. The respect and consideration with which clinicians approached participants made them feel as if they were valued contributors to the clinical encounter. This approach facilitated continued involvement with health care services.

The provision of relevant care also facilitated participants' use of clinical services. Through the provision of meaningful care participants believed they received the care they deserved. They appreciated having their practical needs addressed expediently. This

was often a new or unusual experience for participants and they valued the competency with which clinicians approached their problems. It was worth the effort to pursue health care services, as participants trusted that their providers would successfully address their problems. 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

Through the curtailment of structural barriers participants were able to easily access the care they needed. There were no long waits, concerns about cost or bureaucratic processes to overcome. To a degree, health services were delivered directly to them. The physical location of health care services increased the ease with which participants accessed clinical services. In some instances, services were provided where they resided. Increased access to care was also evident in the convenience of ancillary services such as lab work, low-cost medications and transportation. Finally, the access to payment resources improved, in the participants' perceptions, both their overall access to care and the quality of the care they received.

Convenient Clinical Services. Convenient clinical services included centrally located clinics and easily accessible ancillary services. Clinic locations close to or where participants resided obviated the need for long, and often unaffordable, trips on public transportation. Convenient clinical services also provided affordable medications, laboratory analyses and other needed treatment in an expedient way. Through increased

accessibility to medical care participants received services they might not have otherwise received or been able to obtain on their own.

Louis described how convenient clinical services provided him with both therapeutic consultation and psychiatric care. His encounters with the therapist were a result of Louis residing in the shelter where she was on staff. Therefore there were no barriers to Louis accessing mental health services from her. Through his contact with the therapist he was able to obtain comprehensive mental health services he had not previously experienced.

R: Yeah...I mean 'cause – he (the psychiatrist) took it more seriouser than the person in the prison did. They really took it serious, took me seriously in (at the shelter) . . . But I hear she (the therapist) no longer works there. She went somewhere else or maybe got her own practice or something, I'm not sure. But she took me serious enough to - she said, "I see by the way you're moving and the way you're talking," you know what I mean? 'Cause I had an hour with her every week. If not - if I wanted more, I could have more...Yeah. And that was volunteer. But she referred me to another doctor. And - but I still had my hour with her. But she wanted his opinion. So she wrote on the back of the card a little note, gave me an address, and I went and seen him. Now, and he sat me down and talked to me for an hour too. [So then he] goes, "well, I'm prescribing you some medication. Tell me how you feel.. ." And he gave me - so - this prescription put down - he put down "no cost" on the thing, right? Sent me all the way down to, I forget where it was. Some Walgreen's or something to get the medication? And it was \$129... That's expensive...And they go, "Well, that'll be \$129, please?" I said, "What?" 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, and I woulda thought it was making me - you know what I mean... But he - for them to be \$129, something had to be wrong with me for him to give me that medication. And I knew they were strong from the first day because I, you know, but I don't know who that - I'm gonna find out who that doctor is, or. . . that clinic I went to. (P16: Louis IV#1 16:4 182:195)

The treatment Louis received in the shelter was different from the care in the correctional institution. In prison, Louis's psychiatric symptoms were discounted and he was offered medication, he believed, only to sedate him. However, with the shelter's

mental health services in the shelter, Louis encountered a clinician who took his symptoms seriously. He was able to see her weekly and had addressed his concerns thoroughly, including a consultation with a psychiatrist. Louis was reassured that he would continue to see the therapist but he was impressed with the time the psychiatrist took with him as well. The attention he received from the psychiatrist further validated Louis's sense that he did have some sort of mental health problem as did the prescription for costly medication. Although the medication was available at no cost to him, the expense of it was another indication that Louis merited treatment. The acknowledgment from two clinicians that his problems were real, supported Louis's sense that he needed assistance and encouraged him to take his health problems seriously.

Louis articulated further how the services he received in the shelter ensured that he attended his appointment with the psychiatrist. The support of the therapist motivated him emotionally but her assistance with transportation facilitated his ability to get to the appointment on time.

I: ...how was getting the appointment, getting there?

R: Well, you know what?...She, like I told you, she wanted a second opinion. So I made sure I kept that appointment, and then I explained to her, "Well, you know what? I can't get there," you know what I mean? She made sure I got there and back.

I: 'Cause of transportation?

R: Right...And she even offered to have somebody go with me...Well, she says, "Well, look, if you don't feel comfortable going by yourself, on the bus or whatever, I'll have somebody go with you."...So I said, "No, I can go by myself." You know what I mean? I just don't know how to get there. So she made me a map and everything. She was real uh - I don't know how to say it...She was nice. And when I went back to, to get back in that shelter one time, and then they turned me down? I went to go see her, and she wasn't there. She moved on to something else. So, you know, I'm not sure if any doctor can help me. But she was, she was real helpful. You know what I mean?

(P16: Louis IV#1 16:13 392:395)

When the therapist introduced the idea of a specialty consultation, Louis was concerned he would be unable to make the appointment because of transportation. The therapist assisted Louis with the practical aspects of getting to the appointment but also worried that the stress of traveling to it would be a barrier as well. With her support Louis successfully made it to his meeting with the psychiatrist. The relevant care Louis received from the therapist and the psychiatrist was a result of the physical location of the services; they were provided where he resided. Had he been in another living situation Louis might not have had access to such comprehensive care or been able to access such services on his own. His experience with the therapist both alleviated his psychiatric symptoms and encouraged his pursuit of further care. Upon release from prison, he returned to the shelter for both housing and continued therapeutic services. Although Louis was unable to access such services again, they provided a glimpse of what easily accessible and effective clinical services could be like.

Max also discussed the impact of convenient clinical services both in and out of prison on his ability to address and manage his health problems in the free world. The nurse Max met while incarcerated was influential in motivating Max's engagement with the community health system. In addition to being consistently available to Max, she ensured that he received his discharge medication upon release from prison. This nurse's efficiency in arranging his medications and other necessary treatment over the course his incarceration facilitated Max's long-term interest in caring for and improving his health upon release from prison.

E: But that nurse sounds like she really opened you up in terms of understanding what your health problems are.

S: Yeah. She was like a motherly figure about it, you know? When I was leaving, you know before I paroled ...I was worried about getting my meds for-

they give you a 30-day supply-She said "Don't worry, I've got all that covered for you and everything like that. They'll be in-" they put them in a locker when you parole on a weekend. She goes "Don't worry about it. It's all taken care of." She goes, "I'm looking out for you." And she, like I said, the concerns that she put towards me enlightened me about my health. About my age, my health, my drug use, things that I should check on because of my family history and everything like that.

E: And do you think that what you learned from her is going to help you on the outside?

S: Yeah...well I've never been in a place (drug treatment program) like this right here and, where they have the medical van come. And then the lady came to ask about dental and everything yesterday and I don't know if that's always been like that, you know, like on my last number because I really never put effort into my parole. But now that I see that I'm here it's one of the things that here, it's here. Go ahead. I mean, you know, instead of being out on the streets and not-I don't even, I got this problem and I'm not gonna deal with it...they have a lot to offer, the medical thing and that's one of my concerns is my health. You know, because if you're not healthy you don't have to use dope. You can pass on just from bad health. (P30: Max IV#2 30:2 32:52)

In the past, Max had not taken an interest in his health or his parole. However, the prison nurse had illuminated the importance of caring for his medical problems over the long term. Max was motivated to engage with services regardless of the location or difficulty in accessing them. Therefore, he was pleased to discover that medical and dental services were provided at the substance abuse treatment program where he resided. The immediate access to health care services both supported and energized Max's commitment to managing his health. He appreciated the clinical offerings and quickly began utilizing them. The accessibility of health care services allowed him to address his concerns as well as feel that he was participating in his parole in a new and more positive way.

Max further described the importance of the physical location of clinical services in the following narrative.

R: Well the initial time she just interviewed me and she told me that, to get the card (fecal occult blood test) you know for the samples and all that stuff and that's

what I'm doing now. You know, I gotta take the sample card back on Monday. But I [can take] the sample card to a place close to the program 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. You don't have one set place where you can go because sometimes it's hard to get on the buses and BART and all that. But you know, that's, it's there. I'm gonna use it. I'm gonna use, you know, the resources that are there. Instead of before when I just forget about it...But yeah, that clinic helped me out. And I'm going to keep using it. And when I do transfer I'm gonna use whatever I can get up there. (P30: Max IV#2 30:4 104:104)

Max had an initial consultation at a large, primary care clinic several miles from the drug treatment program where he lived. While he valued the clinic's services, it required both time and expense to get to. At that time, the clinician ordered fecal occult blood test cards that he was to utilize and then return to the clinic. Due to the clinic's smaller satellite locations, Max did not have to travel a great distance to return the cards for processing. Although he would ultimately have to return to the primary clinic to discuss the results and for more in depth care, Max appreciated the satellite clinics because they did not necessitate another long-trip to the main clinic. The clinic's varied locations made it easy for Max to follow-through on both the clinician's request and his desire for health care services.

Mark also experienced convenient clinical services at a community hospital. He had gone to the hospital to obtain care for his hepatitis C. The clinician Mark encountered referred him to the gastroenterology clinic for further evaluation. During his visit to the specialty clinic, Mark received attention from the physician who ordered laboratory tests the same day. Mark appreciated the expediency of the care he received.

R: ...I went to the ho- - I went to the hospital, because I went to see the nurse practitioner...And she, she referred me to the [gastroenterology clinic] at the hospital. ...And so when I went to the hospital, they took care of me. You know? I don't know, they got that stuff - they can do that right quick, take blood and this...the doctor told me that I needed a biopsy. And so they took some more blood, the same day...they told me to call up there, and I called up, and I talked to

the secretary, and she said that they were gonna cancel the biopsy because I was too weak. That's what they said. They said, "We don't want to do this because we might lose too much blood," and it might not be good. You know, at this time to, "We should wait a little till you gain some" . . . strength or whatever, you know? So I never went back.

I: Why?

R: I was - I got busted or I, you know, just disregarded it. I'd get caught up in my little world, you know?

I: But that sounds like it was an OK experience for you.

R: Yeah. Yeah... Yeah. They were really into it, you know?...Because the nurse practitioner, she's a good lady. She cares. You know? And I think she was - I think she was doing a good thing, you know? I don't know if she felt good about it or I felt good or we both felt good about it. But I think she really cared to have me go through all of this stuff, you know? But . . .

I: And what was it about that exchange that you had with her that made you feel like, oh, she really cares?

R: Well, when I went to the hospital... Yeah, because they...they always go through this thing that I don't have no insurance and all of this. But after they ran it down and everything else, they said, "Oh, don't worry about it," you know? "We'll cover it."... (P 3: Mark IV#1 3:26 835:887)

Although Mark never returned to the hospital clinic for additional care, he was impressed by the ease with which the staff assisted him; nothing seemed to be difficult or a problem, including his being uninsured. Mark was grateful for the clinician who believed his problem was serious enough to warrant further attention and for the efficiency with which services were provided. This was perhaps the first time Mark had received such thorough and thoughtful health care services in the community. While the easily accessible services at the hospital were not sufficient to encourage Mark's continued participation in them, they did offer him some insight into his health conditions and a clinical home to return to should he have wanted to reconnect with medical care.

Access to Payment Sources. It was rare for most participants to have access to health care coverage. Those that received coverage did so as a result of chronic and disabling health conditions. Participants' insurance was received primarily as a part of long-term disability benefits, although they also had coverage via employment and

Veteran's Administration benefits. One participant received long-term mental health care through the parole outpatient clinic. Those few participants with insurance or funded care believed that the care they received was of higher quality and more effective in managing their health problems successfully.

Walter discussed the importance of his coverage through Kaiser in maintaining his vision. Walter had received health care through Kaiser as a result of his employment – for 15 years he was a linens supervisor at a county hospital – and then as a component of his disability and Medi-Cal benefits. In the narrative that follows, Walter described how his access to ophthalmologic services at Kaiser prevented the complete loss of his eyesight.

I: So do you think that having had insurance for your eyes all these years is something that's been helpful to you?

R: Yeah, it has been. Without insurance I would be ssss.

I: And can you tell me more about how it's been helpful?

R: It's been helpful with medication, and them seeing me, keeping the treatment going. I don't think, without it I don't think I woulda lasted as long. I think I might have really been lost everything.

I: And how would you have lost everything without your insurance?

R: I wouldn't have been able to see. I already know the difference. I think some of the medications that they prescribed and the helpfulness of the different doctors kept me, kept my eyes focused for all these years. I mean it's been a long time. To be able to be on glaucoma for so long, because I know some people that maybe not even lasted this long. Their eyes, lost them completely. You know? So. That's a good thing. [...] that's when my vision was at Kaiser, that's when my care was like - like I had - I had, you know - you know how you have that feeling that, OK, now I'm having money and doing good. I can get up in here, I might get seen...maybe they take care of you. So they gave me contacts as well as glasses. Any time I came in there they gave me whatever I wanted. I'd go downstairs, just - send me downstairs with a prescription. And, oop, they got them made, and I'm outta there. You know how Kaiser pharmacists, they have people in there spending big money. I would go in there like I got a credit card. My little [laughs] card. Felt good. I felt good about that. I was making good money. (P22: Walter IV#2 22:10 137:150)

The regular access to ophthalmologists and appropriate medications protected the little vision Walter did have. He felt fortunate for this treatment, as he believed it was unusual for someone with severe glaucoma to have any sort of vision left after a prolonged period with the disease. Although Walter continued to have Kaiser as a part of his disability benefits, in this moment he described the coverage and care he received with his employment. As an employed person he had access to more choices and treatments than as one receiving benefits via Medi-Cal. Walter felt empowered by services available to him and was impressed with Kaiser's efficiency in providing them. Easy access to services not only protected and maintained his vision but represented Walter's success as an employed individual as well. The excellent care he received was an indication of Walter's social status. He was part of the mainstream health care system and could have what he wanted when he needed it.

Luke also had Kaiser as a result of his disability and Medi-Cal benefits. However, his coverage lapsed for a period of time, which necessitated his utilizing the county health care system. In the following narrative, he articulated the differences amongst the private, public and prison health systems. In Luke's mind, the care he received from Kaiser was of higher quality than that of the county system. This was particularly evident in how he was treated by the Kaiser staff as opposed to his treatment within the county system.

I: So - what about on the streets?...you have the period where you didn't have health care for a while, and now all of a sudden you have it.

R: Now, I could talk about that. OK. Like when I got my paperwork right, and my health coverage is correct, I go to Kaiser; I just - I heard some people talk bad about Kaiser, but I've always been very pleased with Kaiser. Because maybe I'm comparing it to the health care that I'm used to... They're professional. They're - 95 percent are pleasant, if not just - you know - they're not rude at all. They're

more than - the majority are very pleasant. And there's a big difference between going to Kaiser or the county hospital. You know?...

I: So you see differences between the private sector and public sector?

R: Oh, there's a big difference.

I: And can you tell me more about those differences?

R: ...So there's a difference between like Kaiser, my benefits. There's a difference between county hospitals and there's a difference between prison. And the prison was more of a shuffle, daily thing. And the county hospitals are more - you feel it more. I don't feel degraded in prison, but when I go in like a county hospital, with no insurance and stuff, I feel like - I feel like I'm a burden. And they're not like very caring health care so you feel a little ashamed to be there... You don't feel as welcome. They're not gonna turn you away. I guess. But they're definitely not happy to see you. Kaiser's like, "How do you feel? Aw, that's too bad. Well, would you like a popsicle for that?" You know? Stuff like that... They, they engage you personally. And I think that's a requirement that they look for when they hire people. It's like somebody that's gonna be pleasant, and acceptable to that position, you know... Every hospital I've gone to with health care (health insurance) has been a pleasant experience. You're there 'cause you're not feeling well or something wrong, but it's been a pleasant experience. Every county hospital I've been to, for whatever reason, they've taken care of me, and it seemed like it might be an ordeal for both of us... And the one in prison, it's just daily life. A work schedule. You know, they open at this time and go home at this time. If you're not seen, see you tomorrow. That's just life as it is... you can't go to the county hospital and say, "hey, I want my teeth cleaned." You can't go to the county hospital and say, "I have psoriasis. You know, it just started to break out. Can you give me some cream? And pay for it. Or some shampoo." You can't go in and say, I don't know, like, "My knee's bothering me a little bit. I wonder if I've got arthritis." Or - you can get all that stuff checked out in prison. You know, if you say it's bad enough, they'll check into it. Whereas county hospital, you'd better have - be - come to that emergency room with an emergency or something that needs to be taken care of. They're not here to look at a hangnail. You know?... Unless you've got something major, they don't wanna hear it, 'cause they don't have time or the resources.

(P12: Luke IV#2 12:6 125:134)

Luke always appreciated the care he received from Kaiser. He felt particularly grateful for the cordial and professional way he was treated by the staff. They were not only interested in resolving his problems but in making him comfortable as well. He was welcomed as an important part of the Kaiser organization. This was not the case with the county system where he was seen as an additional and unwanted responsibility on hospital staff. He would receive the required services but it was not a pleasure for county

staff to provide them. As a result, Luke believed he was being both shabbily treated and denigrated. This attitude and behavior vastly differed from the care he received at Kaiser and in the correctional institution. In prison, there was no shame in accessing health services; it was part of the everyday life of incarceration.

Furthermore, the care he received in prison or from Kaiser was more comprehensive than what he received from the county system. The county system was not available to provide non-emergent comprehensive services in the way that the prison system or Kaiser could. County hospital staff did not develop long-term or personal relationships with their patients or encourage consistent follow-up for primary care services. As a result of limited resources and distracted, overworked staff, county medical services compared poorly with the treatment Luke received from Kaiser or from the prison system. Therefore Luke felt fortunate to have two alternative sources of health care. Kaiser possessed both sufficient financial and professional resources to attend to his needs in an efficient and caring way and prison services, while not always the most efficient, were always accessible.

Frank too received disability benefits and Medi-Cal, although his primary access to mental health care was facilitated by the state's correctional system. Regular visits with the parole outpatient clinic (POC) were a condition of Frank's parole supervision. Due to his mental illness and drug addiction, Frank had tendencies towards aggressive and violent behavior. Therefore, with his last incidence of violent behavior – smashing another car into a highway median and then driving away – he was assigned to intensive parole supervision upon release from prison. In the following narrative, he described his feelings about being required to participate in psychiatric services.

I: How do you feel about the care that you've gotten around this problem that you have?

R: Eh. You know it's mandatory for me now...

I: What is mandatory for you?

R: If POC's (parole outpatient clinic) up it's mandatory. Because I've gotten off of it, and just done some way-out things. Now it's mandatory.

I: And so how do you feel about that?

R: It kind of bites.

I: Why?

R: Because. If I screw up-Well no, no. If I stop going, not only will they violate me, it'll be a full-time violation. I get no, did you know that? If you file under POC proposition, un unh. If you stop going to that doctor, they immediately violate you.

I: And send you back to prison.

R: Not only do you have to go back to prison, you have to do your full time. They give you eight months; you have to do eight months. They give you one year; you have to do one year, and that kind of bites.

(P23: Frank IV#1 23:14 880:944)

While Frank did not appreciate the penalty for failing to follow-through with POC, he did acknowledge his need for regular services. Without consistent monitoring and support from POC his behavior was unmanageable and a threat to others and himself. Frank was aware, as he discussed in other narratives, that he was unable to control his behavior when he was not taking psychiatric medications or under psychiatric care. Regular services provided by POC were critical to Frank's capacity to manage his psychiatric symptoms and, as he described in the previous section, remain in the community over the long term. Additionally, he was pleased with the much of the care he received from POC as it provided needed services and support he might not have encountered on his own. Therefore, Frank's mandated access to POC, a thing that in one way restrained him, was also what allowed him to continue on and potentially complete parole.

Ease of Access to Care Conclusion. Easy access to the health care services was unusual for most participants. Those who did experience easy access to care did so as a

result of where they were residing or of the specific clinic they attended. Those participants who had the best access did so as a result of their illnesses and disabilities. Most commonly, these participants had disability income, Medi-Cal and/or mandated care via the correctional system. Therefore, the severity and type of illness made a difference in the regular and continued availability of health care. For those participants without severe and chronic conditions, i.e. ineligible for insurance or disability programs, the ease of access to clinical services was irregular. However, these data indicated that health care not bound to multiple procedural processes and delivered in a more intimate one-to-one manner did facilitate participants' access to and involvement in health care. Through this access they experienced health care as meaningful in addressing their problems and concerns. Their motivation to access such care in the future was increased.

Social and Structural Facilitators to Health Care Conclusion

Social and structural facilitators impacted participants in three primary ways: 1) facilitators increased participants' interest in self-care, 2) facilitators increased participants' desire to participate with health care system, and 3) facilitators resolved participants' problems and improved their circumstances. The primary facilitator of participants' willingness to engage with the health care system was the caring professional demeanor of the clinicians. Such a demeanor not only validated and legitimized patients' sense of their problems and of themselves but it provided a counterbalance to the uncaring professional demeanor they experienced as well. The interest clinicians expressed in participants' problems and the time they took with them stood in opposition to the cursory treatment they had experienced. Participants were not dismissed by their clinicians but considered equal partners in the resolution of their

physical and mental disabilities. Furthermore, the treatments they received were effective and made a difference in their situations. This was in contrast to the frustration participants expressed over the ineffectual treatment they had also experienced.

Clinicians' caring professional demeanor positively impacted participants' health directly and indirectly. In regards to their specific health conditions, many of their problems improved. As a secondary result, their sense of themselves improved as well. Participants expressed a greater interest in and understanding of their health conditions as a result of social and structural facilitators. While these encounters did not counteract participants' entrenchment in their street and prison lives, they did provide them with a sense of hope and possibility. It was this sense of optimism that enhanced their motivation to access health care and address their mental and physical limitations.

The secondary facilitator, ease of access to services, provided an opportunity for treatment not otherwise available as well as access to necessary specialty care. Easily accessible services also facilitated the maintenance and improvement of chronic conditions. Although much of participants' access was related to receiving insurance as a result of disabling or severe illness, uninsured participants benefited from accessible health care services as well. However, the seamless receipt of such care was not consistent for those without insurance. The sporadic access to such care was further influenced by the unstable circumstances of their lives. In these instances, structural facilitators could not overcome the instability of participants' drug addictions and criminal lives. Nevertheless, structural facilitators were important because they offered participants an opportunity for improvement of their health conditions and an understanding how of regular thorough and concerned clinical services could assist them.

Chapter Conclusion

Structural and social barriers delimited participants' involvement in health care services. Financial constraints restricted most participants' health care access to the safety net system of care. The multiple administrative barriers inherent within the safety net system discouraged participants from pursuing services. In addition to the financial and administrative barriers, uncaring and insensitive clinicians dissuaded participants from accessing care. They felt stigmatized for their addiction disorders and for their impoverished circumstances. The dismissive attitude of many clinicians was an indication to participants that their problems were not valid and as a result their interest in self-care or further engagement with clinical services was lost. Additionally, participants' initial motivation to address their problems waned and they became increasingly disaffected from the health care system. The structural barriers to care and clinicians' uncaring professional demeanor narrowed participants' ability to develop meaningful and long-term relationships with clinicians or establish a medical home. As a result of having no stable and lasting clinical relationships, participants were unable to gain access to useful resources, such as low-cost medications, laboratory analysis and appropriate treatments, potentially helpful to their health conditions. Participants also lost opportunities to develop a documented medical history that could have provided evidence necessary for disability claims and health care coverage. Such financial resources could have been helpful not only to their health but to their reintegration efforts as well. Additionally, opportunities to contend with the larger issues and problems related to reintegration, e.g. substance use disorders, were also limited by the barriers to health care access.

As a result of the structural and social barriers to health care, participants' medical conditions often went untreated. Exacerbations of untreated chronic illnesses such as diabetes and coronary artery disease resulted in frequent and unnecessary emergency room treatment. Poorly managed mental illness limited participants' ability to successfully manage the demands of free world living and often resulted in a relapse onto drugs and rearrest. Long-term musculoskeletal problems often resulted in painful arthritis limiting participants' mobility and strength. In each of these cases, participants' untreated mental and physical disabilities decreased their access to the jobs available to them, primarily labor and construction work. Their limited capacity to work in the jobs offered to them, in turn, impacted participants' reintegration efforts, as regular employment was a requirement of parole and necessary to establishing long-term stability in the free world. Furthermore, unemployment limited access to regular income, insurance and the possibility of other health care options. Therefore, the structural and social barriers to health care not only impacted participants' health outcomes but further restricted participants' already limited opportunities and thereby, hindered their efforts towards reintegration.

Social and structural facilitators increased access to needed evaluation and treatment as well as supported participants' interest in their health. Social facilitators, i.e. caring professional demeanor, validated participants' problems as real and legitimized their desire for appropriate care. Clinicians acknowledged participants' personhood and expertise in their own lives and problems. This gave participants a sense of respect as valued contributors to the health care encounter. Clinicians' empathy and consideration of participants' engendered a feeling of trust that their physical and mental illnesses

would be properly cared for. The improvements participants experienced in their wellbeing as a result of empathic and competent care encouraged an interest in pursuing further services.

Structural facilitators, i.e. well-placed clinical services and funded care, also supported participants in accessing health care. Easily available services offered participants an opportunity to experience a more personal and higher level of care. Upon receipt of accessible and financially supported care, participants felt that their immediate concerns had been addressed and their longer-term problems well managed. Additionally, participants had an opportunity to develop significant relationships with clinicians. These meaningful relationships influenced participants' desire for continued health care services. It was this exposure to meaningful and relevant care that allowed for the possibility of trusting and longer-term relationships between clinicians and participants to develop and evolve. Unfortunately, most participants were unable to achieve such a relationship and therefore, their positive interactions with the health care system were brief and temporary. Participants' positive clinical encounters were not sufficient to counteract the impact of their drug addictions and street lives. However, such encounters did resolve some participants' problems as well as provided a model for what health care interactions could be like. Additionally, the positive interactions participants experienced as a result of social and structural facilitators were some of the few caring relationships participants had in their lives at all.

CHAPTER 6: THE IMPACT OF HEALTH CARE ACCESS ON REINTEGRATION

Introduction

This chapter discusses participants' interactions with the health care system and how such interactions influenced the way participants cared for their own health problems within the context of their street and prison lives and their reintegration efforts. This analysis revealed that participants articulated three primary patterns of engagement with the health care system. First, participants were ambivalent about their involvement with an inconsistent and unreliable health care system. Secondly, participants were dismissive of interventions offered by the health care system even when such interventions were helpful. Finally, participants' long-term engagement with street life overrode their health concerns and impacted their reintegration efforts in general. This chapter will illustrate these patterns via paradigm cases. Paradigm cases are specific instances of the phenomena under study. The paradigm cases presented here were chosen because they most clearly represent the types of interactions participants experienced in their efforts to access health care. Although each case is unique to the individual participant's experience, their narratives speak to patterns of engagement with the health care system shared by other participants.

Ambivalent Engagement with an Inconsistent and Unreliable Health Care System

Participants expressed ambivalence about their health conditions being resolved via the health care system. Their reservations were grounded in their personal interactions with urgent and primary care services. Participants were discouraged by the care they received. Such care was characterized as ineffectual and unresponsive to participants' needs and concerns. However, participants were still motivated to seek care because their

health problems had worsened to such a degree they could no longer ignore them. Their ailments and disabilities not only caused them pain and distress but hindered their ability to meet the practical demands of parole, e.g. finding employment. In addition to their addiction disorders, participants perceived their health problems as one of the greatest challenges to successful reintegration.

Participants were overwhelmed by their health problems and worried about their declining health status. Participants' conditions threatened their independence and self-reliance; they could no longer count on their bodies as they had in the past. Participants' inability to cope well with their health problems affected them mentally as well as physically. They experienced feelings of loss over the changes in their physical fitness and were anxious about the longer-term outcomes of their ailments. Furthermore, participants questioned their own capacity to manage their health conditions, overcome their addiction disorders and meet the requirements of life in civil society. John and Louis provided paradigmatic examples of participants' ambivalent engagement with an unexceptional health care system as well as qualms about their own ability to improve their circumstances and establish stability in their home communities.

John. John was a 47-year old Mexican American. He had an extensive criminal history and spent the majority of the last two decades incarcerated in maximum-security facilities. At the time of the interviews he had been released from prison for three months and was relatively new to substance abuse treatment (SAT) programs. John's parole agent had assigned him to the SAT program after John relapsed upon release from prison. His health problems included Hepatitis C, degenerative joint disease and arthritis in his lower spine, and a long-term heroin addiction. John's primary concern was the

progressive deterioration of his back. Over the past several years, he experienced decreased mobility and increased pain in his lower back and legs. John required a cane for support when walking or standing. He believed the pain and immobility in his spine was related primarily to a herniated disc in his lower back in 2003. However, he also sustained a vertebral fracture to his neck in 1987 and acknowledged that the demands of his street life were physically taxing as well.

In the following narrative, John described the injuries to his back and the treatment he received for them. John's most recent injury to his lower back occurred while he was performing landscaping work for friend. At that time, John, recently released from prison, was physically fit and strong. For John, a period of incarceration was an opportunity to care for his health through physical activity and abstinence from drugs. Nevertheless, the landscaping work was fatiguing. Towards the end of the day as he was lifting a wheelbarrow heavy with tan bark, John felt something tear in his lower spine.

R: ...And I remember when I did that one shot, that was it. I felt something. So I finished that day, and...I went home, laid down, couldn't get back up. I was crying like a baby by the time I was like, wow, this is something is really wrong here. And they wanted to take me to the doctor's, and I couldn't move...my mom was like, "I'm gonna call an ambulance." I'm like no. A couple hours later they called the ambulance. They called the ambulance. They came. I went to the hospital...and they give me four shots of morphine. 'Cause I didn't feel the first two. So they gave me two more shots. And they told me to go. So I don't think that was right because I think that they should have ran some tests on me then. 'Cause four shots of morphine, and they just, go out the door. Come on. And I wasn't even really feeling the morphine. I mean I was . . . I was in pain. It was killing me. Get back home, and the morphine wore off. Oh, they gave me some Vicodins, and wore off, and like I said, I'm a heroin addict. Little, two or three Vicodins at that time was not gonna...really do nothing for me. So then after that I went to the county hospital, in excruciating pain. Pills, you know what I mean, just pills...I couldn't even move - now I can kinda like, ...bend over now and pick something up. But back then I couldn't even attempt to do that. And, like I said, I started using. So I can't really blame it on, 100 percent on that, because I

wasn't following through my appointments with my therapy and stuff like that. But I had got arrested again.

I: So you were going to physical therapy. . .

R: Yeah, I was on my way in the door. I had my appointment and everything, but I got busted. And that's the only thing I could say that - it's kind of been my fault. I'm not gonna blame it on the whole medical system.

(P17: John IV#1 17:12 202:212)

Although John continued working to the end of the day, upon arriving home he found himself immobile and in extreme pain. He was living with his mother and she insisted he seek medical attention. John was taken to a community hospital emergency room with the intention of having his pain relieved and problem fixed only to be dejected by the treatment he received. John felt the emergency room clinicians did little more than inject him with pain relievers and discharge him. John believed he had been brushed aside and that his problem had been trivialized. The hospital staff seemed unresponsive to his pain and unwilling to do more than prescribe ineffective pain medication. Despite his frustration with the care he received at the community hospital, John sought further medical care at the county hospital. Although the services he received at the county hospital were more comprehensive and appropriate, John was disheartened by the treatment he received there as well. John's discomfort and immobility persisted and he found he could manage his symptoms efficaciously via his heroin addiction. While this worked for a time, it ultimately interrupted the treatment he was receiving as he was rearrested as a result of his drug use.

John was willing to accept responsibility for his role in the discontinuity of his care, but the sense that the health care system discounted him still remained. Furthermore, this was not the first time he was treated shabbily by the health care system.

In the following narrative, John described how he was treated after a fall in which he fractured three vertebrae in his neck.

R:...But there's another time when I hurt my back years ago, when I hurt my back. The doctors...I'm going to the county doctor...And...they were kinda rude. You know, just the way they kinda treat people, you know what I mean? They're kinda tossing you on the table and shit, and I'm getting pissed off. I got four, five of my partners (his friends) there. And I'm calling for my partners, "Get me up outta here," 'cause now I'm really mad 'cause of the way they're treating me. So I got pissed off. So my partners' taking me outta there. And the next day I go to another hospital, and even there it was like...they just gave me some pills and told me to go home and lay down. That's what it was back then. This was back like - this happened back like in '87...I fell. I fell from about that high on my neck. Bam. Yeah. That fractured my vertebra...(P17: John IV#1 17:12 202:212)

John was angered by the rough treatment he experienced at the county hospital. It seemed the clinicians were intentionally severe and uncaring towards John personally. He refused to tolerate such indifferent treatment and left without receiving any evaluation or intervention. John believed his problem merited more thorough examination and that he deserved a modicum of respect and professionalism from the clinical staff. However, John experienced a similar situation in his attempt to access care at a different hospital the following day. Once again he was supplied with only minimal care and a prescription for pain medications, worthless in light of the illegal but highly effective opiates he had access to. As a result, John's drug addiction became a primary way he managed his pain.

This was particularly true after the injury to his lower back in 2003.

R: (after his work-related injury)...I stayed on my back for three months. I stayed on my back for three months.

I: And did you get any care at that time?

R: Yeah. Yeah. Oh, yeah...They were filling me full of pills, and then therapy, I was steady going up to the county hospital and I wasn't really feeling that, but as much pain as I was in, I had to do something. But then, again, I started using...So when I started using, you know, my drug of choice is heroin. The pain was gone. 'Cause that [laughs] to me, that was the ultimate pain reliever. (P17: John IV#1 17:6 64:66)

As he articulated above, John received continuing care for his back but his pain was never well controlled, despite multiple prescriptions for pain medication. John most likely would have returned to his addiction regardless of his health condition. However, his ability to address his pain more effectively than the health care system provided a rationale for John to continue his drug habit.

While he wanted his back to be fixed, the medical treatment he received seemed to be ineffectual particularly in comparison to his own regimen of care. Through a combination of home therapy and illicit drug use, John was able to resolve his condition to a certain degree. In the subsequent narrative, John described how he independently cared for his back and improved his mobility, although he never regained his previous level of physical fitness and strength.

I: Do you think that if you got the treatment you needed in a timely way it would have made a difference in whether you were rearrested or not?

R: Oh, yeah, yeah...I believe it would have because if they would have did it in a timely fashion, I coulda have gotten it taken care of. And then I would have been more or less focused on the problem... 'Cause I'm talking, it was intervals in between appointments. A month, or we're waiting for this or that, and, "Oh, come see me in a month," and, you know, stuff like that. That's...the county hospitals. Now, if I would have been going to a private doctor...if I had some insurance, it would have been a lot easier for me, yeah, but I didn't have it like that. But I think it would have been a factor there, yeah. To answer your question, yeah. I think it would have been... 'cause I, like I said, I was down for three months. I started...after coming outta bed, I couldn't even shower, I couldn't do none of that. Mom had to help me shower, and then I started with a walker. But this wasn't all being documented [sic] too...I had to start walking again with a walker. And then it came to my cane.

I: And have you had the cane ever since then?

R: Yeah. Yeah. But this is not all being documented...I did my own therapy, to tell you the truth...And as far as taking a shower, that was hell. I mean excuse me, even to handle myself when I used the restroom was really rough. But none of that stuff is documented. That should have been done at the doctor's, I believe...I'm not saying I should have been laid up in the hospital, but I think they should have looked into it a little bit more because...right now thinking about it...if you got money, you're gonna be taken care of. If you don't got money,

you're gonna just, oh well...But, like I said, that's how I started walking again.
(P17: John IV#1 17:13 217:232)

More timely and effective care most likely would have not reduced John's risk of rearrest, as he maintained his involvement in illegal activity throughout his injury. However, more consistent follow-up care might have increased the efficacy of John's own self-care and decreased his reliance on a cane. The system, it seemed to John, was more concerned with its own bureaucratic processes than John's condition. The slow pace of the care discouraged John and he believed it was a result of his impoverished and uninsured circumstances. Over time, John lost interest in seeking care although he believed he needed and would have benefited from it.

John was dispirited because he felt the medical system ignored the gravity of his situation and his own efforts at resolving the problem. The system had done little to help or support him during this period of pain and immobility. John believed the severity of his condition and the length of his convalescence were not acknowledged or recorded by the county hospital, as if John's injury was insignificant. In John's mind, the health care system had shirked its responsibility for him and while he understood he did not require full-time nursing care, he felt his injury merited more than the sporadic and ineffectual care he had experienced thus far. His feeling of never receiving sufficient care for his back continued into his future encounters with the health care system.

Despite his frequent incarcerations and habitual engagement in criminal activity, John never stopped seeking care in the community particularly as his back pain and immobility worsened over time. John was interested in establishing a regular relationship with a clinician only to be frustrated by the inconsistency between providers. In the

following narrative, John articulated his dissatisfaction with having to encounter a different clinician at each visit to the community clinic.

R: ...because the doctors, see, they've been switching doctors also. You know how the clinic is. I mean I'm never gonna stay with one doctor...So the other doctor that comes in, he don't really know [me], I mean on a personal level like the other doctor [does], you know, so what do you want? You know? No examination no more; it's just about some pills...I told him (the new clinician), well, [with] the last regiment [sic] of pills what the other doctor told me, "Well, we're going to get you a regiment [sic] of pills that will, you'll feel comfortable with that aren't gonna be narcotic and help you, help you to get along." To move and stuff, you know? 'Cause, like I say, how I been handling things? Is that the main question? I don't want to use no more...[but] how I'm gonna get no pain, you know what I mean? But that's not gonna get me nowhere. Just like the other times, if I start using, I'll just neglect everything. And I don't want to do it this time. I really want to take care of myself now...and health to me is the number one problem that I do need to take care of.

I: How are you taking care of it right now in the middle of all this chaos?

R: Wow! I'm just hanging in [laughs] there. I mean seriously, I mean seriously. I'm just trying to be strong and hang in there. I mean...there's no other thing I can think of besides that. I just don't want to go, go that negative route. I'm just trying to stay focused on that. It hurts a little bit, but hey, each day that goes by, you know, I'm just trying to - I can't really say I'm struggling because I know pain when I feel pain. This is probably about a 2, a 2 or 3 maybe on the scale. Sometimes it gets a little worse, and sometimes it, it's better, you know?
(P17: John IV#1 17:7 79:92)

With each new clinician, John was required to repeat his medical history and inform the new practitioner about his circumstances. As a result of multiple providers, he was unable to establish a personal and reliable relationship with a specific clinician. The inconsistency between providers left him vulnerable to changes in his treatment plans that were often unnecessary and ineffective. Furthermore, clinicians' competency and sensitivity in addressing John's problem and his addiction disorder varied greatly. In the encounter he described, John had previously seen a provider who was interested in not only resolving John's problem but improving his quality of life as well. However, on his next visit to the clinic he was confronted with a different clinician who seemed abrupt

and disinterested. Although this sort of treatment was not unfamiliar to John it was disappointing.

John was disheartened by his interactions with the health care system but acknowledged that his street and drug life had become untenable. He was interested in finding different ways of coping with his physical ailments but he was also afraid of being in pain. His primary means of pain control had become a liability to his general wellbeing. He no longer wanted to employ drugs either as a pain management technique or as a lifestyle but was at a loss as to how to function beyond what was most familiar to him. Therefore, health care services were the most salient option available to John for improving his health and managing his pain. However, John questioned whether he would receive the care he needed in a timely way. At the time of these interviews John's level of discomfort was tolerable but he worried about what would happen should his condition worsen. While he could cope with his current circumstances, he wondered about his ability to handle an exacerbation of his pain and immobility without drugs. In the following narrative, John articulated his tenuous position in regards to his health status and his recovery from drug addiction.

R: ...I mean if this don't work for me here, then that's why I'll end up in prison. And I know this. If I can't function out in society...And I start using again? And then...I'm gonna do wrong, then I'm gonna be up over there (in prison), and...I'll really be F'd up then, you know? And I don't really want to go that route. I wanna...nip that in the bud even before that happens. But it could happen to me any day. At any time. And that's just reality...And that's the last stop for me, you know? But as far as that right there (as far as functioning in society)...I want my health back...Or at least half, at least 70 percent...Because right now I'm running on 50, 45, and it is frustrating and another thing, my mom's getting kinda old and other people...they really ain't got time to...take me to the doctor or Social Security or, like I say, I took a walk to the BART one time and the bus. Oh, man, that killed me...I was so pissed off because I couldn't do it without stopping every three blocks. Ah, you know, and sweating because it was kinda

hurting...It just - just - that uncomfortable feeling. I didn't like that, you know?
(P17: John IV#1 17:9 160:162)

John expressed a sense of urgency about his situation, as if this was his last chance to be successful in the free world. Success and stability in his home community were things he desired but wondered if he could achieve. Despite his best efforts to change his lifestyle, maintain his sobriety, and avoid criminal activity, the chances that John could return to his street life, and therein prison, were real. John viewed his health as critical to functioning well in free society. However, his immobility had affected the practical aspects of his reintegration efforts. He could no longer do what he used to do, e.g. walk to BART, with the ease and rapidity with which he used to. John's sense of independence and self-reliance was lost and he had to rely on others for assistance; he felt like a burden. Additionally, John's limited ability to cope with his pain placed him at greater risk for drug relapse.

John was not only stymied by his decreased flexibility and strength, he was saddened by the loss of it. Although he believed that through exercise and possibly more consistent health care services he could regain some of his former mobility, the gravity of his situation depressed him. In the following narrative, John further articulated his feelings of loss over his physicality and his doubts as to whether any of his problems would be successfully resolved.

R: ... [when] I'm showering or something, I have to lean on something, and now it's a little bit more harder... 'cause I just can't squat down real fast or make movements because, like I said, my knees are - it's progressive, because I don't feel it in my back no more... It's going down my legs... My back is - thank God my back is still strong right now. Because if my back goes, if the core goes, I'll be laid up again, and I don't want, I don't want to do that, so. I know have to, my short-term goals is to lose some weight and do some exercise, 'cause they got some pretty good equipment back here (at the SAT program) I could exercise with, but it's just, I'm being lazy... I'm being lazy.

I: And why do you think you're being lazy?

R: I'm just waiting. I'm really just waiting...For something, you know what I mean? [laughs]

I: But you don't know what though.

R: I think, I think...I'm waiting for Tinkerbelle to come to hit me with her magic wand, tell me, "You're well now," you know [laughs] what I mean? Not only mentally, but also with my addiction...And that ain't gonna happen...I'm just funning with you, but I know I have to be a little bit more harder on myself, to push myself...I know this. But then it's like the Mexican famous saying, "Oh, manana, I'll do it tomorrow,"...And that's always been a problem with me. I've always been a procrastinator and put shit off, you know, excuse me...and that's serious business there. But I really know one thing. I'm gonna have to start doing something, because in a few more years I'll be 50, and I don't wanna be a cripple 50...I want to be healthy, I wanna overcome this. You know, I really do...and I know if I don't start soon...it's gonna be harder for me to get back on that, you know? You know? That's, that's the thing with that. Yeah. [Chuckles]

(P17: DS007 IV#1 17:8 126:136)

As John expressed previously, he felt fortunate that the degree of discomfort in his lower spine was tolerable. However, he was distressed by the pain and rigidity in his legs; it was as if his body was falling apart in front of him. John feared being disabled once again should his condition worsen. He believed that his back and legs would improve through weight loss and increased activity but he had not actualized any such self-care. John questioned his resolve to participate in anything positive as it related to his health and wellbeing, as if caring for himself seemed a pointless and impossible task. Although he commented that his problem was a lack of commitment and focus, John no longer possessed the determination with which he overcame his initial injury in 2003; to tackle another debilitating exacerbation seemed too much for him to bear and now he hoped for a miracle cure. Additionally, John faced the challenges of recovering from over two decades of drug abuse and street and prison life. While he wanted to be an integrated member of civil society, maintaining his sobriety in the short term was sufficiently arduous and John doubted whether he could do that.

John's qualms about his own capacity to cope with his health problems and addiction disorder influenced his relationship with the health care system. John had hoped that medical care would effectively address his pain and immobility. However, his need for increased function and decreased discomfort in his back consistently went unmet. John was in pain the majority of the time and his reintegration efforts were hindered by his physical limitations. While John was still willing to engage with the health care system, he felt the pressure of time. He was discouraged, thus far, by the system's inability to ameliorate his physical problems or understand the role that drugs played in his life. Despite his frequent interactions with clinical services, John's physical condition and his personal circumstances were growing worse rather than improving. To a degree, further engagement with the system seemed futile. However, John had no other means to cope with his problems. The continued failure to have his problems resolved both increased his risk of relapse and delimited opportunities for bettering his circumstances altogether.

Louis. Louis was 50 year-old white male who had been involved in the correctional system since 1981. At the time of these interviews, Louis had been in the community for 10 months. His health problems included Hepatitis C, anxiety and depression, and a long-term heroin addiction. Additionally, Louis had lost his right hand in his early twenties in a work-related accident. Although Louis felt his primary concerns were his drug addiction and anxiety disorder, he believed that his injury was the root of his problems. The amputation of his hand led to his involvement drugs, criminal activity and eventually prison. The multiple incarcerations, in Louis's mind, caused his anxiety disorder, which made it difficult if not impossible for him to function in free society.

Prior to the loss of his hand, Louis was married with three children. He was stably housed and regularly employed with two jobs. As he related in another narrative, Louis had access to drugs, as several friends and family members both used and sold them. While Louis used drugs intermittently, he did not consider himself to be a drug addict prior to his accident. In the following narratives, Louis described the circumstances of the injury, the treatment he received for it and his belief that the loss of his hand ruined his life.

R: I was working at a casino and I got it caught in a chipper. I was in there fixing the machine...And it turned on. While I was inside of it...I was getting into it about three or four times a night, fixing it when they'd call me. So I went in there just like any other night, went to go fix it, and the machine turned on while I was inside of it. Caught my glove. Pulled me in. And if I didn't yank it out, it would probably went right through the machine. 'Cause the door on it's as big as that door right there. You walk into. It's got 365 teeth in there. Rotating like that. So. And then I was on a harness [sic]. Some guy at the end of the rope, holding me. 'Cause you can't go in there without a harness [sic] on...If he wouldn't have passed out and landed on the rope, I would have went right through the machine. There would be nothing left of me...And that saved me.
(P16: Louis IV#1 16:16 463:473)

The circumstances of Louis's accident were gruesome and potentially life threatening. Louis came very close to being killed had his co-worker not fainted and released the safety harness. His injury was shocking in that Louis was performing his routine duty – a thing he had done many times before without incident. However, as a result of the accident, Louis's circumstances were irrevocably altered and he was unable to return to his former life. Upon release from his month long hospitalization, Louis found he was traumatized and addicted to painkillers.

R: ...I was in the hospital for a month and something. And I came out strung on morphine. They gave me some pills to take. I was eating so many of them 'cause they weren't really doing that good. I don't think I was taking them for the pain. I think I was taking them because they had me strung out on morphine. I'm not really sure. I was making excuses, calling the doctor up, telling him, "Hey, I

dropped the bottle, lost them, did something.” He starts saying, “Look. You ain’t having that many,”...I was just calling him like every week, getting more medication for it. He was giving me 90 at a time. So that’s when I started really using drugs. Back before that I wasn’t using drugs. So then I started using drugs, and one thing led to the next. I ended up moving out, and getting a divorce. Even had a business going up there. I stopped that. And then started my criminal life. Started needing to get money for drugs, heroin, ‘cause that’s the only thing that eased my mind or my pain or whatever I was doing it for. I don’t even know. So that’s how I started. 1981...I went to prison...Every time I got out, the first thing I thought about was drugs, drugs, drugs, drugs. I had nothing out there, you know? (P16: Louis IV#1 16:16 463:473)

Louis attributed the onset of his drug addiction to the care he received while hospitalized. Most likely, the nature of Louis’s injury required intensive pain management during his stay. However, there was no apparent discharge plan for Louis’s pain management upon release. Additionally, it seemed that nothing was done to address the psychological and occupational components of Louis’s injury. As a young man, he had lost his hand, almost his life, in a terrifying accident. It is not clear if he was offered any sort of physical or mental therapy but it was apparent that much of Louis’s struggle lay in his difficulty coping with this unexpected limitation and disfigurement. His pain seemed minor in comparison to the adaptations necessary for reentering his life without a hand.

Nevertheless, Louis left the hospital with a large prescription of opiate pain medication that he overused. Louis was unclear of the medication’s role in his pain control and he believed he used the pills to manage his iatrogenic drug addiction. After a time, Louis’s physician refused to prescribe him further medication and Louis was left with nothing either to control his pain or to manage his addiction; he turned to illegal opiates. Louis’s previously intermittent use became a full-time habit and overwhelming problem. Over time, Louis lost his family and his employment, the foundations of his

stability, and found himself involved in street and prison life. It was unknown whether Louis would have developed an addiction disorder as a result of his easy access to illegal drugs and the many friends and family with substance abuse problems. However, the twenty-year pattern of drugs and incarceration were not what he anticipated for himself at the time of the accident. In the following narrative, Louis elaborated further on his difficulty in coping with life after the loss of his hand.

I: So they were willing to re-employ you?

R: They did re-employ me. But they said that my work performance was different. Oh, yeah, my work performance is different! Come on. You got me going into this room where I just cut my hand off. They didn't want to put me in another position, or in a different area. They wanted to put me back in the same room, on the same job, on the same machine. Well, yeah, I'm gonna be a little spooked. Now I got this prosthetic thing on my arm, metal, all this, and if it (the chipping machine) could catch flesh, can you imagine what it can do to that? So I was - I was spooked pretty bad. So they said my work performance wasn't like it used to be, so they brought me to a committee, and they wanted me to go to another doctor, and they wanted me to do this, wanted me that, and I just gave up. Which I should - well, I was having problems with my family too...that kinda bothered me too. But drugs took care of that. Does that make sense? If I was using dope, I could - all my problems went away. I didn't care about going back to prison, or I didn't care about this, didn't care about that...

(P14: Louis IV#2 14:8 127:141)

Louis was able to return to work after the accident. However, no accommodations were made for the loss of his hand. His employer expected Louis would return as usual without consideration for his recent trauma or new physical limitation. Louis was fearful and reluctant to reenter the chipping machine and his job performance suffered. While Louis's performance was most likely complicated by his drug addiction, his employer seemed unable to understand the impact of Louis's injury on his ability to function as he had in the past. Louis's employer wanted additional evidence of his disability and required Louis undergo further evaluation. This was too much for Louis to cope with and in frustration he relinquished his full-time employment. The loss of his family and home

soon followed and Louis found himself managing the pain and isolation of his circumstances via drugs.

For Louis, the loss of his hand ended what had previously been a secure and agreeable life. After his injury, he was never able to regain a similar kind of stability or sense of purpose. Louis had descended to a depth of misery previously unimaginable to him. He did not have the intrapersonal resources or skills to cope with his new and unwanted circumstances nor was he offered any relevant assistance or support from either the health care system or his employer. In essence, the amputation of his hand ruined his life. Louis further articulated this in the narrative below.

R: ...I've never really had nothing going on for me, ever since I had my accident. Things like went downhill, and it's never - I never came back up.

I: You never recouped.

R: I hit bottom. I don't know how many times. It seems like it's really easy to hit bottom, but it's hard to get back up...So that gives me - it don't give me no confidence whatsoever. Yeah, I'm kinda like I'm getting put down...I don't know what I'm trying to say, but...I feel like if I had two hands, or I never had this accident, I'd probably be married today, wouldn't have went to prison, wouldn't be using drugs, 'cause I wasn't doing any of that before that. So I'm not gonna sit here and say, it's 'cause of my hand. Oooo ooo ooo. 'Cause nobody's telling me to use drugs, but...I'm a five-time loser (he was incarcerated five times). And nobody will give me a chance. So I have to learn to deal with it.

I: Have you learned to deal with it?

R: No. I haven't. But I'm not saying I can't, because I'm willing to try...

(P14: Louis IV#2 14:8 127:141)

Louis's sense of self and personal esteem had been shattered by the accident; he had lost not only a part of his physical self but his family and community as well. While he accepted responsibility for his continued engagement with drugs and criminality, he believed he deserved some form of support and assistance in coping with the significant losses he experienced as a result of his injury. Louis wanted to develop the skills necessary to cope more effectively with life on the outside, skills he had once possessed.

However, he was hampered by limited self-confidence and an anxiety disorder that made it difficult for him to be around others particularly in the free community. In the following narrative, Louis described his beliefs about the origin of his anxiety disorder.

R: ...I guess because all the years I've been in prison, people, you know, you gotta, out a habit of leaning against the wall. You go to the yard and you hit the wall. The first thing you do when you, you know, 'cause a person that comes on the prison yard? You get to - you notice - you know when it's normal, and then you know when there's tension. So I automatically start looking around, or you stoop down. You go to a wall. So nobody comes behind you. So I've learned that so much, I don't like people walking behind me at all. I can't stand it... 'Cause I can't - in a store! Even in a store, when I'm in line at a store, I can't just stand there like this. I have to be sideways, to see who's there and who's on each side of me. I can't stand nobody behind me. I'll go through a quick lane, and if the lanes are too long, or I'll just put the - get down and get outta there. 'Cause that kinda stuff bothers me. [...] And I'd like to try to get rid of that. I don't know if a doctor can help me do that.
(P16: Louis IV#1 16:5 199:215; 16:8 289:301)

Louis attributed his feelings of paranoia and distress to his years in prison. As a means of survival, Louis developed a hypervigilance and heightened awareness to the environment around him. In other narratives, Louis described the institutional violence he experienced as victim and perpetrator throughout his incarcerations. While the prison environs played a significant role in Louis's anxiety disorder, it was also likely that the traumatic manner in which he lost his hand influenced Louis feelings of disquiet and unease. Not only did the event itself disturb Louis but it may have also made him a target in prison, vulnerable to attacks by other inmates, thereby increasing his fear and paranoia of those around him. Louis was affected by his experiences in prison to such a degree that he did not cope well with social situations in free society; Louis could not control his angst even the most benign settings, e.g. the supermarket. Therefore, completing the tasks of daily living was an ordeal for Louis. He disliked feeling skittish and out of control of both his environment and his emotions. Louis wanted help for this problem as it left him

feeling isolated and alone. His anxiety as well as his inability to manage the inherently social nature of life in civil society exacerbated his drug use. Louis used drugs to cope with the intense emotional content of both his symptoms and his belief that he was a failure. His feelings of isolation and alienation affected his capacity to remain in the free community for more than short periods of time. He knew something was wrong with him; he wanted and needed assistance. In the following narrative, he articulated his sense of abnormality resulting from his anxiety disorder and the treatment he had received for it thus far.

R: I knew - I felt not normal. I mean I felt strange around other people and things. I knew what was wrong with me. I didn't know what the name of it was or anything. But she's (the therapist) the one who brought it to my attention...She goes, "You have - just by you, your body language and the way you're talking, you can't sit still and stuff, and with the way you tell me, you've got anxiety pretty bad," and then she was telling me about the panic attack things. And then when I started telling her about my family...I mean she made me talk a lot about my family. And then I understand it, I guess, when you talk about it. It helps, it helps, you know, get it out - get things out, don't hold it in. And I felt real comfortable with her...she made a lotta sense. And she really went out of her way to help me. So. I think me going to her or me going to somebody like her would be - I really - I think I need to...But, see, I just don't want to get no medication. . .I don't want that. I need to know exactly what's wrong with me and what can I do to stop it. Not to block it out. (P16: Louis IV#1 16:14 411:443)

During his last period of community supervision, Louis had access to a therapist as a result of the shelter where he was residing. This was the first time he had sought and received help for his psychiatric symptoms in civil society. While he had psychiatric evaluations in prison, Louis perceived such interactions as attempts to medicate him into docility without actually exploring the root causes of his problem. Therefore, his encounter the therapist was the first comprehensive care he had received since his accident. The therapist immediately recognized and acknowledged Louis's symptoms. She reassured him that his symptoms were a result of significant psychological distress

not a character defect. She listened to Louis and helped him understand what was happening to him. This was unlike the clinicians he saw after the loss of his hand, who poorly managed his pain and seemed unconcerned about his traumatic stress after the accident. The therapist wanted Louis to have at least a small improvement in his situation during his interactions with her. Louis did gain some insight into his problems as a result of his sessions with her. Most importantly, the therapist did not force medications upon him; instead, she offered a means for Louis to understand and cope more effectively with his anxiety.

For a short time, Louis benefited from the therapist's knowledge and concern. However, as he related in another narrative, it was not long before he relapsed onto drugs and was reincarcerated. Nevertheless, Louis believed that similar therapeutic support in the community would help him cope more effectively with his anxiety and paranoia rather than continuing to obfuscate them with illicit drugs. In the narrative below, Louis articulated further his beliefs about the impact of an improvement in his psychological wellbeing.

I: And gaining control over it, what do you think that would give you? How would your life change, in your mind?

R: I think it would make life easier for me...I'm just saying I'd be more comfortable around other people. I would participate in other things. I would go other places, do other things, that I would normally do.

I: What kind of things are those?

R: Like, for instance, going into a casino...I mean I used to go into a casino; I used to work in one. I used to - But. I just - me being able to do what I want to do, when I want to do it, would make things a lot easier for me...You know what I mean?...I just want to be able to do. . . normal things.

(P16: Louis IV#1 16:14 411:443)

Louis felt continued therapeutic services would alleviate his feelings of paranoia and skittishness. With regular therapy, he believed that he would be able to engage more

freely with others and participate in the daily activities of civil society without fear. Additionally, control over his psychiatric symptoms would allow him to regain some semblance of his former life before the loss of his hand.

While Louis was desperate for some sort of positive and caring attention, his anxiety disorder and his primary mechanism for addressing the demands of life in society at-large, i.e. his drug addiction, delimited his ability to participate in clinical services over the long-term. Louis was cognizant of the severity of his circumstances. It seemed that despite even the most appropriate care, Louis's problems were intractable. In the following narrative, Louis articulated his sense of hopelessness at finding a resolution to such a multitude of issues.

R: Yeah, I feel like I have a pretty heavy load on me. I don't know if this has anything to do with it or not, but when I start thinking about all my problems, I feel like there's no way of getting rid of all of them, and it kinda makes you feel like, oh well, you know? But that ain't the way to feel. I don't want to feel like that...But I do feel like that. I don't know how to stop it. I mean I got a lot - I got a lotta problems. Not just depression or anxiety or whatever. Or fear. But I feel like I got - I'm one big problem...You know? Maybe - I wish they had some kind of a pill, that you could take, and it knocks you out for like a year, and you get better and comeback or something. (P14: Louis IV#2 14:14 287:303)

Although Louis may have benefited from proper therapeutic support, such interventions also seemed useless to him. Louis felt he was entrenched in his fundamental ways of coping via drug addiction, criminality and incarceration, and wondered whether he could learn new skills and behaviors more suited to life in free society. As much as he hoped for a solution, the actuality of one seemed remote. Louis believed the severity of his circumstances required extreme measures, possibly in the form of a miracle pill. He experienced feelings of worthlessness that made him question his existence. This sense of futility, rather than his optimistic perspective on therapy, was how Louis encountered his

life and the contexts in which he lived. Louis had never recovered from the loss of his hand but rather masked the pain and suffering he experienced as a result of it with drugs. Despite his personal qualms, Louis was willing to engage in care. However, the substandard care he had received in the past made him doubt the capacity of the health care system to successfully treat his problems. Louis also questioned his own ability to improve his circumstances. He embodied his problems and could not see beyond them. Therefore, Louis's ambivalent engagement with the health care system was delimited both by his own reservations about his self worth and by the feeling that effective treatment for his problems was unavailable to him.

Conclusion. On multiple occasions, participants experienced inadequate and ineffectual treatment from the health care system. They believed they were disregarded and provided substandard treatment and evaluation. Participants were frustrated by the inconsistent and unreliable care they received. Such care neither addressed their long-term problems nor alleviated their short-term discomfort. Participants felt vulnerable to both exacerbations of their conditions and the loss of any stability they might have achieved while in their home communities. Furthermore, the shabby treatment they received often led participants to abandon the health care system altogether as they realized they could manage their mental and physical health problems through their illicit drug habits more effectively than through clinical services.

Participants' ailments and disabilities affected their self-image and self-esteem; they could no longer rely on their bodies as they had in past and felt constrained by their physical limitations. Their unresolved health problems added to participants' uncertainty about successfully reintegrating into their home communities. Frequently participants'

questioned their own resolve to meet the demands of life in civil society. In general, their personal esteem and self-worth was not sufficient for overcoming the daily challenges of life in their home communities. Participants had limited support from health care services as well as a narrow range of coping skills with which to overcome their problems. Therefore, participants often returned to their former ways of being, i.e. drug use, criminality, and incarceration. However, participants wanted nothing more than to live in society in an integrated way. They could no longer cope with their criminal lifestyles either emotionally or physically. They believed that a long-term and stable engagement with the health care system could assist them in their reintegration efforts. Regardless of the substandard care they received in the past, participants still felt that proper treatment and support would help them achieve the stability they wanted for themselves and live more comfortably in free society.

Dismissive Engagement with the Health Care System

In contrast to participants still willing to engage with the health care system despite their ambivalence about its efficacy, another group of participants were dismissive of the clinical services and interventions offered to them. This reaction to medical care was an expression of an apparent pattern of distrust towards all powerful and authoritarian institutions and figures, rather than a specific reaction to the health care system. These participants believed they were the habitual victims of such institutions and therefore, would never be well cared for by the health care system even when they had access to appropriate and potentially helpful treatment. Participants delimited their engagement with health care and rationalized why they should not pursue further or continued care. In their minds, health care was unable to resolve their problems and

could possibly worsen them. Furthermore, participants' personal agency was limited by the belief that they had no control over the outcome of their health conditions or their lives in general. These participants coped with this sense of impotence by immediately and consistently discounting the health care system rather than risk being disregarded or altered by it. Within this perception, participants also avoided taking responsibility for their problems, either for their cause or their resolution.

However, participants still wanted a solution to their health problems. Yet, their recalcitrance to engage with the health care system, even when they had access to it, made successful resolution of their problems challenging. Participants wanted assistance with both their ailments and their reintegration efforts but were unclear about the specific support they desired. While the idea of being helped appealed to participants, their expectations of the help available to them were often unrealistic and required a level of personal involvement and accountability they were unable to provide. Participants hoped their problems would be solved and their circumstances improved without their active participation. Although participants' inability to accept personal responsibility for their circumstances was a barrier to the improvement of their health and to their reintegration, it was also a primary means by which they coped. Through dismissing the help available to them, participants remained entrenched in their current situations and did not have to accept the responsibility that changing their lives required. Therefore, their dismissive engagement with health care was a way in which these participants protected themselves from both having to change and face the possibility they might be unable to do so. Paul provided a paradigmatic example of this pattern of engagement. While he struggled with psychological disorders that further impacted his interactions with the health care system,

this pattern appeared in participants who did not experience such extensive psychiatric symptoms as well.

Paul. Paul, a 42-year old African American, had been involved with the correctional system since he was an adolescent. At 13 years of age Paul was sentenced to a juvenile facility for three and a half years. At the age of 22, Paul was first incarcerated as an adult and over the past two decades had spent less than three years in the free world. At the time of these interviews, he had been in his home community for two months and came directly from prison to the substance abuse treatment (SAT) program. Although participating in the SAT program was his choice, rather than a mandate from his parole agent, he had had difficulty interacting with program staff and other residents. He attributed these difficulties to the SAT program's narrow understanding of the severity of Paul's primary health care problem, osteoarthritis in his knees.

As a result of his arthritis, Paul experienced pain and immobility in his both knees, although the right was worse than the left. His condition had deteriorated over the past several years and now Paul not only had pain on a daily basis but was limited in his physical activity as well. While he had previously received effective treatment for his knees in the community, the pain and stiffness had grown progressively worse. Paul found he could not tolerate the pain and required regular trips to the county hospital as well as occasional pain relief with narcotic medications. Neither Paul's need for continued medical follow-up, nor his desire to use opiate medication to manage his discomfort were unreasonable in themselves; they were, however, incommensurate with the needs of the SAT program, which required both active participation and abstinence from drugs and alcohol. Therefore, Paul was both unable to address his arthritis pain and

immobility and meet the requirements of the SAT program. His conflicted stance between what was required and what he wanted was a central obstacle to his coping effectively with either the SAT program or his health problems. In the following narratives, Paul discussed his beliefs about the origin of his knee problems, how they impacted his life, and the treatment he had received thus far.

I: How you feel about your health and how you think it is now and how it has been in the past?

R: My health used to be okay, you know. My health was okay before I got involved in drugs. Before I got involved in drugs it was real good...when I was playing sports and everything, but now as I got older, as I got older...all the illnesses were coming on. That's a lot of time I was tearing my body using drugs...Now once you put so much poison in your body, it eats your brain cells up, so basically my health problems vary - on a scale from 1 to 10, I would say it's about, about a 4-1/2, 5. (P 6: Paul IV#1 6:4 21:50)

Paul attributed a certain degree of his deteriorating health status to his cocaine addiction and the aging process. During his 20s he had been physically fit and athletic, but continued drug use decreased his strength, stamina and intellectual function. Now, as a middle-aged man, Paul realized the full impact of his addiction on his poor general health. Paul also believed that his osteoarthritis was affected by Osgood-Schlatter's disease, an overuse syndrome that occurs during childhood growth spurts. Pain occurs with physical activity and can be disabling although generally resolves without long-lasting or permanent sequelae. However, Paul felt that his Osgood-Schlatter's, in addition to his athletic endeavors, contributed to his arthritis and its increasing severity over the past several years.

I: And can you tell me a little bit more about how you think your health problem developed?

R: Um, when I was at a young age I had, I was diagnosed with Osgood-Schlatter's... You know, my bones didn't grow with, my knees bones didn't grow with my weight and height and it was a problem then. And the older I got by constantly playing sports putting wear and tear on my knees, start tearing more

cartilage and more fragments, in my knees, my bones had surgery, orthothropic [sic] surgery on before and constantly by the winters and all that. My arthritis has set in 'em real bad. My ankle and all. Arthritis, you know, some mornings I can't get up...It hurts some mornings it's so cold. Some nights...my legs are hurting, my knees are just, are chronic. It's a chronic...It's permanent pain.
(P 6: Paul IV#1 6:4 21:50)

As Paul related in other narratives, he was an excellent athlete as a young man.

He played for a short while on his high school team but he was primarily valued as a street player and was regularly requested to play for different neighborhood teams. For Paul athletics were a critical aspect of his self-identity. Over time, however, the rigors of competitive sports negatively affected the function and mobility of Paul's knees. The degeneration of his joints necessitated arthroscopic surgery in 2002. Despite this surgery Paul's symptoms progressed and had become a chronic problem. He was in significant pain a majority of the time and unable to be active. Therefore, the primary way Paul understood and took care of himself was no longer available to him. Paul mourned the loss of his former physically fit and athletic self.

E: How have you learned new ways to live in your body with these knees and news ways of taking care of yourself?

R: No...I have not learned, I have not learned a new way. ...Cause now since I quit playing (basketball) and I know I can't do strenuous exercises that you do to maintain your weight...it's a chronic problem psychologically and mentally, you know what I'm saying. It's a very bad, a very hard problem, you know. I have never been this big weight-wise, you know. This weight I picked up over this last year. [long pause] You know, so much. There is so much I would like to do still but I know I can't. You know, basically even riding a bicycle. You know, you ride a bicycle you're constantly bending your knees. At times, at times I can't even do that...It burns me up, to be honest, an awful lot, you know, 'cause, you know, like I've got nieces and nephews I be wanting - we be playing and they want to wrestle and play and go to the park and play ball but I can't do all that...It hurts. I play with them as much as I could and then I, I play it off like it ain't hurting but later on it hurts. You know, like when I tried to go to work with the guy and them, we was doing carpenter work and roofing. Just that one day on my knee of working made my knee swell up that big. I had to lay down two days here, you know. And I don't have a work history 'cause like I said 85% of my life I think I was incarcerated. ...Even if I try to psych myself up, I say, okay I be

working at this pace...Well...It's hard. I don't want to be on no general assistance. I'm 42 years old. I need to get into the work atmosphere now while I'm still, so I can at least try to get me 10 years in somewhere...And that's what burns me up 'cause it's very hard for me to find work, very hard cause of constant pain. (P 6: Paul IV#1 6:10 141:166)

With the deterioration of his knees, Paul watched his weight increase. He was a large man, close to six-feet and four-inches tall, and now he was an overweight one. This distressed him as his options for reducing his weight were restricted by his limited mobility. Paul's positive social interactions were also impacted by his disability and he was unable to do the things he most enjoyed. Paul's knee problems negatively affected his capacity to maintain employment as well. The jobs available to him, manual and physical labor, were hard for him to complete. He frequently experienced significant discomfort after a day's work and was unable to work the following day. Paul understood the importance of regular work to his reintegration efforts and worried he would not establish a solid work history as a result of his knees.

Although Paul legitimately suffered from arthritic pain and immobility, it was most likely less influential on his capacity to work than his scant employment history and his long and multiple periods of incarceration. While Paul may have been physically unable to work in the jobs available to him, it was probable that he did not know how to work as well. The idea of a steady job appealed to Paul, as a means to move beyond the confines of his street and prison life, but the focus and attention even the simplest of jobs required may have been too much for him to master. Additionally, Paul was reluctant to accept the one treatment option available to him, a total knee replacement. Such surgery would alleviate his pain and restore most of his former physical function, but Paul had serious reservations.

R: ...I'm about to have surgery on my knee...hopefully they don't do a knee replacement. It's been like kinda weighing on me 'cause do I really wanna have it done or do I - just want them to deal with the pain, because with the knee replacement I will walk with a limp, permanently, from now on...It's just, I don't know if I want to walk with a permanent limp or be having permanent disability. Right now it's already hindered me as a permanent disability because I can't do...a lot of things that I want to, do a lot of work that I was doing at first I can't do, because I can't really put no strain on it... (P 8: Paul IV#2 8:3 13:22)

Paul's physicians at the county hospital recommended and wanted to schedule him for the surgery as soon as possible. Given his physical limitations and discomfort, it seemed that Paul would be amenable to such a readily available treatment. Nevertheless, Paul believed the surgery would leave him more disabled than he already was. Paul's perception that a knee replacement would further hinder his mobility rather than improve it was influenced by his previous arthroscopic surgery in 2002. He described the circumstances around his first surgery in the narratives below.

R: ... [after the surgery] I got all the proper medical treatment I needed...Physical therapy and everything. ...I had the proper surgery, proper therapy... with them working on my leg twisting it making sure the muscles were healing, going to the swimming pool. And I went back to the program (an SAT program different from the one he was in at the time of the interviews) and I want a pain pill, a pain pill to take the pain away. Sometimes just walking on it hurts. And I tell them, "Listen, hey, my leg is really hurting me and I'm just going to go lay down". And they don't want that. "You gotta be caring." "You gotta be in group." "We don't allow medication here." Okay so you don't allow these things here but you allow me to pay...my rent while I'm at the program. I don't need it. So I left the program and went to mom's house and got my proper medical treat[ment].

(P 6: Paul IV#1 6:8 97:100)

Paul withdrew from the SAT program, and returned to his mother's home where he could medicate himself for pain. He continued post-surgery rehabilitation for a time, until all treatment was interrupted by a rearrest. Paul's expectations of the SAT program were unrealistic; most SAT programs for parolees are paid for by the California Department of Corrections and Rehabilitation not personal funds and strictly prohibit the

use of narcotic or illicit substances. However, given his need for physical therapy and pain management, entry into an SAT program immediately following his surgery was not realistic; Paul could not be expected to meet program demands and the SAT program was ill-equipped to address his medical issues. Additionally, there was little apparent communication between the medical system, SAT program and parole department regarding Paul's situation. Therefore, no practical plans were made to accommodate either Paul's medical needs or his addiction disorder.

I: ...And did you finish the course of physical therapy?

R: No.

I: What happened?

R: Well, rides in the car with some dudes you know. We got pulled over. Dude just buy the car from an auction. They search the car and find some dope in the car. Don't nobody know whose dope it is. Okay everybody going to jail so they sent me to jail. I'm [in] jail [and] ain't no more therapy. I didn't get no medical treatment, you know. I didn't get none. My knee healed wrong. I'm messed up 'cause I'm not getting proper therapy, you know what I'm saying? Just at the time we was coming out every other day out our cell, every other morning and so are there mornings you know you got to go to the yard. Probably twice a week, if that much and that was the only therapy I did get by walking around but that wasn't happening so knee kinda settled in and it got worser and worser.

(P6: Paul IV#1 6:9 109:112)

Despite his post-operative pain and immobility Paul still maintained his street lifestyle. It was not long before he and several of his friends were arrested for drug possession. His arrest and subsequent incarceration effectively ended Paul's physical therapy and it was his sedentary time in jail that, Paul believed, most greatly impacted his surgical recovery. Although, in essence, this was true, Paul did not acknowledge his own role in the limited improvement of his knee, as if he was a hapless victim of circumstance. Paul avoided responsibility not only for his health but for his life in general, which hampered his reintegration efforts as much as his actual health conditions. Paul psychologically coped by eliding responsibility. To realize that his own actions

impacted what happened to him was too much to bear. Paul did not have the skills or interior resources to acknowledge that he himself was a primary barrier to moving forward in his life. In the narrative below, this attitude became clearer as Paul further articulated his conflicted expectations of himself and of the health care system.

I: I'm wondering if you got your problem resolved would that help you finish your parole?

R: It's not - you know what? The healthcare don't have anything to do with doing my parole. Parole has to do with my heart and my mind. If I'm not - if I'm not in the right frame of mind, if I'm not in the right frame of mind, I'm not gonna complete parole.

I: And what is the right frame of mind for you to complete parole?

R: Being a positive individual, somebody who can be productive in society. That's what's gonna - that's what's gonna make me complete parole.

(P 8: Paul IV#2 8:24 129:152)

Paul believed that his knee problems were unrelated to his parole supervision. He felt that maintaining a positive mindset and becoming a contributing member of society were the primary factors in his successful completion of parole and establishing long-term stability for himself. While this was true, Paul had not considered the fact that he could not work or even care for himself well because of his osteoarthritis. Additionally, he was frustrated by the medical services he received thus far, although he consistently relied upon such services for assistance. In the narrative below, Paul discussed his reservations about the proposed knee replacement and his conflicted engagement with health care services in general.

I: So how do you think you're gonna complete parole if you can't work?

R: That's what I'm saying. That's, that's the main thing. I'm not a fan of the healthcare because I have been getting a bum runaround...And it's slowly discouraging me more away from it. You know, when I try to be very patient, and deal with them...It's learning me patience, but at the same time my patience is getting short. My patience is getting short...it's just I'm getting tired of dealing with them. I really am, 'cause it's so many runarounds.

I: What would make you less tired of dealing with them?

R: I can't say. I can't say because I never even thought about it. I never even thought about it. I never really thought about it. Hm. I have never thought about that. [Long pause] Hm. I can't even begin to say. [Pause] [Very long pause] Wow. The thing, I don't know what - you know, I don't even know...because they have me - they have me so off balance right now I'm dealing with them, you know?

I: Tell me more about being off balance.

R: OK, the foot. That foot. Now they wanna do the knee. [laughs] This one (his foot) ain't even healed, and now you wanna go cut on this one? Come on, Man. I don't really know, 'cause I'll tell you, to be honest with you...if they do surgery on my knee, and these people (SAT staff) here are telling me that I can't take nothing but some Aspirin or Tylenols. I don't know if I'm gonna be able to stay here. I'm being honest with you. 'Cause that is a whole lotta severe pain.
(P 8: Paul IV#2 8:24 129:152)

Paul was disheartened by his interactions with the health care system. Regardless of his prior satisfactory encounters with medical services, Paul believed his clinical care had been ineffectual and difficult to access. In his mind, the system was disinterested in his problems, despite his steadfast participation in care. Paul felt overpowered by the medical system, as if he had no control over what happened to him. He wanted assistance but was uncertain as to what sort of help he required. He believed he was in a precarious position and at a loss as to how to claim some sort of personal agency within the health care institution.

Paul's feelings of helplessness and dissatisfaction were not completely unfounded. At time of these interviews, Paul had had emergency surgery on his right foot. He was unclear as to why such a procedure was necessary. He believed, as he related in another narrative, that the surgery was done primarily as a learning experience for the hospital's surgical residents. While the truth of this perception cannot be known, Paul's post-surgical care was less than adequate; the sutures were removed too soon and Paul was left with a partially closed incision. As a result he was required to go the hospital every few days for dressing changes and continued monitoring. This not only

placed Paul, once again, in conflict with the SAT program's requirement of regular participation in group activities but increased his reservations about further surgery as well.

Paul's circumstances were complicated by his fear of pain and being unable to manage it appropriately. Paul wanted to successfully complete the SAT program but he also wanted narcotic pain control, rest, and to be able to attend scheduled medical appointments, all things that the SAT program, a social model, non-medical facility, could not accommodate. Paul was stymied by the incomensurability between what he wanted for himself and what his living situation and circumstances demanded. Additionally, both the hospital and SAT program staff were most likely unaware of the challenging position Paul was in as a result of their conflicting interests. Therefore, communication between the two institutions may have enabled Paul to better cope with the requirements of both systems. However, such communication was restricted by Paul's inability to articulate and advocate for his needs. In response to what seemed like insurmountable problems, Paul's preemptory dismissive pattern of coping was most apparent. Paul articulated his recalcitrance in the narrative below.

I: And what does that mean, to not be able to stay here? For you?

R: It hurt. It makes me upset because I want to complete the program. But I don't want to complete this program if I'm gonna be in pain and have to be angry at everybody. 'Cause that make attitudes flare. When the next individual is trying to get his life together...And I'm trying to get mine together. I don't want to be flaring up at him, for stuff he probably didn't even do. You know?

I: Do you feel that that's happened to you in the past?

R: I did that. I did that. I left, I left because of a lot of situation that was going on, like when my foot was hurting. I left 'cause they telling me, OK, you gotta go to meetings, you got to go, you got to get up and go do this, go do that. Hold on. You telling me - you don't want me going to the doctor on a regular, but you want me to get up and go do this and that. You know? I'm cool. I'm cool. So you don't have to worry about me doing that. I'm gonna pack my bags, and I'm gonna leave. And I did. (P 8: Paul IV#2 8:24 129:152)

Similar to what occurred in 2002 after his arthroscopy, Paul felt his health care concerns were thwarted by the SAT program's unreasonable demands. Paul wanted to complete the program but believed his efforts would be hampered by inadequately managed post-surgical pain. Such discomfort would not only impact his participation but his relationships with other residents. More saliently, Paul felt that the staff's inability to accommodate his medical needs impeded his involvement in and completion of the program. This was Paul's perception of what occurred after his most recent foot surgery. He was frustrated by the demands the staff placed upon him. In Paul's mind, program staff were insensitive to his joint and foot pain and did not understand the importance of Paul's continued medical care. He could not tolerate the inflexible and unyielding nature of both the program's staff and regulations and he left. However, Paul was allowed to return to the program as a result of the SAT program coordinator's largesse and understanding.

She (the program coordinator) called me and told me, "Paul, come back"...So I said, "OK, I'm gonna come back here because of the respect that I got for you. But if you have these individuals working here that's not certified to do these positions, jobs they're in, they shouldn't be in here if they don't have - if they don't have the communication skills that they need to deal with individuals."
(P 8: Paul IV#2 8:24 129:152)

In his interactions with either the SAT program or the health care system, Paul did not recognize how his own unyielding nature influenced his circumstances. His limited coping skills affected his ability to be successful in his reintegration efforts, e.g. completing substance abuse treatment. In regards to the total knee replacement, Paul was presented with a reasonable and efficacious option to improve both his health and his

circumstances. Nevertheless, in his mind, such a procedure seemed doomed to fail leaving him worse off than he already was.

Given Paul's most recent encounters with clinical services, his concerns were understandable although somewhat disproportionate to the situation at hand. Paul had had prior surgical and rehabilitative success at the county hospital, in addition to a regular staff physician, who, as he related in another narrative, he trusted and respected. Therefore, Paul's chances to do well during the knee replacement and subsequent therapy were high. It may have also been possible for the SAT program coordinator to make some allowances for both Paul's pain management and recuperation, in light of her previous concern for him. However, Paul seemed unable to consider such possibilities as viable options. Paul's situation was limited less by institutional or administrative obstacles than by his own pattern of response to both the concept of change and the idea that he might be unsuccessful at it. Paul was ill prepared, emotionally and intellectually, for the changes that a new and well-functioning knee or full participation in substance abuse treatment would incur. Paul's dismissive attitude towards potentially helpful solutions restricted his opportunities for success but also served to shield him from failure.

Conclusion. This group of participants' dismissive pattern of engagement made it difficult for them to have their health problems resolved in a timely and meaningful way. They continued to feel poorly and this hindered their reintegration efforts. These participants were often unable to work and were challenged in meeting in their parole requirements, e.g. remaining in substance abuse treatment. The health care and substance abuse treatment systems were most likely unaware of participants' ingrained disinclination to engage in care and possibly perceived participants' as being intractable,

drug seeking or manipulative. Therefore, communication between participants and systems of care was delimited when it most needed to remain open.

However, participants were not ready for extensive intervention. The idea of any sort of change, even a positive health outcome, was overwhelming; participants did not have the skills to cope with such alterations in their situations. Their personal agency was restrained by an inability both to take responsibility for themselves and to place trust in other individuals and systems – things necessary for life in civil society. Therefore, participants remained rooted in their present circumstances and restricted by their pattern of engagement with the health care system; their preemptory dismissal of clinical care limited opportunities for both improved well-being and successful reintegration as well.

*Engagement with Street Life Overrides Health Concerns
and Reintegration Efforts in General*

The majority of participants prioritized their street life and addiction disorders over their health problems. While participants utilized health care services to address specific concerns and circumstances, clinical care was largely perceived as irrelevant or unnecessary within the context of street life. Participants also found themselves in impoverished circumstances upon leaving prison and criminal activity was an easy way to support themselves. Additionally, participants' personal drug habits were one of their primary coping strategies. Their addiction disorders offered relaxation and comfort from the demands of their street lives. Therefore, participants were ambivalent about abandoning their addictions altogether, particularly when they had few other resources or skills with which to manage the stress of their lives. Participants were caught between the unfamiliar demands of the free world and the rhythm and routine of their criminal lives. While they desired to be successful in their reintegration efforts, the rigors of life in civil

society frequently left participants feeling incompetent and inadequate; this made a return to criminal and correctional life, worlds in which they functioned with skill and acumen all the more appealing. Furthermore, most participants began their involvement in street life as children. This long-term engagement with the culture and practices of criminal life increased participants' difficulty in coping with the changes required for a legal life in the free world. Robert most paradigmatically represented both the impact of street life on participants' health and their habitual, but unwanted engagement in criminal life.

Robert. Robert, a 40-year old African-American, was first incarcerated in the state prison system at the age of 21. He was discharged from parole supervision once before in 2005 only to be arrested and convicted for a new crime one month later. At the time of the interviews, Robert had been in the free community for one month with three years of parole to complete. Although Robert was diagnosed with a seizure disorder, his primary problem was his cocaine addiction and his continued engagement in a criminal lifestyle. Robert had been involved in criminal activity since the age of 11 when he started his career as a street-corner lookout for a neighborhood gang. Robert was initially drawn to gang activity as a way to improve the financial means of his family; he was successful in this. As the youngest of three children, Robert was proud of his contributions to the stability of his family. In the narrative below, Robert described how his nascent criminal activity routinely supported his family's subsistence.

R: And, you know, so we was doing real bad for a minute, financially. And I used to go like to Lucky's grocery store and stand out front and carry people's groceries to the car, and they gave me 50 cent or a dollar or whatever till I get enough money, and I buy some hamburger meat and bread for me and my sister and brother to eat. And I was the youngest... That went on for a long time. And, and I guess, I don't know, crime escalated, you know what I mean? The carrying grocery bags stopped being enough money. And I had the opportunity to work in a organization, so I used to stand on the corner, and when a police would come

down the street, I'd holler down the block so they would know the police were coming so they could - the guys that were holding drugs could hide out. And that was - and it kinda gave, made me feel - it gave, made me like kinda like a hero in the family, so to speak...I could, you know, make sure we eat. And I actually helped my mom at one time get the PG&E back on, because our PG&E had got cut off and we [had] a extension cord going from another guy, to our neighbor's house. You know what I mean? So the neighborhood I grew up in till I was like 12, we moved from there to another neighborhood, to another neighborhood, another neighborhood. So for a while we was like, you know, just like misplaced a lot. (P 9: Robert IV#1 9:4 89:110)

Robert was pleased with his competency in managing adult responsibilities as a child. As the primary supporter of his family, Robert achieved some success that he has been unable to duplicate as an adult. Despite his sense of accomplishment in caring for his family, Robert was unsettled by the mercurial nature of his family's circumstances. The structure of gang life provided a sense of stability not otherwise available to him. The gang became his community and thereby, ensured his continued involvement in criminal activity. Several years after his introduction to criminal life, Robert began using drugs as well. It was within this context of his street and drug lifestyle, that Robert was diagnosed with a seizure disorder. In the following narrative, Robert discussed his first seizure at the age of 17.

I: can you tell me something about your seizure disorders? What happened?

R: The first one I had one I think I was like maybe 17...I remember it started right around when I started using crack. And I was - at the time I was staying at motels. And I was going over to my mom's house periodically, right? And I was over there for like a coupla days. And she was in the kitchen, I was in the living room, and I just had a seizure. I was told. I didn't really know. You know, and I woke up and the ambulance came and they took me to the hospital. But at that time my mom let them know I was using drugs, and they gave me - the first time they gave me some Phenobarbital. Right? And after that I went back like, I think it was the next day. Went back the next day and did some tests. And they attributed it to drugs, but they said it was some epileptic, epileptic seizure...That's why they're giving me Dylantin...And after taking it for like, I don't know, maybe four or five days, I started getting real light-

headed...just feeling real weird. So I went back to the doctor, and they brought it down to 200. And I have been on 200 ever since...I think it was like every two months I'd go over there and get a Dylantin [level] something like that...And from there, that's when I started running the streets again. I stopped taking my medicine. And it been like that ever since [laughs]. I get into - when I get into using drugs, I don't take my medicine. (P10: Robert IV#2 10:1 15:42)

At the time of his diagnosis, Robert was living between motel rooms and his mother's house. Although it was not clear if Robert was high at the exact time of the seizure, he recently had begun smoking crack-cocaine. Upon witnessing what she perceived as an epileptic attack, Robert's mother called emergency services. While at the hospital his mother informed medical staff that Robert was also actively using cocaine. The hospital staff informed Robert that his seizure was related to his drug use. They prescribed medication and encouraged Robert to return to the hospital clinic for follow-up care. However, Robert quickly abandoned regular contact with the health care system, he stopped taking his medication and reengaged with both his drug habit and criminal activity. Although his decision to stop his medicines was predominantly dictated by his street lifestyle, the realization that he remained seizure-free when using drugs influenced Robert's sense that his treatment was most likely unnecessary. In the following narrative, Robert articulated the infrequency of his seizures since his diagnosis.

R:...But it's the - the funny thing is when I'm using, I haven't had a seizure, when I was using.

I: So all your seizures have been . . .

R: When I stopped using...And it's like, I don't know, maybe it's detoxing or something like that, but I don't know what it is, it stop. But the next time I had one it was in city jail. And they were transporting me from the holding cell to the lockdown, and I had a seizure, so they took me immediately to the county hospital, and they had a doctor tell me I had a seizure disorder. And I hadn't had one for like a few years...I started having them again...And so they put me back on the Dylantin, the 200

milligrams...And I hadn't had a whole lotta seizures. But due to the fact that I have a history, whenever I go to jail, they immediately give me Dylantin. (P10: Robert IV#2 10:1 15:42)

It was some time before Robert experienced another epileptic episode. The seizure was surprising to Robert because he had received neither medical care nor medication for his disorder in a long while. The medication prescribed by the hospital became Robert's standard treatment regimen and the correctional system became the primary place where he received any care for his seizures at all. Over the course of the next two decades, Robert would remain unconcerned about his seizure diagnosis. The intermittency with which his seizures occurred rarely interrupted Robert's street life and when his condition was at risk of exacerbation, i.e. during periods of incarceration, he was able to control it with the medication immediately prescribed upon reentry to the correctional facility. Robert articulated his motivation for taking his medications during periods of incarceration in the narrative below.

I: And are you taking Dylantin right now?

R: ...I had a bottle when I got here (the SAT program), and I threw it away.

I: And why did you throw it away?

R: 'Cause I don't ever take it when I'm on the street...it makes me light-headed. And when I be in jail, since I had a few seizures in there, I, I take it...But I don't want to get up in that situation [laughs]. But I don't, I don't know what's wrong with me, but I don't really like taking it. I don't like taking pills. That might sound funny, 'cause I use drugs, often. But I don't like taking Aspirin and Tylenols and all that - I don't like taking pills... [but] In jail...Because there's so much steel and all that around there, and I had a - one time I had one and I hit my arm real bad. And then that was worse than the seizure.

I: ...So do you feel vulnerable. . .

R: Yeah, when I'm there. I really do. So - under these circumstances (in the free community) it seems like it's more of a hindrance. I don't know why. I don't know, maybe I'm crazy. But it's - I don't be like - 'cause I don't really feel like I need no pills or something. I don't feel like that. (P10: Robert IV#2 10:2 83:94)

Robert discontinued his seizure medications upon returning to his home community. In the free world, Robert's seizure medication seemed irrelevant and the side effects bothered him. Additionally, taking oral medications troubled Robert in general. He knew this belief was nonsensical particularly when he regularly partook in illicit drugs with more deleterious effects than over-the-counter pain medication. However, while incarcerated Robert was willing to tolerate the side effects of the medication to ensure his safety and security. In the setting of the correctional facility, Robert believed he was at greatest risk of an epileptic event. Therefore, restarting his medication while in prison was relevant and appropriate to him. In contrast, taking medication for the few seizures he experienced in the community seemed unnecessary and burdensome to Robert. The pace and style of his street life could not accommodate the commitment a daily medication required. Furthermore, Robert's addiction disorder and criminal life delimited his interactions with the health care system. In the following narrative, Robert articulated his decision to not pursue care after his most recent seizure in 2005.

R: The last seizure I had, I don't know, it was a couple years ago, I think. Maybe a year. This is 2007, so it was like maybe 2005.

I: And what were the circumstances around that?

R: Yeah, we had been up for a couple days. And uh. I hadn't used like a day and a half. And I was on the bed and I didn't even know that I had a seizure, she (his girlfriend) was like, "You had a seizure." ...I had bit my tongue. She was like, "You want me to call a ambulance." I was like, "No, that's all right." [Laughs] I said, "No, it's cool now. It's over with." So.

I: And is that the main reason why you didn't want to have the ambulance come?

R: Yes, 'cause it was over with. You know? Plus I was under the influence, too. I'm on parole. So it's kind of I never had too many seizures before, but...to go to the hospital, and you're under the influence of drugs and they can contact the police or something [laughs]. (P10: Robert IV#2 10:1 15:42)

Robert believed his most recent seizure was over two years ago. However, he most likely had had other epileptic events that went noticed by him due to his excessive

use of crack cocaine. During the seizure he described above, Robert was not actually high but it had happened during a period of heavy drug use. Robert was unaware that the seizure occurred but his girlfriend witnessed the episode and suggested calling emergency services. Robert refused. In his mind, the seizure itself passed without incident and he was unconcerned about having another one in the immediate future. More importantly, seeking medical care at the county hospital might have placed him at risk for rearrest and reincarceration – things he did not want. Therefore, Robert prioritized his drug addiction and criminal lifestyle above any concerns he had about his health.

Robert's street life and addiction disorder had been his priority for the past twenty years. In addition to delimiting his interactions with the health care system, Robert's criminal history also impeded any long-term stability he might have achieved despite his impoverished background and upbringing. As he entered middle age, Robert acknowledged that the life he lived thus far had outlasted its utility. He recognized the need to change his behaviors in order to create different, more positive opportunities for himself but Robert's criminality restricted his capacity to make and maintain the requisite adjustments necessary for a stable and legal life in civil society. In the following narrative, Robert discussed his growing fatigue with his drug addiction and articulated the hold street life had on his ability to improve his circumstances in any meaningful way.

R: You know, like I said, crack is the only drug I ever used. I don't drink or nothing. If it wasn't for the - if it wasn't for crack, I wouldn't use anything.

I: So what is it about crack?

R: I don't know. [laughs] I hate that shit. 'Cause I lose control, and I don't even be - I don't even enjoy myself when I'm using it. It's just that once I use it, it's like I like the way it feel. Right? The initial feeling. But after that, it really makes me feel bad...I think I'm crazy. To be honest with you, really it's insane.

I: And you think you're crazy because?

R: Because [laughs]...I don't really like it. After I do it, I said, you know, it's stupid, and it takes me away from everything, I be having things going OK. My auntie said I wait till everything going OK to start fucking up...

I: And why do you think that is?

R: I don't know. Fear of success...But honestly I don't know...'Cause it's like, like that struggle, I just start to heal, and then once I get to that point where it might level off where it might just be all downhill from there...I just do some stupid stuff. I think a lot of it's got to do with my self-esteem. You know, my self-image. I really think it has to do with that. So - that's the only thing I can really attribute it to... (P10: Robert IV#2 10:10 194:212)

Despite Robert's growing disinterest in his addiction disorder, he was unable to forsake it completely. His habit still served a purpose in his life by providing pleasure and comfort, however momentary. Nevertheless, the beneficial effects of Robert's addiction quickly dissipated and he was left feeling dejected. Robert had had brief periods of sobriety and stability but these instances were consistently interrupted by his reengagement with drugs. Therefore, anything that he may have gained as a result of his abstinence was very quickly lost and he returned to the chaos and instability of his street life. Robert was stymied by his inability to alter his habitual patterns. He attributed his failure to desist from drugs, and therein crime, to his poor self-image. While there was truth in this, Robert recognized that the pervasive quality of his criminal behavior strongly influenced his capacity to make positive changes in his life as well. He further articulated the impact of his criminality and drug addiction on his life in the following narrative.

I: is it the drugs for you or is it the life?

R: It's been the life, more than anything, because I go back to the life and then after a while all the pressures...Ups and down. The pressures of the criminal lifestyle. I gotta put it like that. Is big, 'cause your life is at stake out there on the streets. And you try to do one thing, and stuff don't work out. It's just like with any other businessman. When you're trying to build your business up and it's stuff falling apart, but you have these responsibilities on the side. It's pressure. And in the past I do some drugs, and it takes pressure off me 'cause I don't care now, but...when you're getting high on drugs, [you] hallucinate...I'm steady

smoking up all my money, but I'm telling myself I'm fitting to stack it... You know what I'm saying? That's just a little example. But the bottom line has always been the lifestyle that took me back... I like nice things. So you have to have a job, even though I want just, to be honest with you, the basic things in life is something I just don't have. And it gets real depressing sometime. You don't have a place to stay. Transportation. Money just to make it on a daily basis. You feel me? ... And it gets depressing. But I have to realize where I'm at. And how I got here... every time I go sell drugs, I do anything, hustling in the streets, I might get a car and get my little apartment or whatever, I wind up using. So I go back to prison, and I start using drugs again... It just don't work. It just don't work. It just don't work... I really have come to the conclusion I don't wanna be a big drug dealer. I don't wanna be no pimp. I don't want to be in the streets. I came to that conclusion. I don't wanna live like that.

I: what brought you to that conclusion?

R: Just all the fucking things that happened to me in my life. I been shot. Stabbed. A lotta things happened to me... And I realize that, in order for me to be successful in my (drug dealing) life, there's a lotta things that I gotta do to a lotta people... including myself. And I'm not willing to do all that. You know, I'm not. I'm really not. I'd rather just go to work every day... I mean it might be sad, you know, that it took me this long to realize all that, but it's OK. [Laughs] I realize it. (P 9:Robert IV#1 9:12 399:414)

Robert compared the demands of criminal activity to the demands of any other business. However, unlike legal businesses, the illegal drug trade was inherently violent and potentially life threatening. The violence and overt aggression required of a successful drug dealer made Robert's day-to-day interactions with others intensely stressful and frightening. Therefore, drugs provided a welcome respite from the ferocity of street life. Drugs also offered an escape from the reality that he was not doing well at all, either as a drug dealer or a member of civil society. Despite his best efforts, Robert was neither increasing his financial stability nor moving beyond the confines of his life as criminal and drug addict. Drugs helped Robert forget these failures and possibly protected him from the notion that his past patterns of behavior were likely to continue into the future.

While Robert acknowledged futility of his criminal life, he repeatedly returned to it. Crime was his primary source of income and without it Robert faced impoverished circumstances, which were difficult for him to tolerate. His poverty dispirited him and further decreased his personal esteem and sense of self. It was during these periods of destitution that the idea of renewing his illegal activity was most salient. Robert was well versed in the requisite duties of a drug dealer; he knew what to do and, despite the pressures, could perform such duties relatively well. Robert had experience and competence as a drug dealer, unlike legal employment for which he had very little.

Robert was aware that continued participation in both, drug dealing and drug using would ultimately result in reincarceration – another thing he hoped to avoid. However, criminal involvement, drug addiction and reincarceration had been the pattern of his life for more than two decades. While he acknowledged his increasing difficulty with persisting in such a pattern, he was at a loss as to how to begin to change it. Even when Robert had gained a modicum of stability for himself he continued to reengage with his street and drug life, which, in essence, was the life he knew best. Therefore, while Robert was interested in the idea of leaving his street and prison life behind to create a new situation for himself, the reality that he would be able to achieve such a situation was much less certain.

Further Exemplars: Mark, Frank, and Matthew. The experiences of Mark, Frank and Matthew further articulated the impact that drug addiction and criminality had on participants' health and reintegration efforts in general. Mark, a 62-year old Puerto Rican-American, seemed unable to escape to influence of drugs on his time in the free community.

I: So how did you come to move around so much in your life? Was it because of your drug dealing?

R: Yeah. Because I was trying to escape. Not only from the drugs, but maybe from myself. And no matter where I went, the problems were still there. Because one thing about a drug addict is, I don't know about other people, but I can say about myself. I don't care where I go. If I'm looking for drugs, I'll find them. It's like a hound dog, you know? I mean you can just – I went up to Seattle, thinking that it was OK up there. And the same day I got there, I meet the guy selling the drugs. I'm trying to get away from that, the first guy I meet is a guy selling drugs. Do I have a sign on my tail, something that says that I'm a drug addict, you know? (P4: Mark IV#2)

Mark had been involved in both using and selling drugs since his early teens.

Drugs were a way he supported himself financially but, as he described in other narratives, drugs also served as his primary means of coping with the isolation and alienation he experienced while in the free community. Throughout his life Mark struggled with depression and feelings of worthlessness that began as a child. Abusive and neglectful parents dominated Mark's home life and much of his surrounding community was subsumed by drug use, crime and poverty. Mark ran away from home at 13 years of age and proceeded to drift from state to state for many years. Mark was unhappy in his life and believed that relocating himself might change his circumstances or at the very least, restrict his access to drugs. However, this was not the case and Mark repeatedly found himself in neighborhoods where there was easy access to drugs and where he was immediately identified as a drug addict. Even in a new city, Mark could never be anonymous. His difficulty in escaping both his drug life and himself also lay in the fact that while he was in a different city he returned to what was most familiar – those neighborhoods and communities where drugs were readily accessible. Furthermore, Mark was poor and establishing himself in a more upscale or less impoverished community would have been challenging for him. Therefore, he was never able to extricate himself

from street life or elude his personal sense of worthlessness; drugs continued to be the predominant way he managed his depression. In the following narrative, Mark discussed how he frequently did not take prescribed antidepressant medication despite his acknowledgement that such medication helped him.

I: So do you feel that the pills are helpful to you?

R: Oh, yeah.

I: So why sometimes do you not take them then?

R: Because I try to experiment with myself...I try to see how I act when I don't take them.

I: And what happens then?

R: I get very edgy, very - I don't know, you say conscious of things...I keep to myself more. Basically, I'm a loner...There's people that can't do drugs alone but I'm one of those guys that like, loves shooting dope alone. I don't need partners and all of this. And so I don't take medication. I love it because I go into my shell...But at the same time, I know that it's not right. I know that it's something wrong...It's a wicked place. I start having a lot of wicked visions. Right away I start thinking about suicide...And I begin to think like do I have enough money to buy enough drugs to overdose...I don't know how many overdoses I've caught in my lifetime, but I've caught a few. And, like I said, I must be a cat with nine lives, because I wind up in the hospital...They, doing that stuff they do and get me out of Narcon or whatever...That's not cool at all...[I feel] like I went to hell and came back...

I: ...do you want to come back?

R: Oh, yeah. Yeah, yeah. You fight it...you don't want to die...But you sometimes welcome this...(P4: Mark IV#1 698)

On the streets, Mark irregularly took his medication although he knew he needed it and acknowledged it helped him. However, Mark would frequently forego his antidepressants in favor of his drug habit. Drugs allowed Mark to descend more deeply into his isolation and social withdrawal. He prided himself on being able to partake in heroin alone, something other addicts were unable to do. Mark knew that his alienated stance and his obsession with the depths of his addiction was abnormal, unhealthy and often life threatening. While a successful overdose would have provided a permanent escape from himself and his addiction disorder, Mark experienced a feelings of relief

upon being rescued. Mark had little interest in living but he did not want to die either.

Therefore, as long as his addiction continued to transport him to a state of oblivion without actually killing him, Mark could cope with his mental illness with little consistent intervention from the health care system.

Matthew's health was less affected by his criminal life than were his economic circumstances. In the following narrative, he articulated the financial demands of free world living and the immediate access to funds that selling drugs provided.

E: what's your cycle of street life like?

R: It's really about selling dope...to accommodate some responsibility towards furnishing things with my kids, I took a little money invested it in some dope, and it became good because it became lucrative. And actually I'm paying rent here, helping out here with my kids, and I went to spend a weekend with them and their mother...and started selling some of the dope in her (his children's mother) neighborhood, which I wasn't familiar with. And sold to two undercover cops. And, you know, it was like actually, I started using too. And it was like that's the big trade secret with me. If I use dope...And anyone I deal with can detect if I'm getting high on crack. Everything about me changes, and I kept it a secret from her, but that's what I was doing. I actually I gave my parole officer a dirty, and he was looking for me...And...he caught up with me and I got that in-custody drug treatment program. And I was waiting for the van to go there. Actually they took me back to court and gave me two more sales cases. So, I just, I took a deal for two years. On parole already so it's a violator with a new beef. I did 14 months off of it, and that changed me. That was the changing point...The most time I ever did was three flat years and they were talking about 12 years now (due to prior convictions for which he never served time). Different ballgame. So it changed my train of thought on what I need to do for myself...

E: do you think you would have been doing this same pattern if you hadn't had this arrest and conviction?

S: Actually the last six years have been this pattern. It's token me up to this point to get popped in the head to say look, when are you gonna stop. One thing, I'm not really getting very rich off this, you know? I'm actually just being able to keep myself clothed...I ain't never had no house on the hill. I ain't had the fanciest cars, and it was no, it's like it's no meaning to my actions. There's no self-satisfaction to it because it's like I just go from just like saying from paycheck to paycheck, or from sack to sack. So it's like I'm really not profiting, or there's no real financial gain. And I say it's just a certain lifestyle you become adapted to that you glorize. You feel like you're really doing something but you know, you're really setting yourself up. And that's what I did. I've set myself up to the point where I'm looking at 12 years. (P25: Matthew IV#1 25:10 288:310)

For a time, Matthew was successful in his drug dealing. He was able to support the needs of his family and afford rent for an apartment of his own. During a week-end visit with his children and their mother, he made the mistake of selling drugs to undercover police officers and was immediately rearrested. Although Matthew was selling in an unfamiliar neighborhood, his judgment was most likely clouded by his own drug use. Matthew attempted to keep his drug use a secret but he knew this was impossible, as he could not hide his addiction from those around him. After his rearrest, Matthew believed he would attend an in-custody drug treatment program and was shocked to learn that he faced twelve years in prison.

Although he ultimately was sentenced to two years, the reality of a lengthy prison term forced Matthew to more honestly examine the implications of his life as a drug dealer. Matthew realized he had subscribed to the idea of the drug life as a glamorous and glorified lifestyle when this was not the case at all. He had neither increased the financial security of his family nor participated meaningfully in any aspect of his children's life. The success he experienced as drug dealer was meager and never enabled him to move beyond the confines of a street lifestyle. Matthew felt restrained by his role as a drug dealer and saw it leading nowhere other than more prison time. The threat of a twelve-year sentence frightened Matthew. He doubted whether he could survive such a period of institutionalization. Therefore, upon his most recent reentry into the community, Matthew was motivated to desist from criminal activity and find legal employment as a means to both improve his financial situation and avoid future reincarcerations.

Frank, a 43-year old man with bipolar disorder, also discussed the importance of drug dealing in improving his financial situation and in maintaining the stability of his family.

R: ...I went to cooking school for a while...[but] I got caught holding (keeping drugs for a drug dealer)...I was holding for this heroin dealer...he made me a deal because when I went back to school, I had to stop doing crank and shit because I'm trying to get my[self together]...Well, she's (Frank's wife) doing a lot of dope, and...I don't want her out scamming (shoplifting) stores and...we had our son. So I told this dealer...I would hold for him and he would give her a couple grams, two or three grams a day to support her habit. He'd come with these things, and there'd be like 50, 60 balloons (bags of heroin) in there at 20 dollars a pop, that's a lot—I'd come out on my break and I'd hand him (some of the balloons), you know—And it lasted for about six or seven months and then somebody dropped a dime. They call me in the office one day, and they went through my locker and he (the school administrator) didn't call the cops, so. He says, "You know, you've been a good student and everything," he said, "I can't have this in my school." I went, I snatched it (the rest of the drugs) too because man, that was like, five, six hundred (dollars); I didn't have the money...I went back to dealing dope. (P23: Frank IV#1)

Frank had been doing well in his home community for a time. He was attending cooking school and had desisted from methamphetamine use. However, his wife had a significant heroin addiction and Frank worried that she would be arrested for shoplifting leaving no one to care for their son while Frank was at school. Frank arranged with a local heroin dealer to store drugs in his school locker if the dealer would supply his wife with enough heroin to sustain her habit. Unfortunately, the school administrator discovered what was Frank was doing and he was asked to leave. Frank's efforts towards developing new professional skills were derailed by his involvement in criminal activity. However, Frank felt he had no other option, as his wife was the only adult available to watch his son while he attended classes. His engagement in street life was necessary were he to successfully complete the training program and have access to legal employment. However, his illegal activity ultimately became a liability that threatened his longer-term

reintegration into the free community. After his dismissal from cooking school, Frank returned to drug dealing full-time, as it was his only means of income.

Conclusion. These participants' general circumstances, in addition to their health concerns, were dominated by their criminal lives. Their street lives informed how they engaged with the world and what possibilities for positive change were available to them. Participants were further restricted by their criminality in that it was their primary source of income. As much as they had grown weary of their lives as drug dealers and addicts, criminal activity was how they subsisted and drug use was how they managed the stress of their criminal behavior. While participants desired increased stability and an improvement in their circumstances, their capacity to overcome the lives they had led thus far seemed insurmountable. Within the context of participants' street and prison lives, opportunities for adopting new, more effective ways of coping with the requirements of parole or with the demands of reintegration were limited. Therefore, participants were resigned to repeat the familiar pattern of criminality, drug use and incarceration for an unknown and extended period of time.

Chapter Conclusion

The predominant patterns of engagement with the health care system evident in this research were: 1) ambivalent engagement with an inconsistent and unreliable health care system; 2) dismissive engagement with the health care system; and 3) engagement with street life overrode health concerns and reintegration efforts in general. The first pattern was a group of participants who perceived the health care system to be inconsistent and unreliable but continued to access medical care. They did so because their health problems directly impacted their reintegration efforts. These participants

looked to health care to improve their health conditions but the ineffectual quality of the care they received left them feeling disappointed and frustrated. As a result, participants lost interest in pursuing further care and often abandoned clinical services altogether. Additionally, participants found they could manage their health conditions through their addiction disorders although their drug habits ultimately became health problems they wanted resolved as well.

Participants' unresolved health concerns left them feeling uncertain about what would happen to them. They were also ambivalent about their own capacity to overcome both their health conditions and their seemingly intractable addictions even with appropriate and supportive care. These participants were conflicted. They believed that proper medical care would improve both their health problems and their reintegration efforts. However, their diminished sense of self worth hampered their ability to advocate for their health care needs and persevere in their interactions with the health care system. Additionally, the substandard care they had received in the past left them questioning whether proper medical care was available to them at all. Their assignment to the safety net or uninsured system of care further exacerbated their doubts about receiving appropriate medical treatment. The health care system was most likely unaware of how disempowered these participants were and not attuned to participants' interest in their own health problems. Therefore, health care, as a system and as individual clinicians, missed opportunities to support and encourage these participants in their efforts to improve both their health and their circumstances in general.

The second pattern observed was participants who dismissed assistance although it was relevant and available. This subgroup of participants immediately discounted the

health care system as helpful even when they had previously experienced some benefit from clinical care. Their dismissal of medical services was in response to an ingrained distrust of all systems of power rather than the medical care itself. The recalcitrance with which these participants approached clinical and supportive services may have given clinicians and service providers the impression that they were difficult or non-compliant patients. However, their reluctance to engage more fully with the health care system was grounded in intrapersonal fragility and limited interior resources with which to cope with change, even when it was beneficial. Participants frequently could not articulate what sort of assistance they needed; they wanted help but not the help that was offered to them. This further frustrated their efforts in accessing meaningful support. As a result of their narrow range of coping and communication skills, their access to relevant care was limited. Despite their expressed dissatisfaction with their unresolved physical problems, participants' dismissal of the care offered to them also ensured that their circumstances would never be beyond their control and they would remain safely ensconced in their familiar and habitual ways of being.

The third pattern, which was most pronounced, was a group of participants' whose drug addictions and street lifestyles influenced their ability to access and receive appropriate treatment for their health problems. Participants' concerns about their health conditions were minimized by their addiction disorders. Their ailments and disabilities became salient only when they impacted participants' street and prison lives. For the most part, participants managed their problems around their criminal lifestyles. However, as their general health as well as their specific medical conditions worsened, their interest in desisting from illegal activity and drug use increased. Despite their interest in

improving their circumstances, participants found their prolonged entanglement in criminal life limited both the opportunities available to them and their capacity to cope effectively with opportunity should it arise.

This third group of participants had difficulty finding employment and most available work was irregular and paid poorly. However, participants were also unable to tolerate the impoverished circumstances under which they had to live in the process of moving from an illegal life to a legal one. The acceptance of their poverty was particularly challenging because illicit activity, an easy remedy to their poverty, was always accessible. While continued involvement in criminal activity was undesirable, participants frequently committed crimes in response to their destitution. Their inability to cope with hardship in any other way than through illegal behavior placed them at increased risk for rearrest and reincarceration, therein thwarting their efforts towards successful reintegration. Additionally, when participants established a modicum of stability, they seemed unable to maintain it. Their addiction disorders and criminal lives, both familiar ways of being in the world, overwhelmed their interest in and commitment to living a legal life in civil society. As a result, participants dismantled what they had established for themselves and reinitiated well-known patterns of addiction, criminality and incarceration once again.

In each of these patterns of engagement with the health care system, participants wanted some improvement in their circumstances. Participants had grown tired of their addictions and found their criminal lifestyles no longer served a purpose either for economic stability or as a sense of community. However, participants were bound by their past experiences as criminals and drug addicts and by their long-term involvement

in the correctional system. They had had little experience with living in civil society. Their current coping skills and practices were insufficient to meet the requirements of legal life and developing new ways of coping seemed arduous. Furthermore, as middle-aged men they could no longer physically keep pace with the action and violence of street life. Participants were conscious of their lives passing them by and the increasingly limited opportunities for success in the free world.

There was a sense of urgency in their current situations as for so long their health had been a secondary consideration. Their bodies had functioned well and they relied on them to do what they needed to do whether it was dealing drugs on the streets or withstanding a prison sentence. However, with the deterioration of their health, they no longer performed well in either their criminal lives or in the legal jobs available to them and they had no other professional skills on which to rely. Maintaining what little health they had was critical to their self-sufficiency and they found themselves dependent upon the health care system; a system that, in participants' experiences, provided substandard care and seemed incapable of understanding their personal dilemmas and circumstances. Nevertheless, they had few other resources available to them. Participants were in a tenuous position; they could not cope with the physical demands of street life but they also did not have the necessary skills and resources to create new lives for themselves. Participants depended upon the health care system as one of the few mechanisms available to resolve their problems. However, the health care system was frequently unable to address the multiple and complex demands of participants' lives and they often found themselves slipping back into their habitual patterns of drug and street life.

CHAPTER 7: IMPLICATIONS FOR CLINICAL CARE, POLICYMAKING AND FUTURE RESEARCH

Introduction

The purpose of this research was to understand the impact of health care access on community reintegration from the perspective of the parolee. The specific aims addressed in this dissertation were: 1) to examine the participants' health care practices and beliefs; 2) identify perceived barriers and facilitators to health care access; and 3) explicate participants' perceptions of the impact of health care access on their reintegration efforts. Through hermeneutic analysis, participants' shared patterns of coping with the health care system and of managing their health problems were revealed. The analysis found that participants' incarceration histories influenced their capacity to successfully interact with the health care system and the free world in general. After multiple and long periods of incarceration, participants had difficulty in coping with life in civil society. In response to their frustration and alienation from society at-large, participants frequently returned to drug use and criminal activity with such behaviors resulting in another arrest and incarceration. There were also commonalities amongst participants in their perceptions of and responses to the barriers and facilitators they encountered in accessing health care. Participants were easily discouraged by the multiple barriers they encountered in their attempts to seek care. However, they responded positively to even the smallest facilitator, e.g. low-cost medication, and such facilitators encouraged participants' interest in participating in their own health care. Finally, this analysis uncovered the specific ways participants took care of their health and interacted with the community health care system. Participants predominantly coped with their ailments independent of the health

care system. Direct clinical services played a small role in resolving participants' health problems and they managed their disabilities on their own, with assistance from family and friends, or not at all. However, many participants had significant illnesses and disabilities and, over time, realized that they could no longer manage their problems without medical intervention. For these participants, accessing and receiving health care had become relevant in a new way and they believed it was critical to their continued self-sufficiency and reintegration efforts.

The results of this research are important because they add to the current literature on the relationship between health care and successful reintegration (Conklin, Lincoln, & Flanigan, 1998; Rich, Holmes, Salas, & Macalino, 2001; Sheu et al., 2002; Vigilante et al., 1999). However, these findings are also valuable because they provide new insights into the interaction between formerly incarcerated individuals and the community health care system. Within the health care and sociological literature, little is known about the experiences of middle-aged men on parole with chronic physical and mental health conditions either regarding their efforts at caring for their problems or the effect of their illnesses on establishing long-term stability in their home communities. Much of the current research has focused on the general housing, employment and substance abuse treatment needs of this population in relation to successful reintegration (Gossop, Trakada, Stewart, & Witton, 2005; Hull, Forrester, Brown, Jobe, & McCullen, 2000; Langan & Levin, 2002; Moos, Moos, & Andrassy, 1999; Travis, Solomon, & Waul, 2001). The influence of illness, health and medical treatment on reintegration is less well understood, particularly from the vantage point of the individual on parole. This study addressed these previously unexplored aspects of the reintegration experience within the

context of participants' correctional system experiences, their addiction practices, and their criminal lives. It illuminated health care practices, beliefs about the relevance of clinical services, and patterns of engagement with the health care system in a group of chronically ill middle-aged men on parole. It also provided evidence of health care's salience to reintegration efforts, as participants' poor health frequently affected their capacity to achieve essential components of reintegration such as employment and housing.

This chapter will discuss the study's findings within the context of relevant research as well as present implications for clinical care, policymaking and future research. The first section will review the relevant findings from this research. The influence of participants' correctional system experiences and addiction practices on their ability to achieve long-term stability in the free community and to effectively interact with the health care system will be discussed. The barriers to and facilitators of medical services on participants' health outcomes will be summarized. Finally, this first section will address the specific patterns of engagement with the health care system that impacted participants' beliefs about the efficacy of clinical services both regarding their health and reintegration efforts. The second section will speak specifically to the clinical, policy and research implications of this research. Implications for improved clinical care, more efficacious policy and further substantive research for this population will be presented.

Review of Relevant Findings

Necessary Adaptations. Participants responded to the demands of the correctional institution in two primary ways: 1) acquiescence and inaction and 2) aggression. These

patterns of coping, i.e. necessary adaptations, were developed in response to the violent and controlling nature of the prison facility. These adaptations served to ensure participants' safety and to make their period of incarceration as trouble-free as possible. As a result of learning new ways to manage within the correctional facility, participants' sense of personal agency and self-esteem were often eroded. They felt badly about whom they had become in order to survive within the institution whether they were passive bystanders or active creators of extreme violence. Furthermore, these adaptations, necessary and useful for prison life, were a liability in the free community and often directly 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-direction and 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 addiction practices 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. They were challenged in maintaining employment, receiving direction from others, or participating with those around them in a positive or prosocial way. Participants coped poorly in the free world in part because their primary ways of coping within the institution were not viable in civil society. Additionally, participants' were disheartened by their inability to function well in

society at-large and disappointed that they had developed such ineffectual and antisocial coping skills at all. Therefore, participants' lives in their home communities were restricted both by ineffective coping skills and decreased personal esteem and sense of self.

While the concept of necessary adaptations and the resultant negative emotional and psychological outcomes have been documented elsewhere in the literature (Goffman, 1961; Haney, 2003), this dissertation research provided further evidence that the skills and behaviors required for correctional life are ill suited to life in civil society. Goffman articulated the process of institutionalization as totalizing, i.e. the inmate, after a long period in the institution, became reliant upon the institution to tend to his basic needs and to provide his sense of self and personal identity. As a result of being transformed and shaped by the institution, the inmate lost his ability to function in civil society. Goffman's process of institutionalization did not reflect the experience of those individuals who were able to overcome their incarceration histories and live successfully 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. Haney also described the difficulties individuals encountered upon release from prison. Haney articulated social withdrawal and alienation, incorporation of exploitative norms of correctional culture, diminished sense of self worth, and institutional dependence as aspects of prisonization – a process of institutionalization specific to the correctional experience. 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.

Participants' ingrained ways of institutional coping also impacted their ability to form meaningful relationships with peers and professionals. Supportive relationships have been identified as an important component in reintegration (Braman, 2004; Cooke, 2005; Langford, Bowsher, Maloney, & Lillis, 1997; Travis et al., 2001). However, participants frequently found themselves estranged from family and friends. Their disaffection from those around them exacerbated feelings of anger and alienation. Participants were without community and no longer had the institutional structure to lend shape to their lives; their personal agency was limited and this made prison appear as reasonable alternative to life in the free world. In many instances, prison was the one place where participants had both community and personal success. Participants were locked in pattern of release and reincarceration that had continued for extended periods of time. While most participants had grown weary of it, they knew of no other way of being in the world.

Barriers and Facilitators to Care. Participants faced multiple barriers in their attempts to access clinical services. Such barriers included bureaucratic and procedural obstacles to care, ineffectual treatment from medical and administrative staff and excessively long wait times for care. Participants believed they were subject to such barriers because of their impoverished social standing. They felt stigmatized for being poor, having a substance use disorder (SUD), and being on parole. Their marginalized social status limited them to safety net hospitals and clinics. As a result of their uninsured status, participants were limited in their medical options for resolving their problems;

they believed that the clinical services they needed and deserved were beyond their grasp. 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.

Participants were frequently overwhelmed by the size and hectic nature of the public health system. Participants' interactions with clinicians and ancillary staff were difficult and unsatisfying. These encounters were often restricted by participants' limited personal agency and inadequate communication and organizational skills – things required for effective interactions with the health care system. In many instances, participants were unable to articulate their concerns or their expectations from the clinical encounter. Practitioners in the health care system did little to facilitate meaningful or efficacious clinical care and for the most part, seemed unaware of participants' difficulty in advocating for their health concerns. Participants were often frustrated by their interactions within the health care system. They were disaffected from the system and doubted the medical system's capacity to tend to their ailments and disabilities. For most participants, the possibility that they would receive any benefit from their clinical encounters for either their health problems or their reintegration efforts seemed remote. As a result, participants limited their engagement with the system, their physical and mental problems persisted, and the health care system, itself, missed opportunities to address specific issues related to their reintegration such as substance use disorders.

Despite their distrust in and disillusionment with the health care system, participants responded well to medical services provided in an efficient and compassionate manner. The primary facilitator of health care access was a clinician's caring professional demeanor. A caring professional demeanor was characterized as a

clinician who demonstrated concern for participants' circumstances, considered them to be equal partners in the relationship and provided relevant care. Through interactions with such clinicians, participants felt respected for their own humanity and individuality. Participants believed these clinicians understood the challenges they had encountered in the past and would continue to support them in the future. The relevant care participants received from these clinical encounters provided opportunities to feel well. For most participants, improvement either in their health or general circumstances was a new or unusual experience. The positive outcomes resulting from such encounters encouraged participants' interest in receiving more regular care. However, their pursuit of such services was frequently interrupted by rearrests and reincarcerations. Participants' involvement in their addiction disorders and criminal activity subsumed their interest in accessing further care even when it was satisfactory. Nevertheless, these interactions were important because participants experienced relevant and meaningful care, however briefly, and were provided with an opportunity to develop a supportive and trusting relationship with another person.

Patterns of Engagement with the Health Care System. There were three predominant patterns of engagement with the health care system: 1) ambivalent engagement with an inconsistent and unreliable health care system; 2) dismissive engagement with the health care system; and 3) engagement in street life overrode health concerns. In the first pattern, participants articulated feelings of ambivalence about their interactions with health care system. These participants' qualms about the health care system were grounded in the barriers and unsatisfying interactions they had encountered when accessing care in the past. In the second pattern of engagement, some participants

perceived the health care system as authoritarian and not to be trusted. These participants often discounted medical care even when it was provided in an appropriate and efficacious manner. They were also limited by a personal agency that it made it difficult for them to see the influence of their own behavior on their reintegration efforts. In the third pattern, participants felt that clinical care was irrelevant within the context of their street and prison lives. The attention and care a chronic illness required was incongruous with the rigors of a criminal lifestyle. Therefore, participants' health problems were commonly secondary concerns necessitating attention only in emergencies or when such problems affected participants' ability to function effectively on the streets or in the correctional facility.

Regardless of their doubts about the efficacy of the health care system, participants' continued to engage with clinical services. Participants' specific health problems had worsened to such a degree that they could no longer manage their ailments and illnesses independently. Their health conditions directly impacted their reintegration efforts in that they were unable to work and had difficulties in meeting the requirements of parole, e.g. regularly reporting to their parole officers. Furthermore, participants were older and could no longer keep pace with street life. For many, maintaining a criminal lifestyle had become exhausting and pointless. Participants realized they had achieved neither financial stability nor a legal work history as a result of their criminality. Their addiction disorders had become unmanageable and the correctional system was no longer a viable and stabilizing influence in their lives. Participants acknowledged that they had to alter the habituated nature of their lives were they to improve their situations. However, they had limited financial and intrapersonal resources with which to address

their multiple problems. In participants' minds, the health care system held some promise for the successful resolution of their health problems; feeling well physically and mentally could have possibly increased their chances for successful reintegration. Therefore, despite their reservations and previous shabby treatment, participants were still motivated to seek medical care.

Unfortunately, for many of the participants, the health care system did not acknowledge their interest in improving their specific medical conditions. Health care, as an institution and as individual clinicians, did not understand the impact of participants' ailments and disabilities on their reintegration efforts. Participants experienced the health care system as operating independently from the participants' themselves, as if they were irrelevant to the functioning of the system. Participants felt that the clinicians they encountered did not appreciate the urgency of their situations. With the deterioration of their health and their decreasing capacity to meet the demands of street and prison life, participants sensed that opportunities for successful reintegration were rapidly escaping them. They needed their mental and physical health not only for employment but to adapt to the unfamiliar habits and practices of life in the free world as well. However, medical staff seemed insensitive to the larger contexts of participants' lives and the influence of their street and prison lives on treatment adherence and continued follow-up care. Participants' connection to medical care was tenuous and easily fractured. In their minds, the health care system was unable to provide the level of service and support they required in their efforts to establish stability in their home communities. Therefore, participants approached their clinical encounters with ambivalence, reticence, and, in some instances, not at all.

Implications for Clinical Care, Policymaking, and Future Research

Implications for Clinical Care. Clinicians working with men on parole need to be sensitive to the multiple and complex needs of this population. Newly released individuals are frequently ill equipped to cope with overcrowded treatment sites so prevalent in the safety net system of care. After many years in prison, formerly incarcerated individuals often become accustomed to the controlled and regimented life of the institution. Their basic needs – housing, food and clothing – are met and, health care and employment are often provided as well. Individuals do not need to organize themselves or act as their own agents in any formal way and over time, they lose the capacity to do this upon reentry to the free community (Goffman, 1961; Haney, 2003; Irwin, 1970). Therefore, coping with an unwieldy and impersonal system such as a public hospital or clinic can be daunting. These individuals often feel overwhelmed and intimidated by the health care system. As a result, they are unable to advocate successfully for their needs and leave the health care encounter feeling dejected and stigmatized. Therefore, clinicians need to actively engage this population, and communicate concern and empathy, and some understanding of their adjustment demands.

Clinicians and ancillary staff can encourage male parolees' engagement with the health care system by demonstrating interest in their problems and taking their complaints seriously. The influence of compassionate care cannot be underestimated for this population. This study found that 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 and cared for in a meaningful and effective way. Therefore, the concept of a caring professional demeanor offers a model for clinicians to work more effectively with this population.

While such a finding may appear to be grounded in common sense, this study's analysis illuminated how frequently such a demeanor or clinical stance can be lost within the hectic pace of community clinics. Clinicians can demonstrate caring and concern in their interactions by merely listening to the individual patient. Clinicians' ability to listen and be empathic was identified as an essential component of a caring professional demeanor. In this study, empathic and non-judgmental responses allowed an opportunity for participants to begin to trust that they would be taken care of or, at the very least, not abused. Clinicians in the community can incorporate such empathic behaviors into their practices by taking a few minutes at the beginning of each encounter to hear what the individual has to say.

In addition to empathic listening, clinicians can demonstrate a caring professional demeanor for the individual patient through the actual provision of care. Medical intervention should be well explicated and effective. Clinicians should make patent their ability to address patients' problems in a timely way. Clinicians should also be prepared to explain several times the goals of treatment and anticipated time to resolution. Plans for follow-up care should be scheduled within an appropriate period of time. Whenever possible, clinicians should contact patients in between appointments. Intermittent phone contact can address patients' questions or problems with the plan of care. Such contact also demonstrates professional caring and concern, which can encourage continued engagement in care. Clinicians should also discuss with patients how medical treatment

may be impacted by their substance use and ask if the suggested treatment seems realistic within context of their lifestyles. Within these discussions, clinicians need to emphasize that patients are equal partners in the relationship and that their circumstances and situations are respected. Interventions, specifically those related to self-care and behavior change, should be guided the reality of patients' lives. Clinicians should develop plans of care based on what the patients believe they can accomplish.

These initial conversations about the role of illicit drugs on medical conditions can provide a basis for more in-depth discussions about patients' addiction practices and interest in changing their circumstances. Clinicians should explore patients' readiness to change and discuss the roles, both negative and positive, that addiction and criminality play in their lives. Clinicians should ask patients directly about the support or assistance they would like from health care services and the clinicians themselves. In turn, clinicians 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, e.g. motivational interviewing and non-violent communication, and clinicians should become adept at least one approach and employ it regularly with this population (Miller & Rollnick, 2002; Rosenberg, 2005).

Consistent and concerned communication allows clinicians to gather information about the efficacy of prescribed interventions and creates opportunities for patients to discuss issues directly affecting their reintegration efforts without judgment or stigma. Such communication can provide the foundation for a trusting and long-term relationship between patient and provider, a rare thing in many parolees' lives. While the specific impact of meaningful clinical relationships on reintegration is not known, there is some

evidence to suggest that individuals who receive relevant and continuous care are less likely to be arrested than those who have not (Sheu et al., 2002; Vigilante et al., 1999). Therefore, health care could provide a venue for the development of positive relationships that have the capacity to sustain newly released individuals in their home communities for an extended period of time. However, further research is necessary to determine what qualities and components of the clinical relationship are most efficacious in addressing both the health care and reintegration needs of men on parole.

Implications for Policymaking and Future Research. It is clear from this research that men reentering society after a prison term need intensive support both immediately following release and over the longer course of their parole supervision. Many parolees face homelessness or reside in unsafe locations upon return to the community. This can be disheartening and individuals manage by coping with their circumstances via reengagement in their addiction disorders and criminal activity. Individuals assigned to a substance abuse treatment (SAT) program may fare better for a time. However, most SAT programs are of short duration with the longest programs lasting only six months. While six months programs are considered to be lengthy by the California Department of Corrections and Rehabilitation (CDCR), it is an insufficient period of time for individuals to replace deeply internalized negative patterns of coping with more effective ones, overcome their drug addictions, find stable employment and housing, and develop a new social support network. These are a daunting tasks for even the most intact individual and can seem impossible for those parolees with severe addiction disorders, mental illness and physical problems. Therefore, formerly incarcerated individuals could benefit from intensive and continuous support over the course of their parole commitment.

One such program provided newly released individuals with individual peer support from a successfully reintegrated former parolee. This program was supported by the California Department of Parole. The peers served as mentors to current parolees, escorted them to and from appointments, and assisted with practical needs such as housing and employment. While this program had a modicum of success, it was disbanded due to restrictions in financial support (S. Poe, personal communication, Summer 2007). There is evidence regarding the positive impact of peer support on rates of recidivism in the health care literature. Vigilante et al. (1999) found that a group of formerly incarcerated women receiving a peer support intervention, in addition to regular clinical care, had lower recidivism rates at three and twelve months than did the control group. Although this study was of women, the results indicate the importance of regular and long-term follow-up in assisting individuals to successfully transition from the institution to the free community. Therefore, reentry policy could benefit from considering the implementation of intensive peer support programs for individuals leaving prisons. Further research could aid in determining the most efficacious components of individualized support programs and the most appropriate venue for the delivery of such interventions whether it be a SAT facility, health care setting or parole department.

This dissertation research also revealed that the size and layers of bureaucracy of the medical institution overwhelmed many participants and limited their attempts to access clinical services. Therefore, smaller, decentralized clinics in locations where parolees regularly frequent, e.g. parole departments, job-training and educational facilities, counseling centers or SAT programs, may increase male parolees utilization of

health care services. Additionally, longer visits, such as 30 minutes as opposed to 15, would provide more individualized attention and opportunities for in-depth discussion regarding the challenges and difficulties patients may be encountering in the community. Extended clinical encounters would allow clinicians to understand patients' circumstances more fully and patients would have the opportunity to be heard. Longer visits could also increase the efficacy of clinical services, as there would be time to address several issues more completely. Finally, through longer and more frequent encounters patients and clinicians could more easily develop a trusting relationship with one another and potentially enhance the benefits of clinical care further.

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 reduce rates of recidivism and increase access to clinical services in incarcerated and formerly incarcerated individuals (Conklin et al., 1998; Rich et al., 2001; Sheu et al., 2002). For example, Conklin et al. described an integrated program that provided continuous clinical services for individuals incarcerated in the Hampden County Correctional Center both during their imprisonment and upon release. The program was developed in collaboration with the Massachusetts Department of Public Health, Tufts Dental School, Western Massachusetts Hospital, and the Hampden County Behavioral Health Network. Incarcerated individuals received physical and mental health services, health education, and intensive discharge planning prior to release. Upon reentry into the community, these individuals were assigned to one of four local community health centers where they received ongoing medical care and case management. These individuals frequently continued care with the same professionals who had seen them during their time in the

correctional facility. As a result of this collaborative program, the barriers to health care access were minimized and patients had the opportunity to develop long-term relationships with health care professionals. Additionally, the correctional facility and community clinics were located in close proximity to where released individuals resided. The geographic location of services further facilitated continuity of care.

This program's recidivism data was limited to the HIV-seropositive patients under its care (n=152). There was a decrease in recidivism rates for this group in comparison to the correctional facility's general population. While the authors were unable to determine the significance of this decrease in recidivism, their findings suggest the importance of continuous clinical services during and post-incarceration. Perhaps more importantly, this model demonstrates that collaboration between correctional institutions and health care agencies is possible. Such collaboration can provide a viable means of caring for individuals enmeshed in the correctional system while increasing opportunities for successful reintegration. Finally, such programs enhance formerly incarcerated individuals' access to clinical services. Increased access provides opportunities to support individuals' interest in their own health problems and more effectively address the complexity of their circumstances.

Results from this dissertation research also suggest the importance of increased access to health care services in managing health problems. In the present study, participants described how easily accessible and affordable care increased their interest in participating in clinical services. Although the services participants accessed were often inconsistently available, both as result of their criminal lives and of the availability of the services themselves, they responded positively to the services they received and actively

sought further care. Further study is needed to determine the impact of consistent health care services on reintegration. Intervention-based research can help define what types of clinical services and programs are most effective for this population. However, qualitative studies can further illuminate the intersection of illness and reincarceration. Such research would elaborate the patterns and practices of engagement with the health care system within the context of reintegration success and failure.

One of the most salient findings from this study related to participants' interest in accessing health care as a result of their age and their deteriorating health. Participants found they could not tolerate the harsh and violent conditions of street and prison life. They had grown weary of their addiction disorders and desired some sort of stability and balance in their lives. Participants were ready to change their lives, not only because they wanted to but because they had to. Therefore, many participants were open to engaging with the clinical services in a new way.

However, results from this study revealed that participants most commonly were discouraged by the health care they received. In many instances, participants felt that their personal motivation to resolve their health problems was not acknowledged either by individual clinicians or the system itself. Clinicians working with these participants may have perceived them as drug seeking and questioned the veracity of their interest in medical care. Clinicians also may have felt overwhelmed by the multiple difficulties these patients faced in the community. Therefore, clinicians' apparent recalcitrance may have been more related to their own sense of hopelessness rather than to any specific action on the part of the participants. However, a substantial portion of these men felt a sense of vulnerability. These new and unfamiliar feelings of fragility made them more

amenable to treatment and continued engagement with health care programs. These participants may have received the greatest benefit from health care services. Such improvements in their health, as a result of regular clinical care, may have positively impacted their reintegration efforts and helped them more effectively address their addiction disorders. While the results of this study cannot substantiate such claims, they do suggest the importance of relevant and timely care in middle-aged male parolees who are actively seeking ways to change their situations and leave their street and prison lives behind them.

Future research should examine effective ways to sustain men on parole's interest in improving their circumstances. Research should also explore at what point in the process of aging and street life that individuals become interested in change, i.e. do men need to completely breakdown before they want to change or does the process begin to occur earlier in their lives? Is their interest in change motivated more by their age or by their declining health status? A related research question could examine how to increase interest in change in men who are actively involved in their criminal lifestyle. Is there an effective point of intervention prior to their complete physical and mental exhaustion? Other research questions could include what clinical interventions and strategies are most efficacious in managing individuals' health problems and supporting their reintegration efforts. Finally, research efforts should begin to focus on the social determinants that impact formerly incarcerated individuals' lives in the free community. Limited education, income inequity and impoverished living environments impact individual reintegration efforts perhaps more than health care access. Therefore, research that emphasizes not only effective clinical interventions for reintegration but addresses the root causes of

incarceration has the greatest potential to increase the rates at which men on parole successfully achieve long-term stability in their home communities.

Chapter Conclusion

This dissertation research explicated the impact of participants' incarceration histories on their ability to function effectively in free society. It articulated the perceived barriers and facilitators to health care access. This study illuminated specific patterns of engagement with the health care system that influenced participants' perceptions of the efficacy of health care on their reintegration efforts. This study represented the complexity of participants' lives in their home communities and the multiple issues they encountered, i.e. drug addiction, poverty, and homelessness, in their attempts to remain in civil society over the long term. Participants struggled with diminished self-esteem and a lack of personal agency, which made it difficult for them to advocate for themselves in the health care arena or believe that they deserved anything more than substandard care.

As participants narrated their lived experiences, it became clear that there was no easy solution to their problems. The data revealed the complex circumstances behind participants' choices to engage in criminal behavior or to take up the use of illicit substances. This study revealed participants' enmeshment in the correctional system as well. For most participants, prison was not perceived as punishment but as a place where their basic needs were met and they had community and occasional success. Prison reflected what their life on the streets was not, i.e. stable, ordered, and purposeful. Therefore, a return to free community while always desired intellectually and emotionally was frequently not what was wanted in reality. Upon release from prison, participants

required a wide variety of supportive services for both the short and long-term. However, such services were often not available and participants found themselves alone and isolated from friends, family and the community in general.

If the needs of formerly incarcerated individuals are to be effectively addressed, then the systems engaged with these individuals must become integrated. Current research has demonstrated that integration between the correctional and community health care systems is possible and efficacious (Conklin et al., 1998; Rich et al., 2001; Vigilante et al., 1999). Such research suggests that multi-agency collaboration not only improves health care outcomes but increases opportunities for successful reintegration as well. This dissertation research also points to the positive impact of accessible care delivered in a respectful and empathic manner on health and reintegration. Therefore, system integration must become a priority if the rates of successful reintegration are to overtake those of recidivism.

Collaboration between the correctional institution and the health care system is not without difficulty particularly in states with high rates of incarceration, numerous prisons and that are geographically large. The integration of systems is further complicated by the different funding streams that underwrite the efforts and directives of prison and health care systems. Additionally, the political climate and public attitude towards the criminal population influence how seamlessly institutional change can occur. However, as evidenced by the Hampden County model, financial restraints and differing institutional objectives can be overcome to create an economically viable, efficient, and humane system of care (Conklin et al., 1998).

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 little or no support from either the parole or health care systems. Opportunities for success are limited even for the healthiest and most intact parolee and further restricted for those with chronic conditions and extensive incarceration histories. The health care system has the potential to be a positive influence in these individuals' lives. However, in order 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 integrate the problems and issues of long-term involvement in street and prison life into its evaluation and treatment of these individuals.

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APPENDICES

Appendix A

YOUR HELP IS NEEDED.

Are you a man, aged 40 to 65 years?

Are you on parole?

Do you have a physical and/or mental health problem?

If you answered yes to any of these questions, you may be able to be a part of a study.

The purpose of the study is to learn if health care can help men finish their parole. Elizabeth Marlow, NP is doing the study. She is a nurse practitioner and a student at UCSF School of Nursing.

You can participate in 2 ways:

- Do 2 private interviews with Ms. Marlow. You will be asked about your health care problems and your experiences with health care while in prison and on parole. You will be asked if you think health care can help you finish your parole. Each interview will be 1 to 2 hours long.
- Participate in 2 group interviews with 4 other men and Ms. Marlow. You will be asked about how health care may help you and other men finish their parole. You will be asked your experiences with health care in prison and on parole. Group interviews will be 1 to 2 hours long.

If you do take part in the study, Ms. Marlow will pay you \$20 cash after each interview. **YOU DO NOT HAVE TO TAKE PART IN THIS STUDY.** Your time at Seventh Step will not be affected.

Would you like to participate?

For more information contact Elizabeth Marlow at (415) 552-0932.

Appendix B

**UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

Study Title: The Impact of Health Care Access on the Community Reintegration of Male Parolees

This is a research study about how health care may help men on parole. The study researchers, Elizabeth Marlow, NP and Catherine Chesla, RN, DNS will explain this study to you. Ms. Marlow is a student at the UCSF School of Nursing. Dr. Chesla is her faculty advisor for this research study.

Research studies include only people who choose to take part. Please take your time to make your decision about participating. You can talk to your family or friends about this study. If you have any questions, you can ask Ms. Marlow.

You are being asked to take part in this study because you are a man on parole with a health problem.

Why is this study being done?

The purpose of this study is to learn if health care helps men finish their parole. Health care can be check-ups with a doctor or a nurse. Health care can be getting your pills or treatments quickly and cheaply.

How many people will take part in this study?

About 30 men will take part in this study. There will be 2 groups.

In the first group, about 10 or 15 men will be interviewed 2 times. In these interviews, Ms. Marlow will talk to 1 man at a time about his health and his experiences in prison and on parole. These interviews are individual interviews.

In the second group, about 15 men will be interviewed 2 times. In these interviews, Ms. Marlow will talk to 5 men twice about their health and their experiences in prison and on parole. These interviews are group interviews.

What will happen if I take part in this research study?

If you say yes to being in this study, here is what will happen:

If you say yes to do an individual interview, you will meet with Ms. Marlow two times. Each interview will take 1 to 2 hours. You will meet in a private room at Seventh Step or another location convenient for you.

If you say yes to do a group interview, you will meet with Ms. Marlow 2 times. You will meet in a private room with Ms. Marlow and 4 other men. The interviews will take 1 to 2 hours. You will meet in a private room at Seventh Step and another location convenient for you and the other participants.

Ms. Marlow will ask you how you take care of your health problems. She will ask you about your experiences with doctors or nurses while you were in prison or on parole. She will ask you if think regular health care could make it easier for you to finish your parole.

Ms. Marlow will ask you about other things in your life that made it easy or hard for you to finish parole.

Ms. Marlow will make a sound recording of your conversation. After the interview, someone will type the recording into a computer. Any names will not be typed into the computer. The recording will be destroyed after it is typed into the computer.

How long will I be in the study?

If you take part in the individual interviews, it will take about 4 hours total.

If you take part in the group interviews, it will take about 4 hours total.

Can I stop being in the study?

Yes. You can stop at any time. Just tell Ms. Marlow or a staff person right away if you don't want to be in the study.

Also, Ms. Marlow may stop you from taking part in this study at any time. This may happen if Ms. Marlow thinks it is not safe for you or if the study is stopped.

What side effects or risks can I expect from being in the study?

- The interviews take a lot of time and may be inconvenient for you. You can stop at any time.
- Some of the questions may make you uncomfortable or upset. You do not have to answer questions that make you uncomfortable or upset. You can end the interview or leave the group at anytime.
- You will be asked about your health problems. Health problems can be a sickness in the body like diabetes or high blood pressure. Health problems can be a sickness in the mind like depression or bi-polar disorder. Talking about your health problems may make you feel sad or blue. If you need to talk to someone about feeling sad or blue, Ms. Marlow has list of people that can help you. She will help make an appointment if you need to.
- If you have more questions, please ask Ms. Marlow.

Are there benefits to taking part in the study?

There are no direct benefits to you from being in the study. However, you will find that

1. You will get to talk about your health problems and health care experiences while in prison and on parole.
2. You can take part in a project that may help other men on parole.
3. You may feel that you are helping doctors, nurses and other people understand your health problems.
4. You may feel that you helping doctors, nurses and other people learn how to take better care of you and help you finish your parole.

What other choices do I have if I do not take part in this study?

You do not have to take part in this study. There will be no penalty to if you do not want to take part in this study. Your program at Seventh Step will not be affected.

Will information about me be kept private?

Ms. Marlow will do her best to make sure that the personal information gathered for this study is kept private. However, she cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

To help protect your privacy, Ms. Marlow has obtained a Certificate of Confidentiality from the National Institutes of Health. With this Certificate, Ms. Marlow cannot be forced to disclose information that may identify you, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings.

Exceptions: A Certificate of Confidentiality does not prevent Ms. Marlow from voluntarily disclosing information about you without your consent. For example, she will voluntarily disclose information about incidents such as child abuse or intent to hurt yourself or others. In addition, the Certificate does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If an insurer, employer, or other person obtains your written consent to receive research information, then the researchers may not use the Certificate to withhold that information. Finally, the Certificate may not be used to withhold information from the federal government needed for auditing or evaluating federally funded projects or information needed by the FDA.

Organizations that may look at and/or copy your research records for research, quality assurance, and data analysis include:

- UCSF's Committee on Human Research

What are the costs of taking part in this study?

You will not be charged for any of the study treatments or procedures.

Will I be paid for taking part in this study?

In return for your time and effort, you will be paid \$20 cash per interview for taking part in this study. You will be paid immediately after you complete each interview.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you in any way. You will not lose any of your regular benefits, and you can still get your care from Seventh Step the way you usually do.

Who can answer my questions about the study?

You can talk to Elizabeth Marlow, NP about any questions or concerns you have about this study. Contact Ms. Marlow at **(415) 552-0932**.

If you have any questions, comments, or concerns about taking part in this study, first talk to Ms. Marlow. If for any reason you do not wish to do this, or you still have concerns after doing so, you may contact the office of the Committee on Human Research, UCSF's Institutional Review Board (a group of people who review the research to protect your rights).

You can reach the CHR office at 415-476-1814, 8 am to 5 pm, Monday through Friday. Or you may write to: Committee on Human Research, Box 0962, University of California, San Francisco (UCSF), San Francisco, CA 94143.

CONSENT

You have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

If you wish to participate in this study, you should sign below.

Date

Participant's Signature for Consent

Date

Signature of Person Obtaining Consent

Appendix C

Interview Guide

Date of Interview: Interview #1 #2

Start time/End Time:

Location:

Interviewee's id#:

Age: Ethnicity: Dx:

Times incarcerated and lengths of incarceration:

Times Paroled:

Length of time for this current parole:

Specific Aim #1: Health Beliefs and Practices

Tell me about your health. (How has it been? How is it now?)

Can you tell me about your health problems? (How did they develop? What do you think or believe brought them on? Who/What contributed to your health problems?)

Tell me about the health care you have gotten in the past. How many times have did you use the prison medical system? Can you tell me about a time you used the prison clinic? (What led up to your going to the clinic? What happened once you were there?)

How do you take care of your health problems without regular care? Can you tell me a story about how you learned how to take care of yourself? (What lead up to learning how to take care of your self? Did someone teach or help you? Who/What has made it easier or harder to take care of your own health? Have you considered do any thing else or different?)

Specific Aim #2 – Perceived Barriers and Facilitators:

What kinds of (people/situations/circumstances/etc.) make it easy or easier for you to take care of your health problem(s)?

Tell me about a time when things went smoothly or well for you which made it easy for you to find a clinic or place that will help you take care of your health problems?. (What happened? Who was involved?)

Can you tell me about a time when it was easy for you to get health care? (What led up to this situation? What did you do? What kinds of things did you/others say or do to make this an easier time for you?) This story might be about a time when someone helped you make a medical appointment or helped with your medications?

What kinds of things (people/situations/circumstances/etc.) make it hard for you to take care of your health problems?

Can you tell me about a specific time you had difficulty getting health care? (What happened? Who was involved?)

Specific Aim #3 – Perceived Impact of Health Care Access

Do you think that regular visits with a doctor, nurse or clinic helps you stay in your community or on the street? Why or why not?

Have you ever felt like a doctor, nurse, social worker or other health care worker cared about you? What happened? Why did you feel this way?

Do you think that getting the health care you need could help you “give back your number” or complete your parole without any violations? Why or why not?

What other things do think would help you finish your parole or give back your number? Do think these things are more important than health care? Why or why not?

In what ways do you think that regular health care would or would not benefit you and help you complete your parole successfully? Can you give me an example?

Who or what else helps you when you are in your community or on the street? Your parole agent? A friend? A girlfriend? A family member? A support group?

If you could have anything at all to help you give back your number and stay out of prison forever, what would it be? Why do you think it would help you?

Specific Aim #4 – Specific Circumstances

How do you see yourself in relation to the time you have spent in prison and on parole? How has being incarcerated and on parole shaped your picture of yourself?

Does health care play any part in how you see yourself? Why or why not?

Psychosocial Resources

Alameda County Parole Outpatient Clinic
(510) 577-2407

ACCESS Mental Health Program
(800) 491-9099

Alameda County Mobile Crisis team
(510) 981-5254

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Date