Health Care after Incarceration

How Do Formerly Incarcerated Men Choose Where and When to Access Physical and Behavioral Health Services?

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February 2018

Most people leaving prison have at least one chronic problem with physical health, mental health, or substance use (Mallik-Kane and Visher 2008). These health problems make it harder to successfully reintegrate into the community after incarceration—affecting people's ability to avoid offending and maintain employment, housing, family relationships, and sobriety. Historically, most people returning from prison lacked health insurance, impeding receipt of care for chronic health conditions and leading to high levels of emergency room use. The option to expand Medicaid under the Affordable Care Act created an opportunity in many states to connect large numbers of returning individuals with health coverage. As states and localities increasingly meet that challenge of enrolling people returning from prison and jail in Medicaid, the question of what factors other than having or lacking health coverage affect people's decisions to access health care in the community takes on greater importance.

The Urban Institute's recent study in Connecticut, an early adopter of Medicaid expansion, found high rates of existing Medicaid coverage among those entering jail (Mallik-Kane et al. 2016), suggesting that coverage expansion had been successful in expanding access to health coverage among justice-involved people. The study tracked the Medicaid services used by those who entered and left jail with Medicaid coverage intact. While nearly all (90 percent) received some outpatient services, two-thirds also used the emergency department. Importantly, half the population had substance abuse treatment needs, but only 18 percent used Medicaid-funded substance abuse treatment services after release.

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Coverage alone may not be sufficient to ensure that formerly incarcerated people access and engage with the types of health services needed to manage their chronic health conditions. Connecting reentry populations with appropriate postrelease health services to manage chronic health conditions is challenging, even when the health conditions are very serious (Baillargeon et al. 2010). Reentry from incarceration is a difficult transition, and health management is often a low priority as people grapple with more basic survival needs (e.g., food and housing), reconnecting with family members, and finding employment (Mallik-Kane 2005).

Returning individuals' perceptions of health and health care in the reentry process remain insufficiently understood. While previous research found that returning individuals rated health as less important than other reentry needs, little is known about the decision factors that prompt returning individuals to seek care. Moreover, we do not know how people navigate the health care system to obtain care, and what internal or external barriers they face. An improved understanding of returning individuals' care-seeking behaviors and perceptions would help in developing more effective efforts to facilitate connection to needed care in the community. We designed this exploratory qualitative study to build upon our prior research in Connecticut on jail-based Medicaid enrollment and to learn more about how recently released men[1] made decisions about seeking health care services for physical, mental health, and substance use issues.

The Connecticut Men's Health Reentry Study

This exploratory interview study of men returning from incarceration in Connecticut was designed to address the knowledge gaps on how people returning from incarceration decide whether and how to access health care by answering four overarching questions:

- What is the decision landscape for justice-involved people seeking health and/or behavioral health care?
- Do the barriers to care result from a lack of knowledge about how to obtain care; low prioritization of health care among competing life tasks; nonrecognition of the need for treatment; or other reasons, such as cost, location, and staff?
- Do justice-involved people see a connection between their unmet health and behavioral health needs and their criminal justice involvement?
- Who do justice-involved individuals trust to help them access care and treatment?

Between May and August 2017, the research team conducted qualitative, semistructured interviews with 30 study-eligible men. We sought to recruit interview participants who were most likely to need to access health care services soon after release. Men with health needs were identified using Connecticut Department of Corrections (DOC) threshold scores for service receipt during incarceration. Connecticut DOC assigns classification scores on a scale of one to five based on the severity of people's medical, mental health and substance use treatment needs. The study team

recruited men with at least one score—medical, mental health, or substance use—of three or above. Those with medical scores of three and above needed regular access to nursing care during incarceration and were targeted for clinical discharge planning services.[2] People with mental health scores of three and above required medication or other treatment services during incarceration and were targeted for clinical discharge planning services.[3] Similarly, those with substance use scores of three and above had moderate to severe substance use problems and were eligible for DOC facility-based intensive outpatient or residential treatment programs.[4]

Study recruitment and interviews were conducted by professional interviewers employed by the University of Connecticut School of Social Work, Department of Mental Health and Addiction Services Research Division. The research team coordinated with the Connecticut DOC and its Division of Parole and Community Services to gain access to study-eligible individuals. Using a query of the DOC's management information system, the research team identified men with health needs who had been released to the community one to six months earlier and were currently under parole supervision in Hartford, Connecticut. Parole officers referred eligible individuals to the study team after completing their routine parole reporting appointment. Most interviewees (26) were recruited in parole offices, but 4 interviewees were recruited directly from correctional facilities and interviewed one to two months after release. Individuals recruited in parole offices were given the option to complete the interview immediately or schedule another time in a community location, such as a coffee shop or library; and individuals recruited before their release were asked to schedule a time to meet in a community location. Study interviews occurred an average of 2.3 months after release from jail or prison. A $25 cash incentive was offered to maximize participation.

The research team employed a semistructured interview guide for all interviews, which covered self-assessment of health needs, health care receipt after release, health insurance coverage, reasons for seeking or not seeking care, decision factors when seeking care, overall reentry concerns, and DOC assistance with health and reentry issues. Additionally, respondents who had not received care were asked hypothetical questions about what would cause them to seek care and how they would go about accessing it. Interviews were audiorecorded and transcribed verbatim. Interview transcripts were coded and analyzed by Urban researchers using a coding structure incorporating all elements of the interview guide. Thematic categories were developed for items to support quantitative analysis. Selected information from the recruitment list was then appended to the coding spreadsheet, including each person's length of stay, the time from release to the interview, and the DOC's in-prison assessment of their health needs.

Study Participants

Characteristics of the 30 men who participated in study interviews are summarized in table 1. The same attributes of the study-eligible population are included for comparison. Overall, the men interviewed were similar to the general population of male Hartford parolees with DOC-indicated health needs along the dimensions captured in DOC data. According to DOC's assessment, the most prevalent need area is substance abuse; 28 of 30 study participants had moderate to severe substance abuse treatment

needs. Nearly one-fifth had medical needs, as defined by a DOC score of three or above; just over a quarter had less severe chronic health needs. One-tenth had mental health treatment needs, as defined by a DOC score of three or above; but more than one-third (12 of 30) had milder or past mental health needs, or a DOC score of two. The vast majority had a Department of Social Services (DSS) number on file with the DOC, indicating prior receipt of Medicaid or other DSS-administered safety net services.

TABLE 1

Characteristics of the Study Population

	Study participants (*n* = 30)	Study-eligible men (*n* = 289)
Age (median)	32 years	34 years
DOC needs score of 3+		
Medical	17%	25%
Mental health	10%	12%
Substance use	93%	94%
Lifetime history of Medicaid or DSS benefits	77%	80%
Sentence imposed >I year	73%	78%
Time served (median)	17 months	15 months
Time served <1 year	33%	44%
Expected time on parole (median)	10 months	8 months
Most common conviction offenses	Supervision viol., 27% Selling narcotics, 17% DUI, 7% Possess narcotics, 7% Conspiracy, 7%	Selling narcotics, 25% Supervision viol., 18% DUI, 7% Possess narcotics, 5% Larceny, 3rd degree, 3%
Criminal history		
Any prior incarceration	93%	86%
Total lifetime incarcerations (median)	6	5

Source: Urban Institute analysis of study recruitment lists generated by the Connecticut Department of Correction Management Information System.
Notes: Study-eligible men were all parolees with a DOC health needs score of 3+ supervised out of the Hartford parole office. DSS = Department of Social Services.

Self-Reported Health Status

To understand how interview respondents viewed their health needs, we asked them about their overall perception of their health, and specifically about their level of health needs around drug or alcohol use, mental health, and physical health issues, which could include dental, vision, or other specialized care needs. Despite the levels of need for care in the respondent population, as determined by DOC, about three-quarters of respondents rated their overall health as excellent, very good, or good. Only about one-quarter reported being in fair or poor health. Two respondents reporting fair or poor health connected their rating to specific injuries, while another two connected their rating to stress and mental health issues. When asked about needs in more specific health and behavioral health categories, however, about three-quarters of interviewees (22) felt they had at least one physical health, mental health, or substance use problem, including about one-third who reported having two or more types of issues.

TABLE 2

Respondent Self-Reported Needs Relative to DOC Needs Scores

N = 30

	Self-Reported Needs			
	Yes	**No**	**Missing**	**Total**
DOC Drug and Alcohol Score				
(1 = No need, 5 = High need)				
2	0	2	0	**2**
3	5	12	1	**18**
4	2	5	0	**7**
5	2	1	0	**3**
Total	**9**	**20**	**1**	**30**
DOC Mental Health Score				
(1 = No need, 5 = High need)				
1	2	13	0	**15**
2	5	7	0	**12**
3	2	1	0	**3**
Total	**9**	**21**	**0**	**30**
DOC Medical Score				
(1 = No need, 5 = High need)				
1	8	9	0	**17**
2	3	4	1	**8**
3	4	0	0	**4**
4	1	0	0	**0**
Total	**16**	**13**	**1**	**30**

Source: Urban Institute analysis of interview data and study recruitment lists generated by the Connecticut Department of Correction Management Information System.

About one-third of participants (9) acknowledged during the interview that they had ongoing drug and alcohol issues, a much lower proportion than had a DOC Drug and Alcohol score of three or more (see table 2).[5] Of those indicating drug and alcohol issues, two described more active struggles with addiction, reporting that they self-medicated with substances daily or every other day. Most interviewees (20), however, said they did not have drug or alcohol issues, though some were receiving substance use treatment services. Some respondents reported having *past* drug or alcohol issues.

The same proportion of respondents (9 of 30) felt they had ongoing mental health needs, but in this case that level of need was greater than indicated by a DOC mental health score suggesting moderate mental health needs (score of 3), although 12 were indicated as having milder mental health needs by the DOC.[6] Most people who self-reported mental health issues had been rated with lower level needs while incarcerated. The types of conditions they mentioned included attention-deficit hyperactivity disorder (ADHD), autism, post-traumatic stress disorder (PTSD), anxiety, and depression. Two respondents specifically linked their mental health issues with the challenges of reentry, for example, "It's just so stressful, so I need a professional point of view on how to cope with life and re-entry back into the community." The remaining two-thirds of participants did not feel they had mental health issues.

More than half (16) of interview respondents reported having some type of physical health condition. This included everyone that the DOC had rated as having serious health and discharge planning needs, as well as one-half those assessed with a score of two, indicating less serious or non-chronic physical issues. Those with the most serious needs reported seizures, back problems, stomach problems, high blood pressure and high cholesterol. Others mentioned issues such as chest pains, dental problems, sleep disturbances, and injuries.

It should be noted that DOC's health scores are intended to determine the level of specialized care needed while incarcerated, and the care need could be different by the time of release. Nonetheless, the observed divergence between the DOC scores and individuals' assessments of their own health are an intriguing finding.

Health Care Received

All but five of the interview participants reported receiving some type of health care service in the time since release, which it should be noted was a relatively short period (2.3 months, on average). Researchers first asked respondents about emergency room usage, then about care or services for substance abuse, mental health and other (physical) health issues, and finally about use of prescription medications.

Only two respondents reported using emergency room services since release. One had been transported by halfway house staff to the ER due to experiencing severe chest pains, while the other individual had visited the emergency room twice in less than two months since his release, explaining that he "didn't know what was going on so I just went to the emergency room." This second individual had been identified by the DOC as having chronic medical needs during incarceration.

Most respondents (19) had received some form of drug and alcohol services in the months since release. Participants reported receiving a wide range of service types, most commonly by attending groups such as intensive outpatient, relapse prevention, Narcotics Anonymous, and Alcoholics Anonymous. Others described seeing a counselor or therapist or a psychiatrist. Relatively few interviewees specified where they received services, but these providers included behavioral health clinics as well as the Veterans Administration, a halfway house, the hospital, and other community service providers. Correctional authorities played a particularly strong role in prompting people to seek drug and alcohol services. Of the 19 interviewees who had accessed services, 12 specified that they had done so because of parole or probation, and one because of a halfway house policy. This role of correctional authorities in connecting people to drug and alcohol services likely accounts at least in part for the fact that over half the respondents receiving such services did not self-identify as having current drug or alcohol issues (see table 2). Five of these men related their current substance use treatment participation to past rather than current problems. As one said, "When you come out of jail, you get stipulated to a CRT program... you get evaluized in [prison name] and they tell you what programs to take...I don't have no addiction or nothing, so I'm guessing they have me there because [of]…drug dealing." Only five participants described seeking treatment services because they felt it was necessary.

Nine respondents reported receiving mental health services, all but one on an ongoing basis. Six participants accessed mental health services at the same provider where they received drug and alcohol treatment; likely because providers, particularly parole-related programs like CRT, provide both types of services. Other participants reported receiving mental health services through the Veterans Administration, a psychiatrist, and a private therapist. Everyone who received mental health services also reported receiving substance use treatment services. As with drug and alcohol services, parole was most commonly identified as a reason for accessing mental health services (four respondents), though for mental health parole officers more often played an encouraging or helpful role rather than mandating services. Unlike with drug and alcohol services, respondent self-perception of mental health needs played an important role in why they sought services. For example, one person described going after noticing similarities with a family member's mental health condition: "I went to check myself…and they started giving me medication…if they coulda given me this when I was younger I could just imagine where I'd be right now. Like it woulda helped me so much, you know what I'm saying?"

Twelve respondents had received services for physical health needs, both in reaction to specific health issues and in a more proactive context. Several participants expressed a desire to have their health checked after being incarcerated, even if they did not have any immediate health issues; of the four participants who got a physical or bloodwork done after release, three specified the desire to get themselves to check on their health generally, while the fourth was required to get a physical by his employer. Another had established a primary care physician with the intent of getting a checkup. Similarly, one participant had gone to the dentist because "in jail you don't get great services," while two participants who were waiting to have insurance coverage noted that they wanted to get a physical once insured. Outside of getting a physical, several participants reported seeing a doctor to address specific health issues, such as injuries, chronic back issues, and a chest cold. Participants who did not receive physical health care generally indicated that they would seek such care in response to an injury or illness, but less often for general health maintenance. Respondents said they would go for reasons such as being sick (9 respondents), injured (9), generally feeling a need to go (5), or experiencing pain (3).

Finally, nine participants had received prescription medications since release. Three participants identified a need to see a doctor to renew a prescription, and two had already done so. One specified that this was for pain management: "I just needed to get my pain meds back. Because before I was incarcerated…usually just using street drugs to deal with the pain in general...Or I would go out to a store and just buy my own ibuprofen, but it wasn't the same."

TABLE 3

Services Received Relative to Self-Identified Need

N = 30

	Received Services since Release			
	Yes-episodic	**Yes-ongoing**	**No**	**Total**
Self-identified drug and alcohol needs/issues				
Yes	2	5	2	**9**
No	2	9	9	**20**
Missing	0	1	0	**1**
Total	**4**	**15**	**11**	**30**
Self-identified mental health needs/issues				
Yes	1	6	2	**9**
No	0	2	19	**21**
Total	**1**	**8**	**21**	**30**
Self-identified medical (physical health) needs/issues				
Yes	8	0	8	**16**
No	3	0	10	**13**
Missing	1	0	0	**1**
Total	**12**	**0**	**18**	**30**

Source: Urban Institute analysis of interview data.

Barriers and Facilitators to Accessing Care

With these findings on perceptions of care needs and access to care in the immediate prerelease period in mind, we now turn to the themes that emerged from the interviews regarding how the interview respondents think about whether and how to access health care services and the barriers and facilitators to doing so.

Most Had Health Insurance and Found It Easy to Use, but Lack of Coverage Was a Barrier for People Released without It

As expected, a large majority of interview participants reported having insurance coverage at the time of the study interview. Of the 30 people interviewed, 25 had insurance: 23 through Medicaid, 1 through an employer, and 1 through the Veterans Health Administration. Over one-third of those with insurance (12) reported DOC or transitional services playing a role in assisting them with obtaining insurance. Those with coverage generally felt the process of getting insurance was straightforward, and most were covered very soon after release. Most participants (24) reported that they had at least *applied* for insurance within one month after release, typically receiving coverage within a few weeks or less of applying. Participants sometimes equated receiving coverage with receiving a physical Medicaid card in the mail, and some interviewees believed they needed to receive their insurance card before they could access services. It is unclear whether this is a misperception on the part of interviewees or if they have

had experiences with providers who refused to schedule or provide services until they could present proof of coverage.

Most participants with coverage described their insurance as easy to use. While insurance was not always explicitly acknowledged as a facilitator to care, cost was notably absent as a barrier to care among people with coverage, and several participants mentioned that they did not have copays for care. However, two interviewees noted that cost remained a concern despite having insurance coverage, and remained wary of having to pay out of pocket for services that weren't covered (e.g., dental care). As interviews were conducted less than six months after release, no interviewees had yet encountered the need to do an annual re-certification for Medicaid. However, one participant anticipated that he would lose coverage since his income had increased and was now too high for Medicaid eligibility.

By contrast, the five interview participants without insurance were more likely to describe delaying or not getting care. Of the five individuals who reported that they had no insurance, two had not applied. Both had been released two or more months before the interview and indicated that competing priorities and lack of time had prevented them from applying. As one described his situation, "I just haven't had the time to go down to DSS because I'll be there for hours and I don't have hours to spare, really." Despite being uninsured, four of the five reported receiving some form of ongoing drug and alcohol services, and one person described getting some mental health counseling. However, none had accessed physical or medical health services or prescription medications since release.

Care Experiences during Incarceration Were Profoundly Negative

Interviewees raised negative memories and opinions of the health care provided in jails and prisons as a point of comparison with services they have received since release. People perceived being treated as "second-class citizens" while incarcerated and related stories of not being trusted, complaints not being taken seriously, and poor care. Although interviewees did not express any reluctance to seek health care based on their DOC experiences, lingering negative perceptions may influence their willingness to seek non-emergency care.

One respondent focused on a lack of individualized responses to health problems: "I hate when they treat you as everybody else. So that's the one thing I didn't like...Just people are different…Like when you're in DOC, if you've got a similar problem with that guy, they just go along with your guys as the same person." Another respondent perceived disrespect, a lack of professionalism, and poor access to care. "Like the health, the doctors, they're all a joke.... They don't, they don't care… You, as a health care provider, you *chose* that job, you chose to go into that field. I mean, can't hold that against somebody because they're in jail." Another respondent described the perceived lack of trust medical providers had in people in prison: "They think everybody's lying if you have an issue, they seem to always think, because there are people that lie about things for whatever reason to get out of their cell or whatever. …So it kinda deters people from really getting the help that they probably need."

Perceptions of Care Received in the Community Were Generally Positive

Many participants had positive views of the health care they received in the community, views that seem likely to facilitate future engagement with care. Positive experiences were discussed across the full range of service types, including physical, mental health, and substance use treatment services (including participants who did not feel they needed substance use services). Participants felt they received good care along a few different dimensions of quality. First, many (11) participants felt that the care they received was effective or helped in some way. For physical care, this often meant addressing a discrete physical issue such as "it's going to take away the pain." One respondent commented that his dentist was, "willing to address the issue by all means, and… it was something that I wasn't used to." Eight participants commented that drug and alcohol treatment helped them to learn about themselves and addiction: "Just that, to learn more about myself…. What's triggering my, you know, drug addiction and why I keep going back to it."

Most interviewees had positive views of providers in the community as approachable, caring, and helpful, which they directly contrasted with their negative views of jail and prison providers. Staff respect and concern for clients created positive perceptions of care, and respondents valued providers who listened to them, regarded them as unique individuals, demonstrated caring attitudes, treated them with trust, and were non-judgmental. A respondent described an important positive relationship with a behavioral health provider in this way: "What I liked the most was the fact that they was able to assure me that I wasn't like far *gone* after being incarcerated for so many years." Another emphasized the importance of care providers who are invested in the people they serve: "Make sure you hire... people that really want to make differences in people's lives. Because some people are just there to get a paycheck every week or every other week. But if you have someone that actually cares…you know, believes in humanity, and it's not what's on the outside, it's what's in the inside, I think you can make a lot of felons, or any offenders, even re-offenders, succeed and strive down the road." One respondent, in particular, expressed a preference for VA services because of the cultural competence around veterans' issues: "I liked there's all veterans there. A lot of people that work there are veterans. You're respected and treated different than a regular hospital."

Criticisms of care in the community, when they did emerge, were typically minor and consistent with longstanding quality concerns among the general population (Ware et al. 1983). A few interviewees discussed wait times to get an appointment or to see a doctor, one felt care was generally not helpful, one noted that his primary care provider was "pretty pushy when it comes to payments," and one expressed discomfort with the crowds in walk-in clinic waiting rooms ("to me it's an uncomfortable feeling to have other people there"). Some participants also voiced a more general aversion to seeing doctors or hospitals, with comments such as, "everybody gets scared when they go to the doctor," "[I don't like] the shots," "I don't like it but I need it," and "I don't like hospitals period—it reminds me of death."

Parole and Other DOC Efforts Facilitated Much of the Care That Men Received after Prison

Parole, and DOC generally, facilitated post-release access to care through a combination of prerelease enrollment assistance, mandated substance use treatment services, referral to substance use treatment services, and subsequent mental health treatment referrals from parole officers or parole-facilitated substance use treatment programs. The role of correctional authorities in propelling people to seek drug and alcohol services was underscored by the two interviewees who reported not being on any form of supervision. Neither had received any drug and alcohol services since release, and both compared this to previous times in their lives when they had been required by parole to do so.

Parole was the main connection to drug and alcohol services: however, this is a complicated relationship, and there is a need to better understand how mandating treatment affects long-term propensity to continue care. Some people expressed that they only needed to be abstinent until their parole was completed. A sizeable share of the men who received substance use treatment services denied a need for such services. Seven participants specified that treatment was mandatory or "forced," while others described parole officers taking on a more service-oriented role in connecting them to services, using words such as "referred" and "recommended." Participants who described their parole officer "referring" them to care as opposed to mandating treatment seemed to hold more positive attitudes towards treatment. Denial of need is commonly discussed in the substance abuse literature (Connors et al. 2013); for individuals on parole, the risk of additional supervision requirements, monitoring or sanctions may also be a strong disincentive to acknowledge a need for care.

Substance abuse services, whether mandated or referred, sometimes led to connections with mental health and other health services. The availability of interdisciplinary, "one stop shop" service providers played an important role in these instances since Hartford parole officers typically referred individuals to community agencies that offered multiple services. Without such co-located interdisciplinary providers, the extent to which people accessed subsequent mental health and reentry services after an initial treatment referral would likely have been far less. Notably, every person who received mental health treatment was also receiving substance use treatment services.

Health Was Not Seen as Linked to Recidivism Risk

The majority of respondents did not believe that physical health, mental health or substance use affected their chances of returning to prison or jail. Notably, few respondents listed physical or behavioral health issues among their greatest reentry challenges, or overtly connected them to their more pressing reentry concerns. Researchers asked respondents how their health might affect *their* chances of going back to jail, and probed specifically about mental health and substance use history as well to get their comprehensive view on physical and behavioral health issues. The majority did not think any of these dimensions of health would have any bearing on their recidivism risk; many simply said no. In a representative response, one respondent said: "My health? I don't think it has nothing to do with going back to jail." When discussing the relationship between health and recidivism in general,

about one-third of respondents (10) thought physical and behavioral health conditions could affect a person's chances of returning to prison or jail. Of these, people most often associated substance use problems with recidivism risk (9 respondents), but 4 people perceived their mental health had a connection and 3 people felt that health generally could affect recidivism.

Whether People Had or Knew How to Find a Usual Source for Routine Care Varied

One-third of respondents (11) said they had a usual source from which they accessed care before their incarceration for at least one type of need, and eight had received services from a usual care provider since release. Of these, a majority were physical (i.e., medical) health care providers, including primary care physicians (6), hospitals and clinics. Fewer participants had a usual source for behavioral health services, and in general, even those that were familiar with a particular clinic, doctor, dentist, or therapist needed to find additional providers to meet other health needs.

Other respondents reported a lack of knowledge of how to find a primary care provider, with some saying they would turn to family members and others in their lives for referrals and advice. Interview participants, including those who had *not* received a particular type of care, were also asked hypothetically where they might go for care and how they would find a provider. These responses highlighted some gaps in knowledge: for example, when asked where they would go for non-emergency health issues (e.g. sick, non-emergency injury), respondents referred to the emergency room (8) and/or hospital (4), and three did not know where they would go. Six specified that they would go to a primary care doctor and four to a clinic, and others listed nonspecific answers such as "a doctor's office." Two participants said that they would go to family members first before seeking services. For a checkup, respondents more often said that they would go to a clinic (7), primary care doctor (7), or hospital (4), though once again some did not know.

Many Respondents Expressed a Preference for Emergency Room Services

A sizeable minority of respondents expressed a preference for accessing care in emergency rooms, due to the immediacy of attention, perceived care quality, and disinclination to wait for an appointment. While only two used the emergency room, about one-quarter of respondents said that they would go there for non-emergency health problems or even a checkup. While participants sometimes acknowledged that this was not ideal (e.g., one did not have insurance and felt this was the only option, others wanted to find a primary care physician), others indicated that this was normal or preferable. One participant explained: "We [my family and I] not gonna…get an appointment, which is gonna be a couple weeks… We gonna go to the emergency room, see what's going on, and then make an appointment. 'Cause at the ER, they're going to tell you what's really going on at that moment." Another participant said he "liked that I had everybody's attention, that everyone was trying to get to the problem. Unlike the DOC… I liked that a lot."

While some respondents indicated they would use walk-in and urgent care clinics for similar reasons of immediacy and effectiveness of care delivery, it appears that knowledge of this option is limited relative to need. This inclination to use the emergency room is likely consistent with a lifetime

history of such care-seeking behavior; a study in the general population suggests that emergency room usage may increase once people gain access to Medicaid coverage (Taubman et al. 2014).

Families Were an Important Source of Motivation and Information for Getting Care

Participants' social networks and relationships played an important role in helping them decide to access care of various kinds and find service providers. As described previously, most participants who accessed care found their provider by asking another person in their life rather than through independent information searches or other means. Of the 25 participants who received health services after release, 19 identified other people in their life who had provided referrals, encouragement, or advice to seek care, and eight cited multiple people who had done so. Interviewees received encouragement to seek care from parole officers (10), family (6), friends (2), employers (2), behavioral health providers (2), and others. Many interviewees wanted to avoid a return to prison so they could remain present, involved, and connected with their family members and said they would heed family members who advised them to get treatment.

Similarly, people who had not accessed care said they would also seek referrals from people they knew. When asked how they would find a provider if they needed one, interviewees most often felt that they would ask someone familiar for a formal or informal referral (7), such as a family member, friend, parole officer, or current provider.

Employment and Other Reentry Priorities Created Real and Perceived Logistical Barriers to Care

Decisions regarding how and whether to access health care occur in the context of a challenging reentry process in which many reintegration needs need to be met. Respondents had difficulties, in general, prioritizing and scheduling health care around other obligations—in particular, work, parole reporting, and family commitments. The greatest share of interview respondents (17) reported that employment was their most significant challenge, with seven specifying that they were currently unemployed. People returning from incarceration are often a hard-to-employ population due to criminal history and generally low skill levels, and respondents were very concerned about gaining and maintaining employment. Several of the 13 respondents who were employed noted that it could be difficult to schedule health appointments around work, and/or that they delayed seeking care because they may have to miss work. This was true sometimes even for more acute needs—for example, one respondent described delaying surgery out of concern for missing work, yet eventually got the surgery because his injury was preventing him from working in any case. Those who were not working were nonetheless anxious about finding work and expressed similar concerns about devoting time to accessing health care. Employment concerns *occasionally* facilitated getting health care, when people needed physical exams or other health care (e.g., treatment of injuries) to gain employment.

About one-third (9) of participants felt their greatest worries or challenges centered around family, including five who were worried about their relationship with their children. Additionally, family was the most commonly reported motivation for avoiding a return to prison, with about one-half of respondents

(16) identifying this as the most important factor. (Having a positive social network and other forms of social support was also identified by four participants.) One respondent stated: "Well my family is the most important thing because they support me. The kids are happy I'm home and I'm staying home." While family obligations, as noted above, could present a difficulty in finding time for health care appointments, thinking about the family could be a motivator for seeking care as needed and a source of trusted advice regarding ways to access care.

Finally, about one-third identified housing as an area of concern. Four respondents indicated that housing was a major challenge or that they were currently homeless, and an additional five were in uncertain or temporary housing situations. Housing instability could reduce care access by crowding it out as a priority, as well as by interfering with things like receiving a Medicaid card through the mail.

Implications

Justice agencies around the country like the Connecticut DOC have devoted substantial resources to ensuring that people leaving incarceration have health insurance. This is done in the hope that coverage will facilitate access to care, supporting mental and physical health, sobriety, community reintegration and recidivism reduction. But coverage is not sufficient to ensure access to care or to care in the optimal settings. The interviews discussed in this brief shed light on the thinking of 30 men who had recently left incarceration regarding whether, when and how to access health care services, which in turn can help better inform reentry and care coordination efforts.

Our recruitment strategy used DOC care need scores to identify a population of people returning from incarceration likely to have a particular need to access health care services in the community. Our findings indicate that the views of our respondents regarding the services they need diverge from those of DOC, at least as reflected by the need scores. This is particularly true for drug and alcohol services, which many of the interview respondents were receiving despite indicating that they did not need them. This is important in light of the strong role that parole played in connecting our respondents to services, particularly for substance abuse and mental health. Without taking a position on whether respondent self-report of DOC scores more accurately reflect the reality of need, this disconnect raises two possible issues: either parole is "over-prescribing" substance abuse services, or parolees with substance use or dependency issues do not perceive themselves in need of services. Worth noting here is that interviews were often conducted at the Hartford parole office, albeit in private rooms, and this may have led respondents to deny or downplay drug and alcohol issues due to fear of punishment or to avoid further stipulations.

This potential disconnect between how the DOC and respondents assessed care needs takes on added significance given how large a role parole plays in connecting people to services and care, through both mandates and referrals. It highlights the importance of assessing service needs correctly at the time of reentry and a complementary need to help the people who are referred to care recognize the necessity and value of treatment services so they will stay engaged after the requirement to comply with parole conditions ends. For populations not under supervision for whom there is presumably less

service engagement, particularly for behavioral health services, it may be important to develop engagement strategies that involve family members so they can help returning individuals make decisions about accessing appropriate care.

Finally, it seems that many of the men participating in our interviews would benefit from more information about care options and navigating the health care system. For example, the preference among a substantial subset of respondents for accessing care via emergency rooms for non-emergency situations could well result in inefficient and unnecessarily expensive provision of care. At the same time, the attributes of emergency room care that are appealing (immediate and focused provision of care) also characterize more appropriate care settings such as walk-in clinics and urgent care. In terms of preventive and ongoing care, several respondents appeared to need guidance in securing a primary care provider. Connecting people returning from incarceration to trusted information sources to help them navigate the complex decisions that go into health care access could be a key strategy to fully realize the anticipated benefits of health coverage for returning citizens.

Notes

1. The study focused on men because they make up approximately 90 percent of all returning individuals. Budget constraints did not permit sufficient data collection and analysis to fully address how women may perceive and seek health services differently.
2. People with less severe or some well-controlled chronic diseases did not meet this threshold and received a score of two.
3. People with past diagnoses or mild mental health disorders did not meet this threshold and received a score of two.
4. People with slight substance abuse histories who could benefit from a brief substance abuse intervention did not meet this threshold and received a score of two.
5. Note that interviewers did not have prior knowledge of individuals' DOC health needs scores. The research team made a deliberate choice to obtain participants' perceptions of their health and base interview questions on this self-assessment. We did not want to put participants on the defensive and jeopardize rapport by asking them to comment on discrepancies between their self-perceptions and the DOC's assessment. Moreover, DOC scores as recorded in the management information system were subject to error if assessments were outdated or information was not updated in a timely manner.
6. These 12 individuals had a mental health needs score of two, indicating mild symptoms or past diagnosis of mental illness.

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Acknowledgments

This report was funded by the US Department of Justice, National Institute of Corrections and the US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (NIC Award 15PR03GKT1). We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at http://www.urban.org/aboutus/our-funding/funding-principles.

We are deeply grateful to the Connecticut Department of Correction for providing us with access and logistical support to conduct the study. We would especially like to recognize the leadership and contributions of Colleen Gallagher, Patrick Hynes, Mary Lansing, Eric Ellison, Margo Testa, Rhianna Gingras, Suzanne Kiniry, Patricia Kupec, Jazmin Molina, Jeffrey Jones, Carmen Farrow, William Faneuff, Daniel Murphy, Grace Lee, and Lynne Neff. We would like thank the University of Connecticut School of Social Work, Department of Mental Health and Addiction Services Research Division team, especially Wendy Ulaszek, Juliany Polar, and Eleni Rodis. Akiva Liberman and Rob Santos provided methodological advice. Akiva Liberman also conducted a helpful review of the initial report manuscript. Travis Reginal assisted with coding interviews and editing this report. Linda Mellgren, consultant to the Office of the Assistant Secretary for Planning and Evaluation, provided the impetus for this study and advice throughout the project; we are incredibly grateful for her leadership and guidance. Finally, we are deeply indebted to the 30 interview participants who shared their time, personal experiences, and insights with us; this research would have been impossible without their contributions.

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